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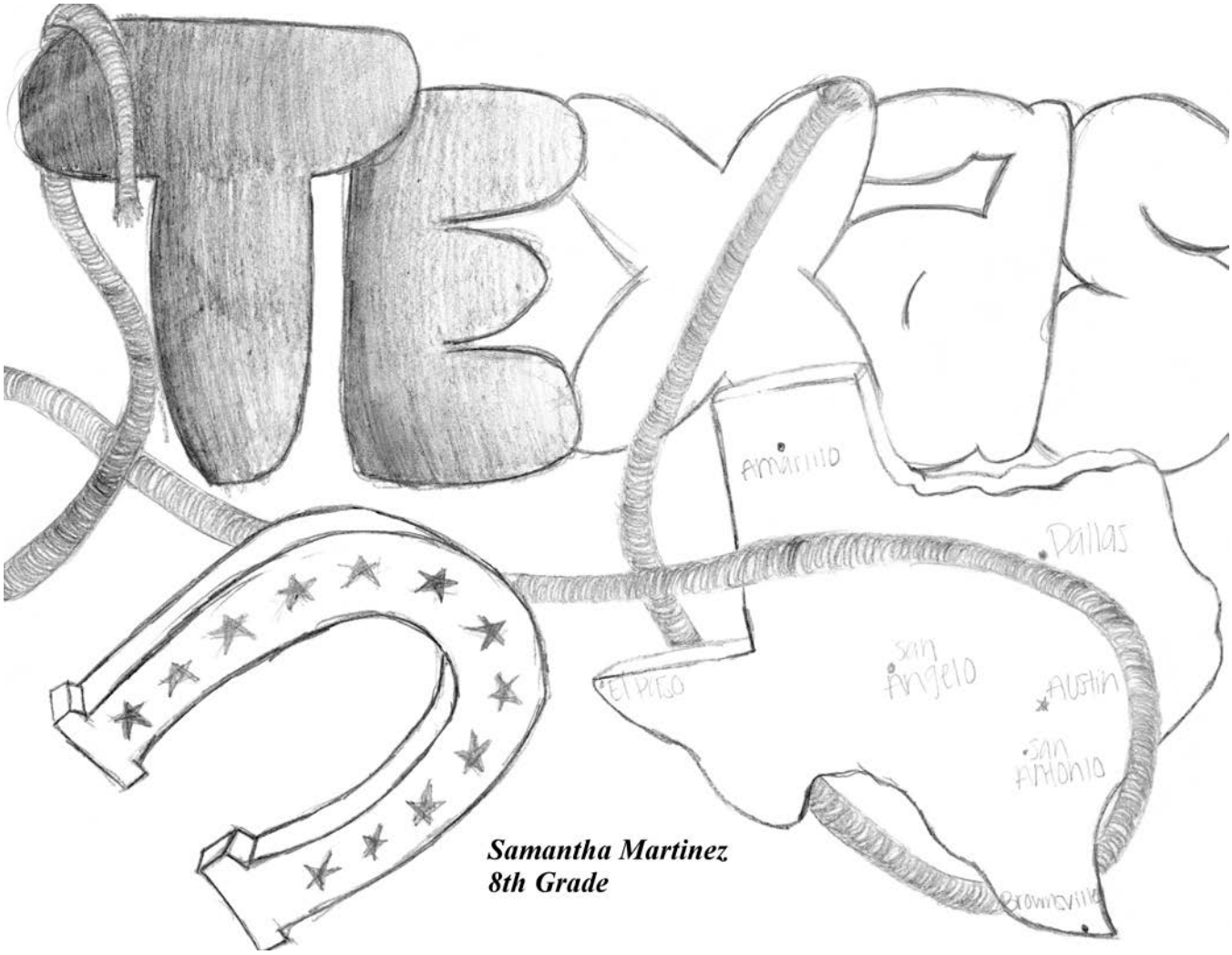

Samantha Martinez
8th Grade

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

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.texas.gov.

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.

THE ATTORNEY GENERAL

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

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

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

Opinions

Opinion No. GA-1074

The Honorable Robert F. Deuell, M.D.

Chair, Committee on Economic Development

Texas State Senate

Post Office Box 12068

Austin, Texas 78711-2068

Re: Whether Texas Triple Chance, a game proposed by the Lottery Commission, violates the Texas Constitution (RQ-1185-GA)

S U M M A R Y

A court is unlikely to conclude that the Texas Lottery Commission's Texas Triple Chance game is unconstitutional merely because it awards a preset prize amount regardless of the number of tickets purchased or because it does not carry forward any unpaid prize money to be awarded to an eventual winner.

Opinion No. GA-1075

The Honorable Rafael Anchia

Chair, Committee on International Trade and Intergovernmental Affairs

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Simultaneous service in multiple official capacities of board members of the Maverick County Hospital District (RQ-1186-GA)

S U M M A R Y

The dual office-holding provision of article XVI, section 40(a) of the Texas Constitution does not prohibit a board member of the Maverick County Hospital District from serving the county in other official capacities.

Whether the conflicting-loyalties aspect of the common-law doctrine of incompatibility prohibits a board member of the Maverick County Hospital District from simultaneously serving as a commissioner of a housing authority where the two entities have contracted with each other depends on whether holding both offices is detrimental to the public interest or whether the performance of the duties of one interferes with the performance of those of the other. Such a determination is a factual inquiry, which cannot be resolved through the opinion process.

A court would likely conclude that the conflicting-loyalties aspect of the common-law doctrine of incompatibility does not prohibit a board member of the Maverick County Hospital District from simultaneously serving as the Maverick County Treasurer.

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

TRD-201403812
Katherine Carey
General Counsel
Office of the Attorney General
Filed: August 13, 2014

♦ ♦ ♦

Cielo Vargas
8th Grade

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353. MEDICAID MANAGED CARE

SUBCHAPTER G. STAR+PLUS

1 TAC §353.608

The Texas Health and Human Services Commission (HHSC) proposes new §353.608, concerning Payments to Qualified Nursing Facilities, to maintain a certain level of funding for non-state government-owned nursing facilities through the creation of a new funding program.

Background and Justification

In 2012, HHSC adopted §355.314 of this title (relating to Supplemental Payments to Non-State Government-Owned Nursing Facilities) to create a nursing facility (NF) upper payment limit (UPL) supplemental payment program. Eligible NFs could apply to participate in this program and, if approved, the NFs could receive supplemental payments based on the difference between the amount paid through fee-for service Medicaid and the amount Medicare would have paid for those same services. As with other supplemental payment programs operated by HHSC, the non-federal share of the supplemental Medicaid payment is funded through intergovernmental transfers (IGTs) provided by the non-state governmental entities that own the participating NFs. Payments have been made under the NF UPL program since October 2013.

Beginning March 1, 2015, NF services will be "carved-in" to managed care. In other words, the capitated payment HHSC makes to Medicaid managed care organizations (MCOs) will include funds for NF services provided by NFs contracted with the MCOs. As a result of the carve-in, HHSC is prohibited from continuing the NF UPL program.

In an effort to continue a certain level of funding to the NF UPL participants, HHSC is creating a new minimum payment to eligible NFs to be made through the MCOs. A NF must meet multiple criteria to be eligible for this minimum payment. First, the NF must be owned by a non-state governmental entity. Second, the NF must make certain representations and certifications on a form to be prescribed by HHSC. Third, the NF must provide an IGT to make up the non-federal share of the additional payment beyond the expected MCO payments. Fourth, the NF must submit an application for approval to receive the mandatory minimum payment no later than the date, to be determined by HHSC, by which the capitation payment rate to be paid to the MCOs must be determined. Additionally, after a certain point, only NFs owned by non-state governmental entities in the same or a contiguous county may be eligible to receive the minimum payment.

The minimum payment will be made on a quarterly basis. Currently, HHSC plans to calculate a capitation rate for the period of March 1, 2015 - August 31, 2015. HHSC will then calculate a new capitation rate for the period of September 1, 2015 - August 31, 2016. This second period will allow for approval for minimum payments for NFs who were not able to make the cut-off for inclusion in the first payment period.

MCOs will be required to pay qualified NFs in two installment payments each quarter. The MCO will make the first payment no later than ten calendar days after a qualified NF or its agent submits a clean claim for a NF day of service. This first payment will be made at or above the prevailing rate established by HHSC for the date of service. The MCO will make the second payment, equal to the difference between the first payment and the minimum payment amount described in this section (essentially the Medicare rate for the same service) for all Medicaid days of service provided during the quarter no later than 110 calendar days after the end of the quarter.

HHSC is proposing a 110 calendar day delay between the end of the quarter and the second payment to allow qualifying NFs 95 days to submit their claims to qualify for the second payment (NFs have up to 365 days to submit claims to qualify for the first payment) and the MCO 15 days to calculate and process the second payment. We considered proposing a 45 calendar day delay which would have allowed NFs 30 days to submit their claims to qualify for the second payment and the MCO 15 days to calculate and process the second payment but wanted to give NFs more time to file claims to qualify for the second payment. We are interested in receiving stakeholder feedback on whether 95 days or 30 days is more appropriate.

Section-by-Section Summary

Proposed new §353.608(a) describes the purpose of the rule.

Proposed new §353.608(b) lists the definitions of certain terms within the rule.

Proposed new §353.608(c) describes the Minimum Payment Amount and lists responsibilities for the MCOs and HHSC.

Proposed new §353.608(d) describes the calculation of the Minimum Payment Amount.

Proposed new §353.608(e) describes the eligibility for both Minimum Payment Amount periods, including application dates, geographic restrictions, and the responsibility to provide an IGT.

Proposed new §353.608(f) provides for a claims filing deadline.

Proposed new §353.608(g) describes the effect of a change in ownership of a nursing facility.

Proposed new §353.608(h) specifies the length of time that the Minimum Payment Amount is available.

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services for HHSC, has determined that, for each year of the first five years the proposed rule will be in effect, there will be no fiscal impact to the state as the non-federal share of the increase in capitation payments due to the amendment will be funded with IGTs from non-state governmental entities.

Ms. Rymal has also determined that there is no anticipated impact to a local economy or local employment for the first five years the proposed rule will be in effect. Only local governments that are already participating in the NF UPL program will be eligible to participate in the program established under this rule. It is not anticipated that the required IGTs from local governments or the Medicaid payments to NFs owned by these local governments will change significantly under the proposed rule from the current NF UPL program IGTs and Medicaid payments.

Ms. Rymal anticipates that, for each year of the first five years the rule will be in effect, there will be no economic cost to persons required to comply with the rule.

Public Benefit

Pam McDonald, Director of Rate Analysis, has determined that, for each year of the first five years the rule will be in effect, the public benefits expected as a result of the new rule will be to ensure continued funding of supplemental payments for qualifying NFs.

Small Business and Micro-Business Impact Analysis

HHSC has determined that there is no adverse economic impact on small businesses or micro-businesses as a result of enforcing or administering the new rule. The implementation of the proposed new rule does not require any changes in practice or any additional cost to the contracted provider, because participation in the minimum payment is voluntary.

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 Pam McDonald, Director of Rate Analysis, Rate Analysis Department, Texas Health and Human Services Commission, Mail Code H-400, P.O. Box 85200, Austin, Texas 78705-5200, by fax to (512) 730-7475, or by e-mail to pam.mcdonald@hhsc.state.tx.us within 30 days after publication of this proposal in the *Texas Register.*

Public Hearing

HHSC will conduct a public hearing on Thursday, September 11, 2014, beginning at 2:30 p.m., to receive comments on proposed new §355.608. The public hearing will be held in the Health and Human Services Commission Public Hearing Room of the Brown-Heatly Building, located at 4900 North Lamar Boulevard, Austin, Texas. Entry is through Security at the main entrance of the building, which faces Lamar Boulevard. Persons requiring Americans with Disabilities Act (ADA) accommodation or auxiliary aids or services should contact the External Relations Division by calling (512) 487-3300 at least 72 hours prior to the hearing so appropriate arrangements can be made.

Statutory Authority

The new rule is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; 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 (Medicaid) payments under Texas Human Resources Code Chapter 32. The new rule implements Texas Government Code, Chapter 531 and Texas Human Resources Code Chapter 32.

No other statutes, articles, or codes are affected by this proposal.

§353.608. Payments to Qualified Nursing Facilities.

(a) Introduction. This section establishes minimum payment amounts for certain non-state government-owned nursing facility providers participating in the STAR+PLUS Program, and the conditions for receipt of these amounts.

(b) Definitions.

(1) Calculation Period--A state fiscal quarter used to calculate the Minimum Payment Amount.

(2) CHOW Application--An application filed with the Department of Aging and Disability Services for a nursing facility change of ownership.

(3) Clean Claim--A claim submitted by a provider for health care services rendered to an enrollee with the data necessary for the managed care organization to adjudicate and accurately report the claim. Claims for Nursing Facility Unit Rate services that meet the Department of Aging and Disability Services' criteria for clean claims submission are considered Clean Claims. Additional information regarding Department of Aging and Disability Services' criteria for clean claims submission is included in HHSC's Uniform Managed Care Manual, which is available on HHSC's website.

(4) DADS--The Texas Department of Aging and Disability Services.

(5) Eligibility Period One--The first period of time for which a Qualified Nursing Facility may receive the Minimum Payment Amounts described in this section, covering dates of service from March 1, 2015, to August 31, 2015.

(6) Eligibility Period Two--The second period of time for which a Qualified Nursing Facility may receive the Minimum Payment Amounts described in this section, covering dates of service from September 1, 2015, to August 31, 2016.

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

(8) Intergovernmental transfer (IGT)--A transfer of public funds from a non-state governmental entity to HHSC.

(9) IGT Responsibility--The quarterly IGT owed for a nursing facility, which is equal to the non-federal share of the increase in the STAR+PLUS MCOs' capitation rates due to the implementation of the Minimum Payment Amounts multiplied by the average number of Medicaid residents from the nursing facility incorporated into the capitation rate multiplied by three.

(10) MCO--A STAR+PLUS managed care organization.

(11) Minimum Payment Amount--The minimum payment amount for a Qualified Nursing Facility, as calculated under subsection (d) of this section.

(12) Network Nursing Facility--A nursing facility that has a contract with an MCO for the delivery of Medicaid covered benefits to the MCO's STAR+PLUS enrollees.

(13) Non-state governmental entity--A hospital authority, hospital district, health district, city or county.

(14) Non-state government-owned Nursing Facility--A nursing facility where a non-state governmental entity holds the license and is a party to the nursing facility's Medicaid provider enrollment agreement with the state.

(15) Nursing Facility Add-on Services--The types of services that are provided in the nursing facility setting by a provider, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, and augmentative communication devices.

(16) Nursing Facility Unit Rate--The types of services included in the DADS daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements as described in §355.308 of this title (relating to Direct Care Staff Rate Component), and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services.

(17) Qualified Nursing Facility--A Network Nursing Facility that meets the eligibility requirements described in subsection (e) of this section and the claims filing deadline described in subsection (f) of this section.

(18) Public Funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a non-state governmental entity that holds the license and is party to the Medicaid provider enrollment agreement with the state. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(19) RUG--A resource utilization group under the RUG-III 34 group classification system, Version 5.20, index maximizing, as established by the state and the Centers for Medicare and Medicaid Services.

(c) Minimum Payment Amount for Qualified Nursing Facilities.

(1) An MCO must pay a Qualified Nursing Facility at or above the Minimum Payment Amount in two installment payments for a Calculation Period, using the calculation methodology described in subsection (d) of this section.

(A) The MCO must make the first payment no later than ten calendar days after a Qualified Nursing Facility or its agent submits a Clean Claim for a Nursing Facility Unit Rate to the HHSC-designated portal or the MCO's portal, whichever occurs first. The MCO will make the first payment for the Nursing Facility Unit Rate at or above the prevailing rate established by HHSC for the date of service. HHSC's website includes information concerning HHSC's prevailing rates. The MCO must make the second payment no later than 110 calendar days after the end of the Calculation Period. The second payment will be the difference between the first payment and the calculated Minimum Payment Amount, as described in subsection (d) of this section.

(B) For purposes of illustration only, if a Qualified Nursing Facility Provider files a Clean Claim for a Nursing Facility Unit Rate on March 6, 2015, the MCO must make the first payment no later than March 16, 2015, and the second payment no later than September 18, 2015.

(2) HHSC will provide each MCO with a list of Qualified Nursing Facilities for each Calculation Period. If a nursing facility's IGT responsibility is not met for a Calculation Period, as required by subsection (e)(5) of this section, HHSC will not include the nursing facility on the list of Qualified Nursing Facilities, and the nursing facility will have forfeited its right to receive the Minimum Payment Amount for that Calculation Period.

(d) Calculation of the Minimum Payment Amount. The MCO must calculate the Minimum Payment Amount using the following methodology:

(1) Calculate the total Medicaid days of service by RUG for Nursing Facility Unit Rate claims for services that were provided:

(A) during the Calculation Period; and

(B) filed within the claims filing deadlines set forth in subsection (f) of this section (represented in paragraph (6) of this subsection as "A").

(2) Multiply this amount by the Medicare skilled nursing facility payment rate for the RUG in effect on the date of service (represented in paragraph (6) of this subsection as "B").

(3) Apply any identified payment adjustments to Nursing Facility Unit Rate claims for services that were provided:

(A) during Calculation Period; and

(B) filed within the claims filing deadlines set forth in subsection (f) of this section (represented in paragraph (6) of this subsection as "C").

(4) Subtract any payments required to be made for Clean Claims for the following types of Nursing Facility Add-on Services that were:

(A) provided during the Calculation Period; and

(B) filed within the claims filing deadlines set forth in subsection (f) of this section (represented in paragraph (6) of this subsection as "D"):

(i) pharmacy services, as described in 40 TAC Chapter 19, Subchapter P (relating to Pharmacy Services);

(ii) specialized services as described in 40 TAC §19.1303 (relating to Specialized Services in Medicaid-certified Facilities);

(iii) customized equipment as described in 40 TAC §19.2614 (relating to Customized Power Wheelchairs); and

(iv) emergency dental services as described in 40 TAC §19.1402 (relating to Medicaid-certified Emergency Dental Services).

(5) The result is the Minimum Payment Amount (represented in paragraph (6) of this subsection as "E").

(6) The following equation represents the calculation methodology for the Minimum Payment Amount: (A X B) ± C - D = E.

(e) Eligibility for Receipt of Minimum Payment Amounts.

(1) A nursing facility is eligible to receive the Minimum Payment Amounts described in this section if it complies with the requirements described in this subpart for each eligibility period.

(2) Eligibility Period One. HHSC must determine that the nursing facility is eligible to receive supplemental payments under HHSC's nursing facility upper payment limit program for the July through September 2014 calculation period, as described in §355.314 of this title (relating to Supplemental Payments to Non-State Government Owned Nursing Facilities). HHSC's eligibility determination must occur no later than September 15, 2014. This means that the non-state governmental entity must have submitted the required application described in §355.314(d) to HHSC by June 30, 2014, and, if the application was a provisional application as described under §355.314(d)(2), DADS must have finalized the CHOW Application by September 15, 2014, with an effective date no later than March 1, 2015.

(3) Eligibility Period Two. To receive the Minimum Payment Amounts for Eligibility Period Two, HHSC must have received completed application forms from the appropriate non-state governmental entity by December 31, 2014, and for any nursing facility undergoing a change of ownership when the application form is submitted, DADS must have finalized the CHOW Application by March 15, 2015, with an effective date no later than September 1, 2015.

(4) Geographic Proximity to Nursing Facility. Any nursing facility with a CHOW Application approved by DADS with an effective date on or after October 1, 2014, must be located in the same or a contiguous county as the non-state governmental entity taking ownership of the nursing facility.

(5) Intergovernmental Transfer. To receive the Minimum Payment Amounts described in this section for a Calculation Period, HHSC must receive an intergovernmental transfer covering the full IGT Responsibility for the nursing facility for that Calculation Period. Once HHSC finalizes the STAR+PLUS MCOs' capitation rates, the IGT Responsibility is set and will not be adjusted for the time period the capitation rates are in effect.

(f) Claims Filing Deadline. A Qualified Nursing Facility must file a Clean Claim for a Nursing Facility Unit Rate no later than 95 calendar days after the end of the Calculation Period within which the service is provided for the claim to qualify for the Minimum Payment Amount described in this section. The MCO must pay a Clean Claim that is filed after this deadline but within 365 calendar days of the date of service, at the standard rate established in the network provider agreement for Nursing Facility Unit Services; however, claims filed after the 95 deadline will not be incorporated in the calculation of the Minimum Payment Amount.

(g) Changes of Ownership. If a Qualified Nursing Facility changes ownership during either of the eligibility periods described in subsection (e) of this section, then the data used for the calculations described in subsection (d) of this section will include data from the facility for the entire Calculation Period, including data relating to payments for days of service provided under the prior owner.

(h) Dates the Minimum Payment Amount is available. The minimum payment requirements described in this section will only cover dates of service from March 1, 2015 to August 31, 2016.

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

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403637
Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 424-6900

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CHAPTER 355. REIMBURSEMENT RATES

The Texas Health and Human Services Commission (HHSC) proposes to amend §355.102, concerning General Principles of Allowable and Unallowable Costs; §355.103, concerning Specifications for Allowable and Unallowable Costs; §355.104, concerning Revenues; §355.105, concerning General Reporting and Documentation Requirements, Methods, and Procedures; §355.111, concerning Administrative Contract Violations; §355.308, concerning Direct Care Staff Rate Component; §355.503, concerning Reimbursement Methodology for the Community-Based Alternatives Waiver Program and the Integrated Care Management-Home and Community Support Services and Assisted Living/Residential Care Programs; §355.505, concerning Reimbursement Methodology for the Community Living Assistance and Support Services Waiver Program; §355.513, concerning Reimbursement Methodology for the Deaf-Blind with Multiple Disabilities Waiver Program; and §355.6907, concerning Reimbursement Methodology for Day Activity and Health Services.

Background and Justification

HHSC, under its authority and responsibility to administer and implement rates, proposes to amend these rules to 1) change the capitalization threshold for assets from $2,500 to $5,000 and adjust the useful life for wheelchair lifts from four years to five years, 2) correct numbering to provide greater clarity, 3) modify cost report training requirements, 4) require providers to use the most current version of the document that defines estimated useful lives of assets, 5) update dates in examples to the current period, 6) delete obsolete language, 7) change the required release date for material pertinent to proposed reimbursements from ten working days before the public hearing to ten calendar days before the public hearing, 8) delete language detailing the contents of material pertinent to proposed reimbursements, and 9) change the compliance period for correcting an administrative contract violation.

Section-by-Section Summary

HHSC proposes to amend §§355.102, 355.104, 355.105, 355.308, 355.503, 355.505, 355.513, and 355.6907 to update references.

HHSC proposes amendments to §355.102 as follows:

Revise subsections (d)(1) and (2) to remove the requirement that all cost report preparers, who have not previously attended cost report training or have not done so for a specific program, attend classroom-based training. With this proposed amendment, all cost report training will be provided as online training.

The proposed amendment to subsections (g)(2), (h)(2) and (j)(1)(D)(iii)(II) adds language to clarify that Intermediate Care Facilities for Individuals with Intellectual Disabilities were formerly known as Intermediate Care Facilities for Persons with Mental Retardation.

HHSC proposes amendments to §355.103 as follows:

Revise subsection (b)(1)(A)(i)(II) to remove date references that are no longer necessary.

Revise subsection (b)(2)(C)-(E) to renumber them as separate paragraphs (3)-(5) to clarify that they are not part of paragraph (2) and should be their own paragraphs. Subsequent paragraphs are renumbered.

Revise subsection (b)(7) to increase the capitalization threshold (the cost at which an asset is required to be depreciated rather than expensed on LTSS cost reports) from $2,500 to $5,000 effective for assets purchased September 1, 2014, or later, for all long-term care programs. This increase will bring the Texas cost reporting rules for long-term services and supports providers into alignment with federal and other state guidance on asset capitalization thresholds.

Revise subsection (b)(7)(B) to specify that providers are required to use the minimum schedules consistent with the most current version of "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association and to change their address given in the subsection.

Revise subsection (b)(7)(C)(ii) and (b)(20)(D)(ii) to update the years given in the examples to make them more current.

Revise subsection (b)(7)(C)(iii) to change the estimated useful life of a wheelchair lift from four years to five.

HHSC proposes amendments to §355.105 as follows:

Delete subsection (b)(4)(viii) as this clause refers to subsection (c)(3), which is being deleted.

Delete subsection (c)(3) to remove the requirement for certain providers to file a Consolidated Report as this language no longer reflects agency procedures and renumber subsequent paragraphs.

Revise subsection (g)(1) to change the required release date for material pertinent to proposed uniform reimbursements from ten working days before the public hearing to ten calendar days before the public hearing and to delete details as to the contents of this material to align the rule language with current practice.

Revise subsection (g)(2) to change the required release date for material pertinent to proposed contractor-specific reimbursements from ten working days before the public hearing to ten calendar days before the public hearing and to delete details as to the contents of this material to align the rule language with current practice.

HHSC proposes to amend §355.111(1)(B) to change the compliance period for a provider to correct an administrative contract violation from 30 days to 15 days.

Fiscal Note

James Jenkins, Chief Financial Officer for the Department of Aging and Disability Services, has determined that during the first five-year period the amendments are in effect there will be no fiscal impact to state government. The amendments 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

HHSC has determined that there will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing or administering the amendments.

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

Public Benefit

Pam McDonald, Director of the HHSC Rate Analysis Department, has determined that for each of the first five years the amendments are in effect, the expected public benefit is that the amended rules will reduce the number of assets a provider is required to track and depreciate, clarify the relationship between certain items of cost, remove the requirement that cost report preparers attend classroom-based training, provide more up-to-date examples and remove obsolete language in the rules. The amended rules will also bring rule language into line with current practice regarding the release of materials pertinent to proposed reimbursements.

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 Judy Myers in the HHSC Rate Analysis Department by telephone at (512) 707-6085. Written comments on the proposal may be submitted to Ms. Myers by fax to (512) 730-7475; by e-mail to judy.myers@hhsc.state.tx.us; or by mail to HHSC Rate Analysis, Mail Code H400, P.O. Box 149030, Austin, Texas, 78714-9030, within 30 days of publication of this proposal in the *Texas Register.*

SUBCHAPTER A. COST DETERMINATION PROCESS

1 TAC §§355.102 - 355.105, 355.111

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 provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

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.

§355.102. 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)(19)[~~(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 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:

(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 complete the state-sponsored online cost report training designed for new preparers and receive a certificate of completion for each program for which a cost report is submitted. Applicable federal and state accessibility standards apply to online training [~~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 may [~~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) 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 chap-

ter, 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 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 Individuals with Intellectual Disabilities (formerly known as Intermediate Care Facilities for Persons with Mental Retardation) [~~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) For all other programs, submission 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 Individuals with Intellectual Disabilities (formerly known as Intermediate Care Facilities for Persons with Mental Retardation) [~~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) 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 Intellectual Disabilities (formerly known as Intermediate Care Facilities for Persons with Mental Retardation) [~~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) 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 ba-

sis. 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)(13)[~~(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)(3)(A)[~~(2)(C)(i)~~] of this section.

(2) Advertising and public relations. See subsection (b)(16)[~~(13)~~] of this section.

(3) Amortization expense. See subsection (b)(10)[~~(7)~~] of this section.

(4) Bad debt expense. See subsection (b)(20)[~~(17)~~](M) of this section.

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

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

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

(8) Charity allowance. See subsection (b)(20)[~~(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)(3)[~~(2)(C)~~] of this section.

(12) Courtesy allowance. See subsection (b)(20)[~~(17)~~](N) of this section.

(13) Depreciation expense. See subsection (b)(10)[~~(7)~~] of this section.

(14) Donated revenues. See subsection (b)(18)[~~(15)~~] of this section.

(15) Donated services, supplies, and assets. See subsection (b)(19)[~~(16)~~] of this section.

(16) Dues or contributions to organizations. See subsection (b)(14)[~~(11)~~] of this section.

(17) Employee relations expenses. See subsection (b)(20)[~~(17)~~] (A) of this section.

(18) Employment-related taxes. See subsection (b)(12)[~~(9)~~](B) of this section.

(19) Endowment income. See subsection (b)(18)[~~(15)~~] of this section.

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

(21) Fines and penalties. See subsection (b)(20)[~~(17)~~](G) of this section.

(22) Franchise tax. See subsection (b)(12)[~~(9)~~](C) of this section.

(23) Finance charges. See subsection (b)(11)[~~(8)~~](E) of this section.

(24) Franchise fees. See subsection (b)(20)[~~(17)~~](C) of this section.

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

(26) Fundraising activities. See subsection (b)(17)[~~(14)~~] of this section.

(27) Gains on disposal of assets. See subsection (b)(10)[~~(7)~~](F) of this section.

(28) Gifts. See subsection (b)(18)[~~(15)~~] of this section.

(29) Goodwill. See subsection (b)(10)[~~(7)~~] and (20)[~~(17)~~](C)(ii) of this section.

(30) Grants, gifts and income from endowments. See subsection (b)(18)[~~(15)~~] of this section.

(31) In-kind donations. See subsection (b)(19)[~~(16)~~] of this section.

(32) Insurance expense. See subsection (b)(13)[~~(10)~~] of this section.

(33) Interest expense. See subsection (b)(11)[~~(8)~~] of this section.

(34) Legal fees. See subsection (b)(3)(B) [~~(2)(C)(ii)~~] of this section.

(35) Life insurance. See subsection (b)(13) [~~(10)~~](G) of this section.

(36) Litigation expenses and awards. See subsection (b)(20)[~~(17)~~](I) of this section.

(37) Lobbying costs. See subsection (b)(20)[~~(17)~~](J) of this section.

(38) Losses on disposal of assets. See subsection (b)(10)[~~(7)~~](F) of this section.

(39) Losses due to theft or embezzlement. See subsection (b)(20)[~~(17)~~](L) of this section.

(40) Management fees. See subsection (b)(6)[~~(3)~~] of this section.

(41) Medicaid as payor of last resort. See subsection (b)(21)[~~(18)~~] of this section.

(42) Medical supplies and medical costs. See subsection (b)(20)[~~(17)~~](F) of this section.

(43) Nonpaid workers. See subsection (b)(4)[~~(2)(D)~~] of this section.

(44) Operating revenue. See subsection (b)(18)[~~(15)~~](D) of this section.

(45) Organization costs. See subsection (b)(20)[~~(17)~~](B) of this section.

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

(47) Penalties. See subsection (b)(20)[~~(17)~~](G) of this section.

(48) Planning and evaluation expenses. See subsection (b)(10)[~~(7)~~](E) of this section.

(49) Promotional activities. See subsection (b)(17)[~~(14)~~] of this section.

(50) Public relations. See subsection (b)(16)[~~(13)~~] of this section.

(51) Repairs and maintenance. See subsection (b)(9)[~~(6)~~] of this section.

(52) Research and development costs. See subsection (b)(20)[~~(17)~~](E) of this section.

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

(54) Self-insurance. See subsection (b)(13)[~~(10)~~](B) of this section.

(55) Staff training costs. See subsection (b)(15)[~~(12)~~](A) of this section.

(56) Startup costs. See subsection (b)(20)[~~(17)~~](D) of this section.

(57) Tax expense and credits. See subsection (b)(12)[~~(9)~~] of this section.

(58) Travel costs. See subsection (b)(15)[~~(12)~~](B) of this section.

(59) Utilities. See subsection (b)(8) [~~(5)~~] of this section.

(60) Volunteers. See subsection (b)(4) [~~(2)(D)~~] of this section.

(61) Voucher-paid expenses. See subsection (b)(20)[~~(17)~~](K) of this section.

(62) Workers' compensation insurance. See subsection (b)(13) [~~(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 hospital 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 (12) [~~(9)~~] of this subsection, concerning tax expense and credits, and paragraph (13) [~~(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 (15) [~~(12)~~] of this subsection, job-related training reimbursements in accordance with paragraph (15) [~~(12)~~] of this subsection, and job certification renewal fees in accordance with paragraph (15) [~~(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 ben-

efits, 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 (15) [~~(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 (13) [~~(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.

(3) [~~(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:

(A) [~~(i)~~] Accounting and audit fees.

(i) [~~(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) [~~(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 (12) [~~(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.

(B) [~~(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.

(4) [~~(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.

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

(A) [~~(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 (15) [~~(12)~~](B) of this subsection; and

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

(6) [~~(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.

(7) [~~(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.

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

(9) [~~(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 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.

(10) [~~(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. For all contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 2015, an asset valued at $5,000 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 the capitalization level for that fiscal period as described above or having a useful life of one year or less. [~~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 the most current version of "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association. Copies of this publication may be obtained by contacting the American Hospital Association, 155 North Wacker Drive, Chicago, IL 60606 [~~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 documentation 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 2013 [~~1994~~] van were purchased in 2014 [~~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 2013 [~~1994~~] minivan were purchased in 2014 [~~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 five [~~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 pe-

riod 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.

(11) [~~(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.

(12) [~~(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.

(13) [~~(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 (E) of this paragraph. 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)(11)[~~(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.

(14) [~~(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 (15) [~~(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 (15) [~~(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.

(15) [~~(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 (B) of this paragraph.

(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 (20) [~~(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.

(16) [~~(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 (10) [~~(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.

(17) [~~(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.

(18) [~~(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.

(19) [~~(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)(10)[~~(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.

(20) [~~(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 (10) [~~(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, 2014 [~~1995~~]. Startup costs would be those costs incurred prior to April 4, 2014 [~~1995~~], which meet the above definition of startup costs. Amortization of the startup costs for this newly-formed business would begin April 2014 [~~1995~~]. If this same corporation received a contract to provide Day Activity and Health Services (DAHS) effective October 1, 2014 [~~1995~~]and if the corporation served its first DAHS client on November 5, 2014 [~~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 2014 [~~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, 2014 [~~1995~~] (since the contract effective date occurred prior to serving the first DAHS client) would be amortized beginning with October 2014 [~~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 unallowable 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.

(21) [~~(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.

(22) [~~(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.

§355.104. Revenues.

A provider must report in the format specified by the Texas Health and Human Services Commission (HHSC) revenues that reflect the activity of the provider and that are directly related to the provision of contracted client care or services. A provider may not report revenues from other programs or activities in which the contracted provider may be engaged.

(1) Revenues should be reported net of charity allowances and courtesy allowances, and bad debt expense.

(2) Any revenues received directly by the provider through a voucher or from other direct payment systems as described in §355.103(b)(20)[~~(17)~~](K) of this title (relating to Specifications for Allowable and Unallowable Costs) must not be reported on the cost report unless specifically requested by the program-specific reimbursement methodology rules, HHSC procedures, or cost report instructions.

(3) For guidelines in reporting revenue received as a federal grant, refer to §355.103(b)(18)[~~(15)~~] of this title and to program-specific reimbursement methodology rules.

(4) For guidelines in offsetting revenues against certain expenses, refer to §355.103(b)(18)[~~(15)~~](D) of this title.

(5) For reporting interest income:

(A) report as interest income, with no offset to interest expense, any interest earned on funded depreciation accounts, qualified pension funds, and debt service reserve funds required by non-related party lenders; and

(B) report as interest income, interest earned from all other sources, after first netting this income against interest expenses in the following sequence:

(i) interest incurred on working capital loans; and

(ii) interest incurred on all other loans except mortgage loans. Mortgage loans are not to be offset.

§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 this section to determine costs appropriate for use in the reimbursement determination process.

(b) Cost report requirements. Unless specifically stated in program rules or excused as described in paragraph (4)(D) of this subsection, 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)(11)[~~(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 trans-

portation 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)(10)[~~(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)(10)[~~(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)(15)[~~(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)(13)[~~(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 Individuals with an Intellectual Disability or Related Conditions (ICF/IID), Home and Community-based Services (HCS) and Texas Home Living (TxHmL) 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)(18)[~~(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;

(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); and

[(viii)] ~~if applicable, be submitted with the correct Consolidated Reporting Group Number as described in subsection (c)(3) of this section.~~]

(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, or policy clarifications. Refer to program-specific reimbursement methodology rules, cost report instructions, 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) 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) 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. A provider that is not enrolled in Attendant Compensation Rate Enhancement as described in §355.112 of this title (relating to Attendant Compensation Rate Enhancement) for a specific program or the Nursing Facility Direct Care Staff Rate enhancement as described in §355.308 of this title (relating to Direct Care Staff Rate Component) during the reporting period for the cost report in question, is excused from the requirement to submit a cost report for such program if the provider meets one or more of the following conditions:

(i) For all programs, if the provider performed no billable services during the provider's cost-reporting period.

(ii) For all programs, if the cost-reporting period would be less than or equal to 30 calendar days or one entire calendar month.

(iii) For all programs, if circumstances beyond the provider's control, such as the loss of records due to natural disasters or removal of records from the provider's custody by a regulatory agency, make cost-report completion impossible.

(iv) For all programs, if all of the contracts that the provider is required to include in the cost report have been terminated before the cost-report due date.

(v) For the Nursing Facility, ICF/IID, Assisted Living/Residential Care (AL/RC), and Residential Care (RC) programs, if the total number of days that the provider performed service for HHSC or DADS recipients during the cost-reporting period is less than the total number of calendar days included in the cost-reporting period.

(vi) For the Day Activity and Health Services (DAHS) program, if the provider's total units of service provided to HHSC or DADS recipients during the cost-reporting period is less than the total number of calendar days included in the cost-reporting period times 1.5.

(vii) For the Home-Delivered Meals program, if a provider agency served an average of fewer than 500 meals a month for the designated cost report period.

(viii) For the Department of Family and Protective Services (DFPS) 24-Hour Residential Child-Care program, if:

(I) the contract was not renewed;

(II) only Basic Level services were provided;

(III) the total number of state-placed days (DFPS days and other state agency days) was 10 percent or less of the total days of service provided during the cost-reporting period;

(IV) the total number of DFPS-placed days was 10 percent or less of the total days of service provided during the cost-reporting period;

(V) for facilities that provide Emergency Care Services only, the occupancy rate was less than 30 percent during the cost-reporting period; or

(VI) for all other facility types except child-placing agencies and those providing Emergency Care Services, the occupancy rate was less than 50 percent during the cost-reporting period.

(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.

(2) For SHARS, providers must submit cost reports to HHSC Rate Analysis as specified in §355.8443 of this title.

[~~(3) For Primary Home Care (PHC), Community Living Assistance and Support Services (CLASS)--Direct Service Agency (DSA), CLASS--Case Management Agency (CMA), and Community Based Alternatives (CBA)--Home and Community Support Services (HCSS), if a provider's legal entity controls more than one contract within a single program, the provider must submit a separate Consolidated Cost Reporting Schedule for each legal entity for each program.~~]

[~~(A) HHSC sends the Consolidated Cost Reporting Schedule to the provider for completion. The provider must complete and return the completed Consolidated Cost Reporting Schedule to HHSC Rate Analysis no later than 30 days after the end of the provider entity's fiscal year or 30 days after HHSC's transmittal date of the schedule to the provider, whichever due date is later.~~]

[~~(B) Upon receipt of the provider's completed Consolidated Cost Reporting Schedule, HHSC Rate Analysis will determine, and notify the provider of, the provider's Consolidated Reporting Group Number(s) as well as a list of the contract numbers associated with the Consolidated Reporting Group Number(s) for use in completing the provider's cost report(s).~~]

[~~(C) Providers in the programs named in this paragraph must submit cost reports to HHSC Rate Analysis no later than 120 days after the end of the provider entity's fiscal year or 120 days after HHSC's transmittal date of the Consolidated Cost Reporting Schedule to the provider for completion, whichever due date is later.~~]

[~~(D) Failure on the provider's part to submit a Consolidated Cost Reporting Schedule timely is not a good cause for failure to submit cost reports by the cost report due date specified in this paragraph.~~]

(3) [~~(4)~~] 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.

(4) [~~(5)~~] 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) 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 calendar [~~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 calendar [~~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 compensation. HHSC may place upper limits or caps on related-party compensation as follows:

(1) For related-party administrators and directors, the upper limit for compensation is equal to the 90th percentile in the array of all non-related-party annualized compensation as reported by all contracted providers within a program. In addition, the hourly compensation 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 compensation is equal to the 90th percentile in the array of all non-related party annualized compensation as reported by all contracted providers within a program. In addition, the hourly compensation 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 compensation 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 Individuals with an Intellectual Disability or Related Conditions, 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), 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 compensation is limited to reasonable and necessary costs as described in §355.102 of this title.

§355.111. Administrative Contract Violations.

The Texas Health and Human Services Commission (HHSC) may take the following actions for administrative contract violations.

(1) HHSC grants the following compliance periods for administrative contract violations:

(A) For failure to submit a cost report by the due date, HHSC grants the provider a compliance period of no more than 15 calendar days.

(B) For all other administrative contract violations, HHSC grants the provider a compliance period of no more than 15 [~~30~~] calendar days to correct a contract violation. At the end of the compliance period, if HHSC determines that a contract violation is not corrected, but determines that the provider has made substantial progress toward correcting the contract violation, HHSC may grant an additional one-time extension period of up to 15 calendar days.

(2) If the contract violation is not corrected within the compliance period, HHSC imposes vendor hold on payments to the provider.

(3) If a contract violation is not corrected within 60 days from the date the provider is placed on vendor hold, HHSC may cancel the provider's contract on the 61st day. A provider may request an appeal hearing of the contract cancellation. Formal appeals are conducted in accordance with the provisions of §§357.481 - 357.498 of this title (relating to Hearings Under the Administrative Procedure Act). 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. If the provider appeals the contract cancellation by HHSC and the adverse action is sustained by an administrative law judge or judicial proceeding, the effective date of the contract cancellation is the date specified in the notice of contract cancellation. Unless otherwise specifically provided for, HHSC makes no payment for ser-

vices provided by the provider after the effective date of the provider's contract cancellation. HHSC may continue payments for no more than 30 calendar days from the date HHSC or its designee cancels or fails to renew a provider's contract if HHSC determines that:

(A) reasonable efforts are being made to transfer clients to another provider or to alternate care; and

(B) additional time is needed to effect an orderly transfer of the clients.

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

Filed with the Office of the Secretary of State on August 11, 2014.

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Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 424-6900

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SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §355.308

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 provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

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.

§355.308. Direct Care Staff Rate Component.

(a) Direct care staff cost center. This cost center will include compensation for employee and contract labor Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs); Licensed Vocational Nurses (LVNs), including DONs and ADONs; medication aides; and nurse aides performing nursing-related duties for Medicaid contracted beds.

(1) Compensation to be included for these employee staff types is the allowable compensation defined in §355.103(b)(1) of this title (relating to Specifications for Allowable and Unallowable Costs) that is reported as either salaries and/or wages (including payroll taxes and workers' compensation) or employee benefits. Benefits required by §355.103(b)(1)(A)(iii) of this title (relating to Specifications for Allowable and Unallowable Costs) to be reported as costs applicable to specific cost report line items are not to be included in this cost center.

(2) Direct care staff who also have administrative duties not related to nursing must properly direct charge their compensation to each type of function performed based upon daily time sheets maintained throughout the entire reporting period.

(3) Nurse aides must meet the qualifications enumerated under 40 TAC §19.1903 (relating to Required Training of Nurse Aides) to be included in this cost center. Nurse aides include certified nurse aides and nurse aides in training as per 40 TAC §94.3(k) (relating to Nurse Aide Training and Competency Evaluation Program (NATCEP) Requirements).

(4) Contract labor refers to personnel for whom the contracted provider is not responsible for the payment of payroll taxes (such as FICA, Medicare, and federal and state unemployment insurance) and who perform tasks routinely performed by employees. Allowable contract labor costs are defined in §355.103(b)(3)[~~(2)(C)~~] of this title (relating to Specifications for Allowable and Unallowable Costs).

(5) For facilities receiving supplemental reimbursement for children with tracheostomies requiring daily care as described in §355.307(b)(3)(F) of this title (relating to Reimbursement Setting Methodology), staff required by 40 TAC §19.901(14)(C)(iii) (relating to Quality of Care) performing nursing-related duties for Medicaid contracted beds are included in the direct care staff cost center.

(6) For facilities receiving supplemental reimbursement for qualifying ventilator-dependent residents as described in §355.307(b)(3)(E) of this title (relating to Reimbursement Setting Methodology), Registered Respiratory Therapists and Certified Respiratory Therapy Technicians are included in the direct care staff cost center.

(7) Nursing facility administrators and assistant administrators are not included in the direct care staff cost center.

(8) Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, medication aide, or certified nurse aide, the staff member is not to be included in the direct care staff cost center but rather in the cost center where staff members with that licensure or certification status are typically reported.

(9) Paid feeding assistants are not included in the direct care staff cost center and are not to be counted toward the staffing requirements described in subsection (j) of this section. Paid feeding assistants are intended to supplement certified nurse aides, not to be a substitute for certified or licensed nursing staff.

(b) Rate year. The standard rate year begins on the first day of September and ends on the last day of August of the following year.

(c) Open enrollment. Open enrollment for the enhanced direct care staff rates will begin on the first day of July and end on the last day of that same July preceding the rate year for which payments are being determined unless the Texas Health and Human Services Commission (HHSC) notified providers prior to the first day of July that open enrollment has been postponed or cancelled. Should conditions warrant, HHSC may conduct additional enrollment periods during a rate year.

(d) Enrollment contract amendment. An initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care staff rate. Participating and nonparticipating facilities may request to modify their enrollment status (i.e., a nonparticipant can request to become a participant, a participant can request to become a nonparticipant, a participant can request to change its enhancement level) during any open enrollment period. Nonparticipants and participants requesting to increase their enrollment levels will be limited to requesting increases of three or fewer enhancement levels during any single open enrollment period unless such limits are waived by HHSC. Requests to modify a facility's

enrollment status during an open enrollment period must be received by HHSC Rate Analysis by the last day of the open enrollment period as per subsection (c) of this section. If the last day of the open enrollment period falls on a weekend, a national holiday, or a state holiday, then the first business day following the last day of the open enrollment period is the final day the receipt of the enrollment contract amendment will be accepted. An enrollment contract amendment that is not received by the stated deadline will not be accepted. A facility from which HHSC Rate Analysis has not received an acceptable request to modify their enrollment by the last day of the open enrollment period will continue at the level of participation in effect during the open enrollment period within available funds until the facility notifies HHSC in accordance with subsection (r) of this section that it no longer wishes to participate or until the facility's enrollment is limited in accordance with subsection (i) of this section. If HHSC determines that funds are not available to continue participation at the level of participation in effect during the open enrollment period, facilities will be notified as per subsection (ee) of this section. To be acceptable, an enrollment contract amendment must be completed according to instructions, signed by an authorized representative as per the Texas Department of Aging and Disabilities Services (DADS) signature authority designation form applicable to the provider's contract or ownership type, and be legible.

(e) New facilities. For purposes of this section, for each rate year a new facility is defined as a facility delivering its first day of service to a Medicaid recipient after the first day of the open enrollment period, as defined in subsection (c) of this section, for that rate year. Facilities that underwent an ownership change are not considered new facilities. For purposes of this subsection, an acceptable enrollment contract amendment is defined as a legible enrollment contract amendment that has been completed according to instructions, signed by an authorized representative as per the DADS signature authority designation form applicable to the provider's contract or ownership type, and received by HHSC within 30 days of the mailing of notification to the facility by HHSC that such an enrollment contract amendment must be submitted. New facilities will receive the direct care staff base rate as determined in subsection (k) of this section with no enhancements. For new facilities specifying their desire to participate on an acceptable enrollment contract amendment, the direct care staff rate is adjusted as specified in subsection (l) of this section, effective on the first day of the month following receipt by HHSC of the acceptable enrollment contract amendment. If the granting of newly requested enhancements was limited as per subsection (j)(3) of this section during the most recent enrollment, enrollment for new facilities will be subject to that same limitation.

(f) Staffing and Compensation Report submittal requirements.

(1) Annual Staffing and Compensation Report. For services delivered on or before August 31, 2009, providers must file Staffing and Compensation Reports as follows. All participating facilities will provide HHSC, in a method specified by HHSC, an Annual Staffing and Compensation Report reflecting the activities of the facility while delivering contracted services from the first day of the rate year through the last day of the rate year. This report will be used as the basis for determining compliance with the staffing requirements and recoupment amounts as described in subsection (n) of this section, and as the basis for determining the spending requirements and recoupment amounts as described in subsection (o) of this section. Participating facilities failing to submit an acceptable Annual Staffing and Compensation Report within 60 days of the end of the rate year will be placed on vendor hold until such time as an acceptable report is received and processed by HHSC.

(A) When a participating facility changes ownership, the prior owner must submit a Staffing and Compensation Report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the ownership-change effective date. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section. The new owner will be required to submit a Staffing and Compensation Report covering the period from the day after the date recognized by HHSC or its designee as the ownership-change effective date to the end of the rate year.

(B) Participating facilities whose contracts are terminated either voluntarily or involuntarily must submit a Staffing and Compensation Report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the contract termination date. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section.

(C) Participating facilities who voluntarily withdraw from participation as per subsection (r) of this section must submit a Staffing and Compensation Report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the rate year to the date of withdrawal as determined by HHSC. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section.

(D) Participating facilities whose cost report year coincides with the state of Texas fiscal year as per §355.105(b)(5) of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures) are exempt from the requirement to submit a separate Annual Staffing and Compensation Report. For these facilities, their cost report will be considered their Annual Staffing and Compensation Report.

(2) For services delivered on September 1, 2009, and thereafter, cost reports as described in §355.105(b) of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures) will replace the Staffing and Compensation Report with the following exceptions:

(A) For services delivered from September 1, 2009, to August 31, 2010, participating facilities may be required to submit Transition Staffing and Compensation Reports in addition to required cost reports. The Transition Staffing and Compensation Report reporting period will include those days in calendar years 2009 and 2010 not included in either the 2009 Staffing and Compensation report or the facility's 2010 cost report.

(B) When a participating facility changes ownership, the prior owner must submit a Staffing and Compensation Report covering the period from the beginning of the facility's cost reporting period to the date recognized by HHSC or its designee as the ownership-change effective date. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section. The new owner will be required to submit a cost report covering the period from the day after the date recognized by HHSC or its designee as the ownership-change effective date to the end of the facility's fiscal year.

(C) Participating facilities whose contracts are terminated either voluntarily or involuntarily must submit a Staffing and Compensation Report covering the period from the beginning of the facility's cost reporting period to the date recognized by HHSC or its designee as the contract termination date. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section.

(D) Participating facilities who voluntarily withdraw from participation as per subsection (r) of this section must submit a Staffing and Compensation Report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the facility's cost reporting period to the date of withdrawal as determined by HHSC. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section. These facilities must still submit a cost report covering the entire cost reporting period. The cost report will not be used for determining any recoupment amounts.

(E) For new facilities as defined in subsection (e) of this section, the cost reporting period will begin with the effective date of participation in enhancement.

(F) Existing facilities which become participants in the enhancement as a result of the open enrollment process described in subsection (c) of this section on any day other than the first day of their fiscal year are required to submit a Staffing and Compensation Report with a reporting period that begins on their first day of participation in the enhancement and ends on the last day of the facility's fiscal year. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section. These facilities must still submit a cost report covering the entire cost reporting period. The cost report will not be used for determining any recoupment amounts.

(G) A participating provider that is required to submit a cost report or Attendant Compensation Report under this paragraph will be excused from the requirement to submit a report if the provider did not provide any billable services to DADS recipients during the reporting period.

(3) Other reports. HHSC may require other Staffing and Compensation Reports from all facilities as needed.

(4) Vendor hold. HHSC or its designee will place on hold the vendor payments for any participating facility that does not submit a timely report as described in paragraph (1) of this subsection, or for services delivered on or after September 1, 2009, a timely report as described in paragraph (2) of this subsection completed in accordance with all applicable rules and instructions. This vendor hold will remain in effect until HHSC receives an acceptable report.

(A) Participating facilities that do not submit an acceptable report completed in accordance with all applicable rules and instructions within 60 days of the due dates described in this subsection or, for cost reports, the due dates described in §355.105(b) of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures), will become nonparticipants retroactive to the first day of the reporting period in question and will be subject to an immediate recoupment of funds related to participation paid to the facility for services provided during the reporting period in question. These facilities will remain nonparticipants and recouped funds will not be restored until they submit an acceptable report and repay to HHSC, or its designee, funds identified for recoupment from subsections (n) and/or (o) of this section. If an acceptable report is not received within 365 days of the due date, the recoupment will become permanent and, if all funds associated with participation during the reporting period in question have been recouped by HHSC or its designee, the vendor hold associated with the report will be released.

(B) Participating facilities with an ownership change or contract termination that do not submit an acceptable report completed in accordance with all applicable rules and instructions within 60 days of the change in ownership or contract termination will become nonparticipants retroactive to the first day of the reporting period in question and will be subject to an immediate recoupment of funds related to participation paid to the facility for services provided during the reporting period in question. These facilities will remain nonparticipants and recouped funds will not be restored until they submit an acceptable report and repay to HHSC or its designee funds identified for recoupment from subsections (n) and/or (o) of this section. If an acceptable report is not received within 365 days of the change of ownership or contract termination date, the recoupment will become permanent and if all funds associated with participation during the reporting period in question have been recouped by HHSC or its designee, the vendor hold associated with the report will be released.

(5) Provider-initiated amended accountability reports and cost reports functioning as Staffing and Compensation Reports. Reports must be received prior to the date the provider is notified of compliance with spending and/or staffing requirements for the report in question as per subsections (n) and/or (o) of this section.

(g) Report contents. Annual Staffing and Compensation Reports and cost reports functioning as Staffing and Compensation Reports will include any information required by HHSC to implement this enhanced direct care staff rate.

(h) Completion of Reports. All Staffing and Compensation Reports and cost reports functioning as Staffing and Compensation Reports must be completed in accordance with the provisions of §§355.102 - 355.105 of this title (relating to General Principles of Allowable and Unallowable Costs, Specifications for Allowable and Unallowable Costs, Revenues, and General Reporting and Documentation Requirements, Methods, and Procedures) and may be reviewed or audited in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). Beginning with the state fiscal year 2002 report, all Staffing and Compensation Reports and cost reports functioning as Staffing and Compensation Reports must be completed by preparers who have attended the required nursing facility cost report training as per §355.102(d) of this title (relating to General Principles of Allowable and Unallowable Costs).

(i) Enrollment limitations. A facility will not be enrolled in the enhanced direct care staff rate at a level higher than the level it achieved on its most recently available, audited Staffing and Compensation Report or cost report functioning as its Staffing and Compensation Report. HHSC will issue a notification letter that informs a facility in writing of its enrollment limitations (if any) prior to the first day of the open enrollment period.

(1) Requests for revision. A facility may request a revision of its enrollment limitation if the facility's most recently available, audited Staffing and Compensation Report or cost report functioning as its Staffing and Compensation Report does not represent its current staffing levels.

(A) A request for revision of enrollment limitation must include the documentation specified in subparagraph (B) of this paragraph and must be received by HHSC Rate Analysis by hand delivery, United States mail, or special delivery mail no later than 30 calendar days from the date on the notification letter. 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. A request for revision that is not received by the stated deadline and that is not submitted on the form specified by HHSC will not be accepted and the enrollment limitation specified in the notification letter will apply.

(B) A facility that requests a revision of its enrollment limitation must submit documentation, in the form specified by HHSC in the notification letter, which shows that, for the period beginning September 1 of the current rate year and ending April 30 of the current

rate year, the facility met a higher staffing level than the notification letter indicates. In such cases, the facility's enrollment limitation will be established at the level supported by its request for revision documentation. It is the responsibility of the facility to render all required documentation at the time of its request for revision. Requests not in the form specified by HHSC in the notification letter and requests that fail to support a staffing level different than indicated in the notification letter will result in a rejection of the request and the enrollment limitation specified in the notification letter will apply.

(C) A request for revision must be signed by an individual legally responsible for the conduct of the facility or legally authorized to bind the facility, 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 DADS signature authority designation form for the interested party on file at the time of the request, or a legal representative for the interested party. A request for revision that is not signed by an individual legally responsible for the conduct of the interested party will not be accepted and the enrollment limitation specified in the notification letter will apply.

(D) If the facility's Staffing and Compensation Report or cost report functioning as its Staffing and Compensation Report for the rate year that included the open enrollment period described in subsection (d) of this section shows the facility staffed below the level it presented in its request for revision, HHSC will immediately recoup all enhancement payments associated with the request for revision documents and the facility will be limited to the level supported by the report for the remainder of the rate year.

(E) At no time will a facility be allowed to enroll in the enhancement program at a level higher than its current level of enrollment plus three additional levels unless otherwise instructed by HHSC Rate Analysis.

(2) New owners after a change of ownership. Enhancement levels for a new owner after a change of ownership will be determined in accordance with subsection (y) of this section. A new owner will not be subject to enrollment limitations based upon the prior owner's performance. This exemption from enrollment limitations does not apply in cases where HHSC or its designee has approved a successor-liability-agreement that transfers responsibility from the former owner to the new owner.

(3) New facilities. A new facility's enrollment will be determined in accordance with subsection (e) of this section.

(j) Determination of staffing requirements for participants. Facilities choosing to participate in the enhanced direct care staff rate agree to maintain certain direct care staffing levels above the minimum staffing levels described in paragraph (1) of this subsection. In order to permit facilities the flexibility to substitute RN, LVN and aide (Medication Aide and nurse aide) staff resources and, at the same time, comply with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN equivalent minutes. Conversion factors to convert RN and aide minutes into LVN equivalent minutes are based upon most recently available, reliable relative compensation levels for the different staff types.

(1) Minimum staffing levels. HHSC determines, for each participating facility, minimum LVN equivalent staffing levels as follows.

(A) Determine minimum required LVN equivalent minutes per resident day of service for various types of residents using time study data, cost report information, and other appropriate data sources.

(i) Determine LVN equivalent minutes associated with Medicare residents based on the data sources from this subparagraph adjusted for estimated acuity differences between Medicare and Medicaid residents.

(ii) Determine minimum required LVN equivalent minutes per resident day of service associated with each Resource Utilization Group (RUG-III) case mix group and additional minimum required minutes for Medicaid residents reimbursed under the RUG-III system who also qualify for supplemental reimbursement for ventilator care or pediatric tracheostomy care as described in §355.307 of this title (relating to Reimbursement Setting Methodology) based on the data sources from this subparagraph adjusted for acuity differences between Medicare and Medicaid residents and other factors.

(B) Based on most recently available, reliable utilization data, determine for each facility the total days of service by RUG-III group, days of service provided to Medicaid residents qualifying for Medicaid supplemental reimbursement for ventilator or tracheostomy care, total days of service for Medicare Part A residents in Medicaid-contracted beds, and total days of service for all other residents in Medicaid-contracted beds.

(C) Multiply the minimum required LVN equivalent minutes for each RUG-III group and supplemental reimbursement group from subparagraph (A) of this paragraph by the facility's Medicaid days of service in each RUG-III group and supplemental reimbursement group from subparagraph (B) of this paragraph and sum the products.

(D) Multiply the minimum required LVN equivalent minutes for Medicare residents by the facility's Medicare Part A days of service in Medicaid-contracted beds.

(E) Divide the sum from subparagraph (C) of this paragraph by the facility's total Medicaid days of service, with a day of service for a Medicaid RUG-III recipient who also qualifies for a supplemental reimbursement counted as one day of service, compare this result to the minimum required LVN-equivalent minutes for a RUG-III PD1 and multiply the lower of the two figures by the facility's other resident days of service in Medicaid-contracted beds.

(F) Sum the results of subparagraphs (C), (D) and (E) of this paragraph, divide the sum by the facility's total days of service in Medicaid-contracted beds, with a day of service for a Medicaid recipient who also qualifies for a supplemental reimbursement counted as one day of service. The results of these calculations are the minimum LVN equivalent minutes per resident day a participating facility must provide.

(G) In cases where the minimum required LVN-equivalent minutes per resident day of service associated with a RUG-III case mix group or supplemental reimbursement group change during the reporting period, the minimum required LVN-equivalent minutes for the RUG-III case mix group or supplemental reimbursement group for the reporting period will be equal to the weighted average LVN-equivalent minutes in effect during the reporting period for that group calculated as follows:

(i) Multiply the first minimum required LVN equivalent minutes per resident day of service associated with the RUG-III case mix group or supplemental reimbursement group in effect during the reporting period by the most recently available, reliable Medicaid days of service utilization data for the time period the first minimum required LVN equivalent minutes were in effect.

(ii) Multiply the second minimum required LVN equivalent minutes per resident day of service associated with the RUG-III case mix group or supplemental reimbursement group in

effect during the reporting period by the most recently available, reliable Medicaid days of service utilization data for the time period the second minimum required LVN equivalent minutes were in effect.

(iii) Sum the products from clauses (i) and (ii) of this subparagraph.

(iv) Divide the sum from clause (iii) of this subparagraph by the sum of the most recently available, reliable Medicaid days of service utilization data for the entire reporting period used in clauses (i) and (ii) of this subparagraph.

(2) Enhanced staffing levels. Facilities desiring to participate in the enhanced direct care staff rate are required to staff above the minimum requirements from paragraph (1) of this subsection. These facilities may request LVN-equivalent staffing enhancements from an array of LVN-equivalent enhanced staffing options and associated add-on payments during open enrollment under subsection (d) of this section.

(3) Granting of staffing enhancements. HHSC divides all requested enhancements, after applying any enrollment limitations from subsection (i) of this section, into two groups: pre-existing enhancements that facilities request to carry over from the prior year and newly-requested enhancements. Newly-requested enhancements may be enhancements requested by facilities that were nonparticipants in the prior year or by facilities that were participants in the prior year desiring to be granted additional enhancements. Using the process described herein, HHSC first determines the distribution of carry-over enhancements. If HHSC determines that funds are not available to carry over some or all pre-existing enhancements, facilities will be notified as per subsection (ee) of this section. If funds are available after the distribution of carry-over enhancements, HHSC then determines the distribution of newly requested enhancements. HHSC may not distribute newly requested enhancements to facilities owing funds identified for recoupment from subsections (n) and/or (o) of this section.

(A) HHSC determines projected Medicaid units of service for facilities requesting each enhancement option, and multiplies this number by the rate add-on associated with that enhancement option as determined in subsection (l) of this section.

(B) HHSC compares the sum of the products from subparagraph (A) of this paragraph to available funds.

(i) If the product is less than or equal to available funds, all requested enhancements are granted.

(ii) If the product is greater than available funds, enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds. Based upon an examination of existing staffing levels and staffing needs, HHSC may grant certain enhancement options priority for distribution.

(4) Notification of granting of enhancements. Participating facilities are notified, in a manner determined by HHSC, as to the disposition of their request for staffing enhancements.

(5) In cases where more than one enhanced staffing level is in effect during the reporting period, the staffing requirement will be based on the weighted average enhanced staffing level in effect during the reporting period calculated as follows:

(A) Multiply the first enhanced staffing level in effect during the reporting period by the most recently available, reliable Medicaid days of service utilization data for the time period the first enhanced staffing level was in effect.

(B) Multiply the second enhanced staffing level in effect during the reporting period by the most recently available, reliable Medicaid days of service utilization data for the time period the second enhanced staffing level was in effect.

(C) Sum the products from subparagraphs (A) and (B) of this paragraph.

(D) Divide the sum from subparagraph (C) of this paragraph by the sum of the most recently available, reliable Medicaid days of service utilization data for the entire reporting period used in subparagraphs (A) and (B) of this paragraph.

(k) Determination of direct care staff base rate.

(1) Determine the sum of recipient care costs from the direct care staff cost center in subsection (a) of this section in all nursing facilities included in the Texas Nursing Facility Cost Report database used to determine the nursing facility rates in effect on January 1, 2000 (hereinafter referred to as the initial database).

(2) Adjust the sum from paragraph (1) of this subsection as specified in §355.108 of this title (relating to Determination of Inflation Indices) to inflate the costs to the prospective rate year.

(3) Divide the result from paragraph (2) of this subsection by the sum of recipient days of service in all facilities in the initial database and multiply the result by 1.07. The result is the average direct care staff base rate component for all facilities.

(4) For rates effective September 1, 2009 and thereafter, to calculate the direct care staff per diem base rate component for all facilities for each of the RUG-III case mix groups and for the default groups, divide each RUG-III index from §355.307(b)(3)(C) of this title (relating to Reimbursement Methodology) by 0.9908, which is the weighted average Texas Index for Level of Effort (TILE) case mix index associated with the initial database, and then multiply each of the resulting quotients by the average direct care staff base rate component from paragraph (3) of this subsection.

(5) The direct care staff per diem base rates will remain constant except for adjustments for inflation from paragraph (2) of this subsection. HHSC may also recommend adjustments to the rates in accordance with §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(l) Determine each participating facility's total direct care staff rate. Each participating facility's total direct care staff rate will be equal to the direct care staff base rate from subsection (k) of this section plus any add-on payments associated with enhanced staffing levels selected by and awarded to the facility during open enrollment. HHSC will determine a per diem add-on payment for each enhanced staffing level taking into consideration the most recently available, reliable data relating to LVN equivalent compensation levels.

(m) Staffing requirements for participating facilities. Each participating facility will be required to maintain adjusted LVN-equivalent minutes equal to those determined in subsection (j) of this section. Each participating facility's adjusted LVN-equivalent minutes maintained during the reporting period will be determined as follows.

(1) Determine unadjusted LVN-equivalent minutes maintained. Upon receipt of the staffing and spending information described in subsection (f) of this section, HHSC will determine the unadjusted LVN-equivalent minutes maintained by each facility during the reporting period.

(2) Determine adjusted LVN-equivalent minutes maintained. Compare the unadjusted LVN-equivalent minutes maintained

by the facility during the reporting period from paragraph (1) of this subsection to the LVN-equivalent minutes required of the facility as determined in subsection (j) of this section. The adjusted LVN-equivalent minutes are determined as follows:

(A) If the number of unadjusted LVN-equivalent minutes maintained by the facility during the reporting period is greater than or equal to the number of LVN-equivalent minutes required for the facility or less than the minimum LVN-equivalent minutes required for participation as determined in subsection (j)(1) of this section; the facility's adjusted LVN-equivalent minutes maintained is equal to its unadjusted LVN-equivalent minutes; or

(B) If the number of unadjusted LVN-equivalent minutes maintained by the facility during the reporting period is less than the number of LVN-equivalent minutes required of the facility, but greater than or equal to the minimum LVN-equivalent minutes required for participation as determined in subsection (j)(1) of this section, the following steps are performed.

(i) Determine what the facility's accrued Medicaid fee-for-service direct care revenue for the reporting period would have been if their staffing requirement had been set at a level consistent with the highest LVN-equivalent minutes that the facility actually maintained, as defined in subsection (j) of this section.

(ii) Determine the facility's adjusted accrued direct care revenue by multiplying the accrued direct care revenue from clause (i) of this subparagraph by 0.85.

(iii) Determine the facility's accrued allowable Medicaid fee-for-service direct care staff expenses for the rate year.

(iv) Determine the facility's direct care spending surplus for the reporting period by subtracting the facility's adjusted accrued direct care revenue from clause (ii) of this subparagraph from the facility's accrued allowable direct care expenses from clause (iii) of this subparagraph.

(v) If the facility's direct care spending surplus from clause (iv) of this subparagraph is less than or equal to zero, the facility's adjusted LVN-equivalent minutes maintained is equal to the unadjusted LVN-equivalent minutes maintained as calculated in paragraph (1) of this subsection.

(vi) If the facility's direct care spending surplus from clause (iv) of this subparagraph is greater than zero, the adjusted LVN-equivalent minutes maintained by the facility during the reporting period is set equal to the facility's direct care spending surplus from clause (iv) of this subparagraph divided by the per diem enhancement add-on as determined in subsection (l) of this section plus the unadjusted LVN-equivalent minutes maintained by the facility during the reporting period from paragraph (1) of this subsection according to the following formula: (Direct Care Spending Surplus/Per Diem Enhancement Add-on for One LVN-equivalent Minute) + Unadjusted LVN-equivalent Minutes.

(C) For adjusted LVN-equivalent minutes calculated on or after March 1, 2004, requirements relating to the minimum LVN-equivalent minutes required for participation in subparagraphs (A) and (B) of this paragraph do not apply.

(n) Staffing accountability. Participating facilities will be responsible for maintaining the staffing levels determined in subsection (j) of this section. HHSC will determine the adjusted LVN-equivalent minutes maintained by each facility during the reporting period by the method described in subsection (m) of this section. HHSC or its designee will recoup all direct care staff revenues associated with unmet staffing goals from participating facilities that fail to meet their staffing requirements during the reporting period.

(o) Spending requirements for participants. Participating facilities are subject to a direct care staff spending requirement with recoupment calculated as follows:

(1) At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service direct care staff revenues (net of revenues recouped by HHSC or its designee due to the failure of the facility to meet a staffing requirement as per subsection (n) of this section) by 0.85.

(2) Accrued allowable Medicaid direct care staff fee-for-service expenses for the rate year will be compared to the spending floor from paragraph (1) of this subsection. HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid direct care staff fee-for-service expenses from facilities whose Medicaid direct care staff spending is less than their spending floor.

(3) At no time will a participating facility's direct care rates after spending recoupment be less than the direct care base rates.

(p) Dietary and Fixed Capital Mitigation. Recoupment of funds described in subsection (o) of this section may be mitigated by high dietary and/or fixed capital expenses as follows.

(1) Calculate dietary cost deficit. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If costs are greater than revenues, the dietary per diem cost deficit will be equal to the difference between accrued, allowable Medicaid dietary per diem costs and accrued Medicaid dietary per diem revenues. If costs are less than revenues, the dietary cost deficit will be equal to zero.

(2) Calculate dietary revenue surplus. At the end of the facility's rate, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If revenues are greater than costs, the dietary per diem revenue surplus will be equal to the difference between accrued Medicaid dietary per diem revenues and accrued, allowable Medicaid dietary per diem costs. If revenues are less than costs, the dietary revenue surplus will be equal to zero.

(3) Calculate fixed capital cost deficit. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs as defined in §355.306(b)(2)(A) of this title (relating to Cost Finding Methodology). If costs are greater than revenues, the fixed capital cost per diem deficit will be equal to the difference between accrued, allowable Medicaid fixed capital per diem costs and accrued Medicaid fixed capital per diem revenues. If costs are less than revenues, the fixed capital cost deficit will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year.

(4) Calculate fixed capital revenue surplus. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs as defined in §355.306(b)(2)(A) of this title (relating to Cost Finding Methodology). If revenues are greater than costs, the fixed capital revenue per diem surplus will be equal to the difference between accrued Medicaid fixed capital per diem revenues and accrued, allowable Medicaid fixed capital per diem costs. If revenues are less than costs, the fixed capital revenue surplus will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities

with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year.

(5) Facilities with a dietary per diem cost deficit will have their dietary per diem cost deficit reduced by their fixed capital per diem revenue surplus, if any. Any remaining dietary per diem cost deficit will be capped at $2.00 per diem.

(6) Facilities with a fixed capital cost per diem deficit will have their fixed capital cost per diem deficit reduced by their dietary revenue per diem surplus, if any. Any remaining fixed capital per diem cost deficit will be capped at $2.00 per diem.

(7) Each facility's recoupment, as calculated in subsection (o) of this section, will be reduced by the sum of that facility's dietary per diem cost deficit as calculated in paragraph (5) of this subsection and its fixed capital per diem cost deficit as calculated in paragraph (6) of this subsection.

(q) Adjusting staffing requirements. Facilities that determine that they will not be able to meet their staffing requirements from subsection (m) of this section may request a reduction in their staffing requirements and associated rate add-on. These requests will be effective on the first day of the month following approval of the request.

(r) Voluntary withdrawal. Facilities wishing to withdraw from participation must notify HHSC in writing by certified mail and the request must be signed by an authorized representative as designated per the DADS signature authority designation form applicable to the provider's contract or ownership type. Facilities voluntarily withdrawing must remain nonparticipants for the remainder of the rate year. Facilities that voluntarily withdraw from participation will have their participation end effective on the date of the withdrawal, as determined by HHSC.

(s) Notification of recoupment based on Annual Staffing and Compensation Report or cost report. Facilities will be notified, in a manner specified by HHSC, within 90 days of the determination of their recoupment amount by HHSC of the amount to be repaid to HHSC or its designee. If a subsequent review by HHSC or audit results in adjustments to the Annual Staffing and Compensation Report or cost report as described in subsection (f) of this section that changes the amount to be repaid to HHSC or its designee, the facility will be notified in writing of the adjustments and the adjusted amount to be repaid. HHSC or its designee will recoup any amount owed from a facility's vendor payment(s) following the date of the notification letter. Providers notified of a recoupment based on an Annual Staffing and Compensation Report described in subsection (f)(2)(A) or (f)(2)(F) of this section may request that HHSC recalculate their recoupment after combining the Annual Staffing and Compensation Report with the provider's next cost report or Staffing and Compensation Report, as appropriate. The request must be in writing and must be received by HHSC Rate Analysis by hand delivery, United States mail, or special mail delivery no later than 30 days after the date on the written notification of recoupment. 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. The written request must be signed by an individual legally responsible for the conduct of the provider, 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 signature authority designation form for the provider at the time of the request, or a legal representative for the provider. The administrator or director of a facility or program is not authorized to sign the request unless the administrator or director holds one of these positions. HHSC will not accept a request that is not signed by an individual responsible for the conduct of the provider.

(t) Change of ownership and contract terminations. Facilities required to submit a Staffing and Compensation Report due to a change of ownership or contract termination as described in subsection (f) of this section will have funds held as per 40 TAC §19.2308 (relating to Change of Ownership) until an acceptable Staffing and Compensation Report is received by HHSC and funds identified for recoupment from subsections (n) and/or (o) of this section are repaid to HHSC or its designee. Informal reviews and formal appeals relating to these reports are governed by §355.110 of this title (relating to Informal Reviews and Formal Appeals). HHSC or its designee will recoup any amount owed from the facility's vendor payments that are being held. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (x) of this section will be jointly and severally liable for any additional payment due to HHSC or its designee. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in the recoupment of the owed funds from other Medicaid contracts controlled by the responsible entity, placement of a vendor hold on all Medicaid contracts controlled by the responsible entity and will bar the responsible entity from receiving any new contracts with HHSC or its designees until repayment is made in full. The responsible entity for these contracts will be notified as described in subsection (s) of this section prior to the recoupment of owed funds, placement of vendor hold and barring of new contracts.

(u) Failure to document staff time and spending. Undocumented direct care staff and contract labor time and compensation costs will be disallowed and will not be used in the determination of direct care staff time and costs per unit of service.

(v) All other rate components. All other rate components will be calculated as specified in §355.307 of this title (relating to Reimbursement Setting Methodology) and will be uniform for all providers.

(w) Appeals. Subject matter of informal reviews and formal appeals is limited as per §355.110(a)(3) of this title (relating to Informal Reviews and Formal Appeals).

(x) Responsible entities. The contracted provider, owner, or legal entity that received the revenue to be recouped upon is responsible for the repayment of any recoupment amount.

(y) Change of ownership. Participation in the enhanced direct care staff rate confers to the new owner as defined in 40 TAC §19.2308 (relating to Change of Ownership) when there is a change of ownership. The new owner is responsible for the reporting requirements in subsection (f) of this section for any reporting period days occurring after the change. If the change of ownership occurs during an open enrollment period as defined in subsection (c) of this section, then the owner recognized by HHSC or its designee on the last day of the enrollment period may request to modify the enrollment status of the facility in accordance with subsection (d) of this section.

(z) Contract cancellations. If a facility's Medicaid contract is cancelled before the first day of an open enrollment period as defined in subsection (c) of this section and the facility is not granted a new contract until after the last day of the open enrollment period, participation in the enhanced direct care staff rate as it existed prior to the date when the facility's contract was cancelled will be reinstated when the facility is granted a new contract, if it remains under the same ownership, subject to the availability of funding. Any enrollment limitations from subsection (i) of this section that would have applied to the cancelled contract will apply to the new contract.

(aa) Determination of compliance with spending requirements in the aggregate.

(1) Definitions. The following words and terms have the following meanings when used in this subsection.

(A) Commonly owned corporations--two or more corporations where five or fewer identical persons who are individuals, estates, or trusts control greater than 50 percent of the total voting power in each corporation.

(B) Entity--a parent company, sole member, individual, limited partnership, or group of limited partnerships controlled by the same general partner.

(C) Combined entity--one or more commonly owned corporations and one or more limited partnerships where the general partner is controlled by the same person(s) as the commonly owned corporation(s).

(D) Control--greater than 50 percent ownership by the entity.

(2) Aggregation. For an entity, commonly owned corporation, or combined entity that controls more than one participating nursing facility contract, compliance with the spending requirements detailed in subsection (o) of this section can be determined in the aggregate for all participating nursing facility contracts controlled by the entity, commonly owned corporations, or combined entity at the end of the rate year, the effective date of the change of ownership of its last participating NF contract, or the effective date of the termination of its last participating NF contract rather than requiring each contract to meet its spending requirement individually. Corporations that do not meet the definitions under paragraph (1)(A) - (C) of this subsection are not eligible for aggregation to meet spending requirements.

(A) Aggregation Request. To exercise aggregation, the entity, combined entity, or commonly owned corporations must submit an aggregation request, in a manner prescribed by HHSC, at the time each Staffing and Compensation Report or cost report is submitted. In limited partnerships in which the same single general partner controls all the limited partnerships, the single general partner must make this request. Other such aggregation requests will be reviewed on a case-by-case basis.

(B) Frequency of Aggregation Requests. The entity, combined entity, or commonly owned corporations must submit a separate request for aggregation for each reporting period.

(C) Ownership changes or terminations. Nursing facility contracts that change ownership or terminate effective after the end of the applicable reporting period, but prior to the determination of compliance with spending requirements as per subsection (o) of this section, are excluded from all aggregate spending calculations. These contracts' compliance with spending requirements will be determined on an individual basis and the costs and revenues will not be included in the aggregate spending calculation.

(bb) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes NF nursing care to a Medicaid recipient under 40 TAC §19.2326 (relating to Medicaid Swing Bed Program for Rural Hospitals), HHSC or its designee makes payment to the hospital using the same procedures, the same case-mix methodology, and the same RUG-III rates that HHSC authorizes for reimbursing NFs receiving the direct care staff base rate with no enhancement levels. These hospitals are not subject to the staffing and spending requirements detailed in this section.

(cc) Reinvestment. For services delivered on or before August 31, 2009, HHSC will reinvest recouped funds in the enhanced direct care staff rate program, to the extent that there are qualifying facilities. For services delivered beginning September 1, 2009, and thereafter, HHSC will not reinvest recouped enhanced direct care staff rate funds.

(1) Identify qualifying facilities. Facilities meeting the following criteria during the most recent completed reporting period are qualifying facilities for reinvestment purposes.

(A) The facility was a participant in the enhanced direct care staff rate or, for state fiscal years 2004 and 2005 only, had been a participant at level 0 in state fiscal year 2003 and was reclassified as a nonparticipant due to the elimination of level 0 in state fiscal year 2004.

(B) The facility's unadjusted LVN-equivalent minutes as determined in subsection (m)(1) of this section were greater than the number of LVN-minutes required of the facility as determined in subsection (j) of this section.

(C) The facility met its spending requirement as determined in subsection (o) of this section.

(D) An acceptable Annual Staffing and Compensation Report for the reporting period was received by HHSC Rate Analysis at least 30 days prior to the date distribution of available reinvestment funds was determined.

(E) The Medicaid contract that was in effect for the facility during the reinvestment reporting period is still in effect as an active contract when reinvestment is determined or, in cases where a change of ownership has occurred, HHSC or its designee has approved a Successor Liability Agreement between the contract in effect during the reinvestment reporting period and the contract in effect when reinvestment is determined.

(2) Distribution of available reinvestment funds. Available funds are distributed as described below.

(A) HHSC determines units of service provided during the most recent completed reporting period by each qualifying facility achieving, with unadjusted LVN-equivalent minutes as determined in subsection (m)(1) of this section, each enhancement option above the enhancement option awarded to the facility during the reporting period and multiplies this number by the rate add-on associated with that enhancement in effect during the reporting period.

(B) HHSC compares the sum of the products from subparagraph (A) of this paragraph to funds available for reinvestment.

(i) If the product is less than or equal to available funds, all achieved enhancements for qualifying facilities are retroactively awarded for the reporting period.

(ii) If the product is greater than available funds, retroactive enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until achieved enhancements are granted within available funds.

(3) All retroactive enhancements are subject to spending requirements detailed in subsection (o) of this section. Revenue from retroactive enhancements is not eligible for mitigation of spending recoupment as described in subsection (p) of this section.

(4) Retroactively awarded enhancements do not qualify as pre-existing enhancements for enrollment purposes.

(5) Notification of reinvested enhancements. Qualifying facilities are notified in a manner determined by HHSC, as to the award of reinvested enhancements.

(dd) Disclaimer. Nothing in these rules should be construed as preventing facilities from adding direct care staff in addition to those funded by the enhanced direct care staff rate.

(ee) Notification of lack of available funds. If HHSC determines that funds are not available to continue participation for facilities from which it has not received an acceptable request to modify their enrollment by the last day of an enrollment period as per subsection (d) of this section or to fund carry-over enhancements as per subsection (j)(3) of this section, HHSC will notify providers in a manner determined by HHSC that such funds are not available.

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

Filed with the Office of the Secretary of State on August 11, 2014.

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Jack Stick
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 424-6900

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SUBCHAPTER E. COMMUNITY CARE FOR AGED AND DISABLED

1 TAC §§355.503, 355.505, 355.513

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 provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

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.

§355.503. Reimbursement Methodology for the Community-Based Alternatives Waiver Program and the Integrated Care Management-Home and Community Support Services and Assisted Living/Residential Care Programs.

(a) General requirements. The Texas Health and Human Services Commission (HHSC) applies the general principles of cost determination as specified in §355.101 of this title (relating to Introduction). Providers are reimbursed for waiver services provided to individuals who meet the criteria for alternatives to nursing facility care. Additionally, providers are reimbursed a one-time administrative expense fee for a pre-enrollment assessment of potential waiver participants. The pre-enrollment assessment covers care planning for the participant.

(b) Other sources of cost information. If HHSC has determined that there is not sufficient reliable cost report data from which to determine reimbursements and reimbursement ceilings for waiver services, reimbursements and reimbursement ceilings will be developed by using data from surveys; cost report data from other similar programs, consultation with other service providers or professionals experienced in delivering contracted services; and other sources.

(c) Waiver reimbursement determination. Recommended reimbursements are determined in the following manner:

(1) Unit of service reimbursement. Reimbursement for personal assistance services and in-home respite care services, and cost per unit of service for nursing services provided by a registered nurse (RN), nursing services provided by a licensed vocational nurse (LVN), physical therapy, occupational therapy, speech/language therapy, supported employment, employment assistance, and day activity and health services will be determined on a fee-for-service basis in the following manner:

(A) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report.

(B) Total allowable costs are reduced by the amount of the pre-enrollment expense fee and requisition fee revenues accrued for the reporting period.

(C) Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices). The prospective reimbursement period is the period of time that the reimbursement is expected to be in effect.

(D) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Medicare Contributions, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(E) Allowable administrative and facility costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver service's units of service to the amount of total waiver units of service.

(F) For nursing services provided by an RN, nursing services provided by an LVN, physical therapy, occupational therapy, speech/language therapy, supported employment, employment assistance, and in-home respite care services, an allowable cost per unit of service is calculated for each contracted provider cost report for each service. The allowable cost per unit of service, for each contracted provider cost report is multiplied by 1.044. This adjusted allowable cost per unit of service may be combined into an array with the allowable cost per unit of service of similar services provided by other programs in determining rates for these services in accordance with §355.502 of this title (relating to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

(G) For personal assistance services, two cost areas are created:

(i) The attendant cost area includes salaries, wages, benefits, and mileage reimbursement calculated as specified in §355.112 of this title (relating to Attendant Compensation Rate Enhancement).

(ii) Another attendant cost area is created which includes the other personal attendant services costs not included in clause (i) of this subparagraph as determined in subparagraphs (A) - (E) of this paragraph. An allowable cost per unit of service is determined for each contracted provider cost report for the other attendant cost area. The allowable cost per unit of service for each contracted provider cost

report are arrayed. The units of service for each contracted provider cost report in the array are summed until the median unit of service is reached. The corresponding expense to the median unit of service is determined and is multiplied by 1.044.

(iii) The attendant cost area and the other attendant cost area are summed to determine the personal assistance services cost per unit of service.

(2) Per day reimbursement.

(A) The reimbursement for Adult Foster Care (AFC) and out-of-home respite care in an AFC home will be determined as a per day reimbursement using a method based on modeled projected expenses, which are developed using data from surveys, cost report data from other similar programs, consultation with other service providers or professionals experienced in delivering contracted services, and other sources. The room and board payments for AFC Services are not covered in these reimbursements and will be paid to providers from the client's Supplemental Security Income, less a personal needs allowance.

(B) The reimbursement for Assisted Living/Residential Care (AL/RC) will be determined as a per day reimbursement in accordance with §355.509(a) - (c)(2)(E)(iii) of this title (relating to Reimbursement Methodology for Residential Care).

(i) The per day reimbursement for attendant care for each of the six levels of care will be determined based upon client need for attendant care.

(ii) A total reimbursement amount will be calculated and the proposed reimbursement is equal to the total reimbursement less the client's room and board payments.

(iii) The room and board payment is paid to the provider by the client from the client's Supplemental Security Income (SSI), less a personal needs allowance.

(iv) The reimbursement for out-of-home respite in an AL/RC facility is determined using the same methodology as the reimbursement for AL/RC except that the out-of-home respite rates:

(I) are set at the rate for providers who choose not to participate in the attendant compensation rate enhancement; and

(II) include room and board costs equal to the client's SSI, less a personal needs allowance.

(v) When the SSI is increased or decreased by the Federal Social Security Administration, the reimbursement for AL/RC and out-of-home respite provided in an AL/RC facility will be adjusted in amounts equal to the increase or decrease in SSI received by clients.

(C) The reimbursement for out-of-home respite care provided in a Nursing Facility will be based on the amount determined for the Nursing Facility case mix class into which the CBA participant is classified.

(D) The reimbursement for Personal Care 3 will be composed of two rate components, one for the direct care cost center and one for the non-direct care cost center.

(i) Direct care costs. The rate component for the direct care cost center will be determined by modeling the cost of the minimum required staffing for the Personal Care 3 setting, as specified by the Department of Aging and Disability Services, and using staff costs and other statistics from the most recently audited cost reports from providers delivering similar care.

(ii) Non-direct care costs. The rate component for the non-direct care cost center will be equal to the non-attendant portion of the non-apartment assisted living rate per day for non-participants in the Attendant Compensation Rate Enhancement. Providers receiving the Personal Care 3 rate are not eligible to participate in the Attendant Compensation Rate Enhancement and receive direct care add-on's to the Personal Care 3 rates.

(3) Emergency Response Services. The reimbursement for Emergency Response Services will be determined as monthly reimbursement ceiling, based on the ceiling amount determined in accordance with §355.510 of this title (relating to Reimbursement Methodology for Emergency Response Services (ERS)).

(4) Requisition fees. Requisition fees are reimbursements paid to the CBA home and community support services contracted providers for their efforts in acquiring adaptive aids, medical supplies, dental services, and minor home modifications for CBA participants. Reimbursement for requisition fees for adaptive aids, medical supplies, dental services, and minor home modifications will vary based on the actual cost of the adaptive aids, medical supplies, dental services, and minor home modifications. Reimbursements are determined using a method based on modeled projected expenses, which are developed by using data from surveys; cost report data from similar programs; consultation with other service providers and/or professionals experienced in delivering contracted services; and/or other sources.

(5) Pre-enrollment expense fee. Reimbursement for pre-enrollment assessment is determined using a method based on modeled projected expenses that are developed by using data from surveys; cost report data from other similar programs; consultation with other service providers and/or professionals experienced in delivering contracted services; and other sources.

(6) Home-Delivered Meals. The reimbursement for Home-Delivered Meals will be determined on a per meal basis, based on the ceiling amount determined in accordance with §355.511 of this title (relating to Reimbursement Methodology for Home-Delivered Meals).

(7) Exceptions to the reimbursement determination methodology. HHSC may 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).

(d) Authority to determine reimbursement. The authority to determine reimbursement is specified in §355.101 of this title.

(e) Reporting of cost.

(1) Cost reporting guidelines. If HHSC requires a cost report for any waiver service in this program, providers must follow the cost-reporting guidelines as specified in §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) Excused from submission of cost reports. If required by HHSC, a contracted provider must submit a cost report unless the provider meets one or more of the conditions in §355.105(b)(4)(D) of this title.

(3) Number of cost reports to be submitted.

(A) Contracted providers participating in the attendant compensation rate enhancement.

(i) At the same level of enhancement. If all the contracts under the legal entity participate in the enhancement at the same level of enhancement, the contracted provider must submit one cost report for the legal entity.

(ii) At different levels of enhancement. If all the contracts under the legal entity participate in the enhancement but they participate at more than one enhancement level, the contracted provider must submit one cost report for each level of enhancement.

(B) Contracted providers not participating in the attendant compensation rate enhancement. If all the contracts under the legal entity do not participate in the enhancement, the contracted provider must submit one cost report for the legal entity.

(C) Contractors participating and not participating in attendant compensation rate enhancement.

(i) At the same level of enhancement. If some of the contracts under the legal entity do not participate in the enhancement and the rest of the contracts under the legal entity participate at the same level of enhancement, the contracted provider must submit:

(I) one cost report for the contracts that do not participate; and

(II) one cost report for the contracts that do participate.

(ii) At different levels of enhancement. If some of the contracts under the legal entity do not participate in the enhancement and the rest of the contracts under the legal entity participate in the enhancement but they participate at more than one enhancement level, the contracted provider must submit:

(I) one cost report for the contracts that do not participate; and

(II) one cost report for each level of enhancement.

(4) Reporting and verification of allowable cost.

(A) 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 reimbursements. HHSC excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services, and are consistent with federal and state regulations.

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

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

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

(5) Allowable and unallowable costs. Providers must follow the guidelines in determining whether a cost is allowable or unallowable 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), in addition to the following.

(A) Client room and board expenses are not allowable, except for those related to respite care.

(B) The actual cost of adaptive aids, medical supplies, dental services, and home modifications are not allowable for cost reporting purposes. Allowable labor costs associated with acquiring adaptive aids, medical supplies, dental services, and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable for cost reporting purposes. Refer to §355.103(b)(20) [~~(17)~~](K) of this title.

(f) Reporting revenue. Revenues must be reported on the cost report in accordance with §355.104 of this title (relating to Revenues).

(g) Reviews and field audits of cost reports. Desk reviews or field audits are performed on cost reports for all contracted providers. The frequency and nature of the field audits are determined by HHSC to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and 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). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this title (relating to Informal Reviews and Formal Appeals).

§355.505. Reimbursement Methodology for the Community Living Assistance and Support Services Waiver Program.

(a) General requirements. The Texas Health and Human Services Commission (HHSC) applies the general principles of cost determination as specified in §355.101 of this title (relating to Introduction). Providers are reimbursed for waiver services provided to Medicaid-enrolled persons with related conditions. Additionally, providers will be reimbursed a one-time administrative expense fee for a pre-enrollment assessment of potential waiver participants. The pre-enrollment assessment covers care planning for the participant.

(b) Reporting of cost.

(1) Providers must follow the cost reporting guidelines as specified in §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) Number of cost reports to be submitted. All legal entities must submit a cost report unless the number of days between the date the legal entity's first Texas Department of Aging and Disability Services (DADS) client received services and the legal entity's fiscal year end is 30 days or fewer.

(A) Contracted providers participating in the attendant compensation rate enhancement.

(i) At the same level of enhancement. If all the contracts under the legal entity participate in the enhancement at the same level of enhancement, the contracted provider must submit one cost report for the legal entity.

(ii) At different levels of enhancement. If all the contracts under the legal entity participate in the enhancement but they participate at more than one enhancement level, the contracted provider must submit one cost report for each level of enhancement.

(B) Contracted providers not participating in the attendant compensation rate enhancement. If all the contracts under the legal entity do not participate in the enhancement, the contracted provider must submit one cost report for the legal entity.

(C) Contractors participating and not participating in attendant compensation rate enhancement.

(i) At the same level of enhancement. If some of the contracts under the legal entity do not participate in the enhancement and the rest of the contracts under the legal entity participate at the same level of enhancement, the contracted provider must submit:

(I) one cost report for the contracts that do not participate; and

(II) one cost report for the contracts that do participate.

(ii) At different levels of enhancement. If some of the contracts under the legal entity do not participate in the enhancement and the rest of the contracts under the legal entity participate in the enhancement but they participate at more than one enhancement level, the contracted provider must submit:

(I) one cost report for the contracts that do not participate; and

(II) one cost report for each level of enhancement.

(3) Excused from submission of cost reports. If required by HHSC, a contracted provider must submit a cost report unless the provider meets one or more of the conditions in §355.105(b)(4)(D) of this title.

(c) Waiver reimbursement determination methodology.

(1) Unit of service reimbursement or reimbursement ceiling by unit of service. Reimbursement or reimbursement ceilings for related-conditions waiver services, habilitation, nursing services provided by a registered nurse (RN), nursing services provided by a licensed vocational nurse (LVN), physical therapy, occupational therapy, speech/language therapy, behavioral support, auditory integration training/auditory enhancement training (audiology services), nutritional services, employment assistance, supported employment, day activity and health services, and in-home and out-of-home respite care services will be determined on a fee-for-service basis. These services are provided under §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(2) Monthly reimbursement. The reimbursement for case management waiver service will be determined as a monthly reimbursement. This service is provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(3) Reporting and verification of allowable cost.

(A) 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 reimbursements. HHSC excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information that are necessary for the provision of services and are consistent with federal and state regulations.

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

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

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

(4) Reimbursement determination. Recommended unit of service reimbursements and reimbursement ceilings by unit of service are determined in the following manner:

(A) Unit of service reimbursement for habilitation, and cost per unit of service for nursing services provided by an RN, nursing services provided by an LVN, physical therapy, occupational therapy, speech/language therapy, behavioral support services, auditory integration training/auditory enhancement training (audiology services), nutritional services, employment assistance, supported employment, and in-home and out-of-home respite care are determined in the following manner:

(i) The total allowable cost for each contracted provider cost report will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

(ii) The total allowable cost is reduced by the amount of the administrative expense fee and requisition fee revenues accrued for the reporting period.

(iii) Each provider's total allowable cost, excluding depreciation and mortgage interest, is projected from the historical cost reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices).

(iv) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Medicare contributions, Workers' compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(v) Allowable administrative and facility costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver service's units of service to the amount of total waiver units of service.

(vi) Each provider's projected total allowable cost is divided by the number of units of service to determine the projected cost per unit of service.

(vii) For nursing services provided by an RN, nursing services provided by an LVN, physical therapy, occupational therapy, speech/language therapy, in-home respite care, behavioral support services, auditory integration training/auditory enhancement training (audiology services), nutritional services, employment assistance, and supported employment, the projected cost per unit of service, for each provider is multiplied by 1.044. This adjusted allowable cost per unit of service may be combined into an array with the allowable cost per unit of service of similar services provided by other programs in determining rates for these services in accordance with §355.502 of this title (relating to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

(viii) For habilitation services two cost areas are created:

(I) The attendant cost area includes salaries, wages, benefits, and mileage reimbursement calculated as specified in §355.112 of this title (relating to Attendant Compensation Rate Enhancement).

(II) Another attendant cost area is created which includes the other habilitation services costs not included in subclause (I) of this clause as determined in clauses (i) - (v) of this subparagraph to create an other attendant cost area. An allowable cost per unit of service is calculated for the other habilitation cost area. The allowable costs per unit of service for each contracted provider cost report are arrayed and weighted by the number of units of service, and the median cost per unit of service is calculated. The median cost per unit of service is multiplied by 1.044.

(III) The attendant cost area and the other attendant cost area are summed to determine the habilitation attendant cost per unit of service.

(ix) For out-of-home respite care, the allowable costs per unit of service are calculated as determined in clauses (i) - (vi) of this subparagraph. The allowable costs per unit of service for each contracted provider cost report are multiplied by 1.044. The costs per unit of service are then arrayed and weighted by the number of units of service, and the median cost per unit of service is calculated.

(B) The monthly reimbursement for case management services is determined in the following manner:

(i) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

(ii) Total allowable costs are reduced by the amount of administrative expense fee revenues reported.

(iii) Each provider's total allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices).

(iv) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Medicare contributions, Workers' compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(v) Each provider's projected total allowable costs are divided by the number of monthly units of service to determine the projected cost per client month of service.

(vi) Each provider's projected cost per client month of service is arrayed from low to high and weighted by the number of units of service and the median cost per client month of service is calculated.

(vii) The median projected cost per client month of service is multiplied by 1.044.

(C) The unit of service reimbursement for day activity and health services is determined in accordance with §355.6907 (Relating to Reimbursement Methodology for Day Activity and Health Services).

(D) HHSC also adjusts reimbursement according to §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs) if new legislation, regulations, or economic factors affect costs.

(5) The reimbursement for support family services and continued family services will be determined as a per day rate using a method based on modeled costs which are developed by using data from surveys, cost report data from other similar programs, payment rates from other similar programs, consultation with other service providers and/or professionals experienced in delivering contracted services, or other sources as determined appropriate by HHSC. The per day rate will have two parts, one part for the child placing agency and one part for the support family.

(d) Administrative expense fee determination methodology.

(1) One-time administrative expense fee. Reimbursement for the pre-enrollment assessment and care planning process required to determine eligibility for the waiver program will be provided as a one-time administrative expense fee.

(2) Administrative expense fee determination process. The recommended administrative expense fee is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar services, and other relevant sources.

(e) Requisition fees. Requisition fees are reimbursements paid to the CLASS direct service agency contracted providers for their efforts in acquiring adaptive aids, medical supplies, dental services, specialized therapies, and minor home modifications for CLASS participants. Reimbursement for requisition fees for adaptive aids, medical supplies, dental services, specialized therapies, and minor home modifications will vary based on the actual cost of the adaptive aids, medical supplies, dental services, specialized therapies, and minor home modifications. Reimbursements are determined using a method based on modeled projected expenses which are developed by using data from surveys; cost report data from similar programs; consultation with other service providers and/or professionals experienced in delivering contracted services; and/or other sources.

(f) Allowable and unallowable costs.

(1) Providers must follow the guidelines in determining whether a cost is allowable or unallowable 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) as well as the following provisions.

(2) Participant room and board expenses are not allowable, except for those related to respite care.

(3) The actual cost of adaptive aids, medical supplies, dental services, and home modifications is not allowable for cost reporting purposes. Allowable labor costs associated with acquiring adaptive aids, medical supplies, dental services, and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable. Refer to §355.103(b)(20) [~~(17)~~](K) of this title (relating to Specifications for Allowable and Unallowable Costs).

(g) Authority to determine reimbursement. The authority to determine reimbursement is specified in §355.101 of this title (relating to Introduction).

(h) Reporting revenue. Revenues must be reported on the cost report in accordance with §355.104 of this title (relating to Revenues).

(i) Reviews and field audits of cost reports. Desk reviews or field audits are performed on all contracted providers' cost reports. The frequency and nature of the field audits are determined by HHSC to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and 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). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this title (relating to Informal Reviews and Formal Appeals).

(j) Reporting requirements. The program director's full salary is to be reported on the line item of the cost report designated for the director.

§355.513. Reimbursement Methodology for the Deaf-Blind with Multiple Disabilities Waiver Program.

(a) General information. The Texas Health and Human Services Commission (HHSC) applies the general principles of cost determination as specified in §355.101 of this title (relating to Introduction). Providers are reimbursed for waiver services provided to individuals who are deaf-blind with multiple disabilities.

(b) Other sources of cost information. If HHSC has determined that there is not sufficient reliable cost report data from which to set reimbursements and reimbursement ceilings for waiver services, reimbursements and reimbursement ceilings will be developed by using rates for similar services from other Medicaid programs; data from surveys; cost report data from other similar programs; consultation with other service providers or professionals experienced in delivering contracted services; and other sources.

(c) Waiver rate determination methodology. If HHSC deems it appropriate to require contracted providers to submit a cost report, recommended reimbursements for waiver services will be determined on a fee-for-service basis in the following manner for each of the services provided:

(1) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report.

(2) Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices). The prospective reimbursement period is the period of time that the reimbursement is expected to be in effect.

(3) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Medicare Contributions, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(4) Allowable administrative and overall facility/operations costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver service's service units reported to the amount of total waiver service units reported. Service-specific facility and operations costs for out-of-home respite and day habilitation services will be directly charged to the specific waiver service.

(5) For nursing services provided by a registered nurse (RN), nursing services provided by a licensed vocational nurse (LVN), physical therapy, occupational therapy, speech/language therapy, behavioral support services, audiology services, dietary services, employment assistance, and supported employment, an allowable cost per unit of service is calculated for each contracted provider cost report in accordance with paragraphs (1) - (4) of this subsection. The allowable costs per unit of service for each contracted provider cost report is multiplied by 1.044. This adjusted allowable costs per unit of service may be combined into an array with the allowable cost per unit of service of similar services provided by other programs in determining rates for these services in accordance with §355.502 of this title (relating to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

(6) Requisition fees are reimbursements paid to the Deaf Blind with Multiple Disabilities (DBMD) Waiver contracted providers for their efforts in acquiring adaptive aids, medical supplies, dental services, and minor home modifications for DBMD participants. Reimbursement for adaptive aids, medical supplies, dental services, and minor home modifications will vary based on the actual cost of the adaptive aid, medical supply, dental service, and minor home modification. Reimbursements are determined using a method based on modeled projected expenses, which are developed by using data from surveys; cost report data from similar programs; consultation with other service providers or professionals experienced in delivering contracted services; or other sources.

(7) For day habilitation, residential habilitation, chore, and intervener (excluding Interveners I, II and III) services, two cost areas are created:

(A) The attendant cost area, which includes salaries, wages, benefits, and mileage reimbursement calculated as specified in §355.112 of this title (relating to Attendant Compensation Rate Enhancement).

(B) An "other direct care" cost area, which includes costs for services not included in subparagraph (A) of this paragraph as determined in paragraphs (1) - (4) of this subsection. An allowable cost per unit of service is determined for each contracted provider cost report for the other direct care cost area. The allowable costs per unit of service for each contracted provider cost report are arrayed. The units of service for each contracted provider cost report in the array are summed until the median unit of service is reached. The corresponding expense to the median unit of service is determined and is multiplied by 1.044.

(C) The attendant cost area and the other direct care cost area are summed to determine the cost per unit of service.

(8) For Interveners I, II and III, payment rates are developed based on rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma approach in accordance with §355.105(h) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). Interveners I, II and III are not considered attendants for purposes of the Attendant Compensation Rate Enhancement described in §355.112 of this title and providers are not eligible to receive direct care add-ons to the Intervener I, II or III rates.

(9) Assisted living services payment rates are determined using a pro forma approach in accordance with §355.105(h) of this title. The rates are adjusted periodically for inflation. The room and board payments for waiver clients receiving assisted living services are covered in the reimbursement for these services and will be paid to providers from the client's Supplemental Security Income, less a personal needs allowance.

(10) Pre-enrollment assessment services and case management services payment rates are determined by modeling the salary for a Case Manager staff position. This rate is periodically updated for inflation.

(11) The orientation and mobility services payment rate is determined by modeling the salary for an Orientation and Mobility Specialist staff position. This rate is updated periodically for inflation.

(12) HHSC may 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).

(d) Authority to determine reimbursement. The authority to determine reimbursement is specified in §355.101 of this title.

(e) Reporting of cost.

(1) Cost-reporting guidelines. If HHSC requires a cost report for any waiver service in this program, providers must follow the cost-reporting guidelines as specified in §355.105 of this title.

(2) Excused from submission of cost reports. If required by HHSC, a contracted provider must submit a cost report unless the provider meets one or more of the conditions in §355.105(b)(4)(D) of this title.

(3) Reporting and verification of allowable cost.

(A) 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 reimbursements. HHSC excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers, in order to ensure the database reflects costs and other information necessary for the provision of services and is consistent with federal and state regulations.

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

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

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

(4) Allowable and unallowable costs. Providers must follow the guidelines 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), in determining whether a cost is allowable or unallowable. In addition, providers must adhere to the following principles:

(A) Client room and board expenses are not allowable, except for those related to respite care.

(B) The actual cost of adaptive aids, medical supplies, dental services, and minor home modifications is not allowable for cost-reporting purposes. Allowable labor costs associated with acquiring adaptive aids, medical supplies, dental services, and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable. Refer to §355.103(b)(20) [~~(17)~~](K) of this title.

(f) Reporting revenue. Revenues must be reported on the cost report in accordance with §355.104 of this title (relating to Revenues).

(g) Reviews and field audits of cost reports. Desk reviews or field audits are performed on cost reports for all contracted providers. The frequency and nature of field audits are determined by HHSC staff to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and 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). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this title (relating to Informal Reviews and Formal Appeals).

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

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Jack Stick
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 424-6900

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SUBCHAPTER G. ADVANCED TELECOMMUNICATIONS SERVICES AND OTHER COMMUNITY-BASED SERVICES

1 TAC §355.6907

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 provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

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.

§355.6907. Reimbursement Methodology for Day Activity and Health Services.

(a) Day Activity and Health Care Services. Day activity and health care facilities provide noninstitutional care to clients residing in the community through rehabilitative nursing and social services. The Texas Department of Aging and Disability Services (DADS) reimburses Day Activity and Health Services (DAHS) provider agencies for the services they provide to clients.

(b) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1997 and subsequent years, providers must apply the information in this section. The Texas Health and Human Services Commission (HHSC) applies the general principles of cost determination as specified in §355.101 of this title (relating to Introduction).

(c) Cost-reporting guidelines. Providers must follow the cost-reporting guidelines as specified in §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(d) Exclusion of cost reports.

(1) 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 reimbursement. HHSC excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and

other information which are necessary for the provision of services and are consistent with federal and state regulations.

(2) Individual 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.

(e) Review of cost reports. HHSC may perform desk reviews or field audits on cost reports for all contracted providers. HHSC determines the frequency and nature of the desk reviews and field audits to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and 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). Providers may request an informal and, if necessary, an administrative hearing to dispute an action taken by HHSC under §355.110 of this title (relating to Informal Reviews and Formal Appeals).

(f) Reimbursement determination. HHSC determines reimbursement in the following manner.

(1) A contracted provider must submit a cost report unless the provider meets one or more of the conditions in §355.105(b)(4)(D) of this title.

(2) HHSC staff allocate payroll taxes and employee benefits to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Workers' Compensation Insurance (WCI), Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(3) HHSC staff project all allowable expenses, excluding depreciation and mortgage interest, for the period from each provider's reporting period to the next ensuing reimbursement period. HHSC staff determine reasonable and appropriate economic adjusters as described in §355.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. HHSC staff also adjust reimbursement if new legislation, regulations, or economic factors affect costs as specified in §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(4) HHSC staff combine allowable reported costs into the following four cost areas:

(A) Attendant cost area. This cost area is calculated as specified in §355.112 of this title (relating to Attendant Compensation Rate Enhancement).

(B) Other direct care costs. This cost area includes other direct care staff; food and food service costs; activity costs; and other direct service costs.

(C) Facility cost area. This cost area includes building, maintenance staff, and utility costs.

(D) Administration and transportation cost area. This cost area includes transportation, administrative staff, and other administrative costs.

(5) For the cost areas described in paragraph (4)(B) - (D) of this subsection, allowable costs are totaled by cost area and then divided by the total units of service for the reporting period to determine the cost per unit of service. HHSC staff rank from low to high all provider agencies' projected costs per unit of service in each cost area. The median projected unit of service cost from each cost area is then determined. Those median projected unit of service costs from each cost area are totaled. That resulting total is multiplied by 1.044 and becomes the recommended reimbursement.

(6) The reimbursement determination authority is specified in §355.101 of this title (relating to Introduction).

(g) Allowable and unallowable costs. Providers must follow the guidelines specified in §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs) in determining whether a cost is allowable or unallowable. Providers must follow the guidelines for allowable and unallowable costs specified in §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(h) DAHS-specific allowable costs. Allowable costs specific to the DAHS program are:

(1) certain medical equipment and supplies, if they are related to the services for which DADS has contracted. This may include, but is not limited to, supplies and equipment considered necessary to perform client assessments, medication administration, and nursing treatment.

(2) transportation costs if they are related to the services for which DADS has contracted. This includes the costs of garaging a vehicle that is primarily used to transport clients to and from the DAHS center. The vehicle may be garaged off-site of the center for security reasons or for route efficiency management. In these cases of off-site vehicle garaging, a mileage log is not required if the vehicle is not used for personal use and is used solely (100%) for the delivery of DAHS services.

(i) DAHS-specific unallowable costs. Unallowable costs specific to the DAHS program are:

(1) physician's fees for completion of physician orders; and

(2) costs for which the provider received federal funds which should have been offset as specified in §355.103(b)(18)[~~(15)~~](B) of this title (relating to Specification for Allowable and Unallowable Costs).

(j) Reporting revenue. Revenue must be reported on the cost report according to §355.104 of this title (relating to Revenue).

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

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Jack Stick
Chief Counsel
Texas Health and Human Services Commission
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TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 17. MARKETING AND PROMOTION

SUBCHAPTER J. GO TEXAN CERTIFIED RETIREMENT COMMUNITY PROGRAM

4 TAC §17.603, §17.604

The Texas Department of Agriculture (the department) proposes amendments to 4 TAC §17.603, concerning assistance for GO TEXAN Certified Retirement Communities, and §17.604, concerning use of department marks by GO TEXAN Certified Retirement Community members. The amendments are proposed to clarify program benefits, ensure proper use of the GO TEXAN Certified Retirement Community certification mark, and to make the sections consistent with changes made to Texas Agriculture Code, §12.40 by Senate Bill 1214, 83rd Legislative Regular Session, 2013 (SB 1214).

The amendments to §17.603 add benefits for GO TEXAN Certified Retirement Communities, including but not limited to training, marketing, and partnerships for promotional campaigns. The amendments to §17.604 provide clarification and direction regarding use of the GO TEXAN Retirement Community Certification Mark by communities. Additionally, the amendments clarify the existing application requirements regarding the current certification fees, as are required by statute, to provide that a community shall not be required to pay fees until they are invoiced by the department upon approval of an application. No change has been made to the current fee amount.

Bryan Daniel, administrator for trade and business development, has determined that for the first five years the proposed rules are in effect, there will not be fiscal implications for state or local government as a result of the administration or enforcement of the proposed rule amendments.

Mr. Daniel also has determined that for each year of the first five years the proposed amendments are in effect the public benefit anticipated as a result of the proposed amendments will be to provide increased awareness and recognition of the GO TEXAN Certified Retirement Community Program. There will be no fiscal implications for microbusinesses, small businesses or other entities required to comply with the proposal.

Written comments on the proposal may be submitted to Bryan Daniel, Administrator for Trade and Business Development, Texas Department of Agriculture, P.O. Box 12847, Austin, Texas 78711. Written comments must be received no later than 30 days from the date of publication of the proposed amendments in the *Texas Register.*

The amendments are proposed under the Texas Agriculture Code, §12.040, as amended by SB 1214, which authorizes the department to adopt rules to establish and maintain a certified retirement community program and to set a fee for program participation.

The code affected by the proposal is the Texas Agriculture Code, Chapter 12.

§17.603. Providing Assistance to Certified Communities.

(a) The department shall provide the following assistance to certified communities:

(1) training opportunities for community representatives [~~assistance in the training of local staff and volunteers~~];

(2) [~~ongoing oversight and~~] guidance in marketing, plus updates on retirement trends;

(3) [~~provide information on eligibility for~~] inclusion in the department's electronic marketing [~~state's media~~] efforts, public relations campaigns and promotions[~~, including being on the department's internet website~~];

(4) [~~provide~~] information on cooperative participation in the development of advertising materials, including, but not limited to: literature, advertising and signage [~~eligibility for state financial assistance for brochures, support material, and advertising~~]; and

(5) opportunities to partner with state, regional and national tourism associations, other state agencies and/or other program partners to develop cooperative campaigns promoting the community. [~~an evaluation and program assessment on maintaining and improving the community's desirability as a home for retirees.~~]

(b) Upon the department's notice of approval of an application and payment of the required certification fee by the community, the department will meet with community representatives [~~for certification, a staff member will schedule a visit to the applicant community~~] to discuss the Program and the community's needs. [~~with the sponsor and other interested parties, including a discussion of what specific assistance will be provided to the certified community by the department.~~]

(c) The department [~~Staff~~] will consult with the community annually to [~~and~~] evaluate the effectiveness of the Program.

(d) The department may revoke approval to use the GO TEXAN Certified Retirement Community certification mark [~~GO TEXAN~~] if a community [~~or a sponsor~~] fails to comply with the Program guidelines, including payment of fees or misuse of the mark, as defined in §17.56 of this chapter (relating to Termination of Registration to Use the GO TEXAN Registration Mark).

§17.604. Certification and Use of the "Texas Certified Retirement Community" or Other Department Marks; Expiration and Renewal of Certificate.

(a) Certification. Certification under this program shall entitle [~~allow~~] the [~~approved~~] community to use the GO TEXAN Certified Retirement Community certification mark [~~words "Texas Certified Retirement Community" as well as any marks created by the department for use in the program,~~] to promote the community to retirees, potential retirees and to any other interested parties. Use of the mark is subject to the rules set forth in §17.55 of this chapter (relating to Registration and Use of the GO TEXAN Certification Mark).

(b) Expiration and renewal of Certification.

(1) A community's certification expires on the fifth anniversary of the date the initial certification is issued.

(2) To be considered for recertification by the department[~~,~~] an applicant community must[~~:~~]

[~~(A)~~] complete and submit a new application. [~~(including appropriate fees); and~~]

[~~(B) submit data demonstrating the success or failure of the community's efforts to market and promote itself as a desirable location for retirees and potential retirees.~~]

(3) The department shall invoice applicant for required fees upon tentative approval of the application.

(4) The applicant will not receive final approval until required fees have been received by the department.

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

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Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 463-4075

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TITLE 13. CULTURAL RESOURCES

PART 1. TEXAS STATE LIBRARY AND ARCHIVES COMMISSION

CHAPTER 1. LIBRARY DEVELOPMENT
SUBCHAPTER C. MINIMUM STANDARDS FOR ACCREDITATION OF LIBRARIES IN THE STATE LIBRARY SYSTEM

13 TAC §§1.71, 1.72, 1.77, 1.83

The Texas State Library and Archives Commission proposes to amend 13 TAC §§1.71, 1.72, 1.77, and 1.83, regarding minimum standards for accreditation of libraries. The proposed revisions would clarify the definition relating to county funds in "Population Served," clarify terms and the wording structure, and propose new or updated provisions for "Library Service, Local Government Support, and Other Requirements."

Deborah Littrell, Director, Library Development and Networking, has determined that for the first five years the sections are in effect there will be no fiscal implications for state or local governments as a result of enforcing or administering the amended rules. Ms. Littrell does not anticipate either a loss of, or an increase in, revenue to state or local government as a result of the proposed changes. The public benefit of the proposed amended sections is to clarify the current standards and better reflect current practices in librarianship to strengthen local libraries. There will be no impact on small businesses, micro-businesses, or individuals as a result of enforcing the amendments.

Written comments on this proposal may be submitted to Deborah Littrell, Director, Library Development and Networking Division, Texas State Library, Box 12927, Austin, Texas 78711; by fax to (512) 936-2306; or by e-mail to dlittrell@tsl.texas.gov.

The amendments are proposed under the authority of Government Code §441.127, that provides the Commission authority to establish accreditation standards for system membership.

The proposed amended sections affect the Government Code §441.127.

§1.71. Definition of Population Served.

For a city, nonprofit corporation, and/or county-established library receiving public monies for public library service, the population served by a public library is the population in the most recent decennial census or official population estimate of the United States Department of Commerce, Bureau of the Census, if available. If a library does not report receiving public monies for public library service, that library will be assigned no population. Calculations will be based upon the following.

(1) In counties with one or more public libraries that receive only city and private funds, each library is credited with serving the population of the city or cities from which it receives funds or with which it has a contract.

(2) In counties with only one public library and that library receives county funds, the library is credited with serving the entire county population.

(3) In counties with more than one public library that receives both city and county funds, the libraries that receive city and county funds are credited with serving their city population plus a percentage of the population living outside the cities. This percentage is the ratio of each city's population to the total of all the populations of cities with public libraries within the county.

(4) In counties with a library established by the county commissioners court and that receives no city funds or an incorporated library that receives no city funds, and one or more city libraries that receive county funds, the city libraries that receive county and city funds are credited with serving their city populations plus a percentage of the county population living outside the cities. The percentage is the ratio of each city's population to the county population. The county library or incorporated library that receives county funds and no city funds serves all county residents not served by a city library.

(5) In counties with one library that receives county funds and one or more public libraries that do not receive county funds, the library that receives county funds is credited with serving the county population less the populations of cities with public libraries.

(6) In counties with more than one library that receives county funds and no city funds, the county population living outside cities with public libraries will be prorated among the libraries in the same ratio as the county funds are allocated [~~expended~~].

(7) When school districts contract with one or more nonprofit corporations, cities, or counties for public library services as part of their students' educational program, the State Library will estimate the total population living within the school district.

(8) Libraries that enter into agreements or contracts with counties, cities, or school districts to provide public library services will be assigned population under this section whether or not there is an exchange of funds.

(9) In libraries where the population of a federal or state eleemosynary or correctional institution or military installation exceeds 10% of the entire population of the area served by a public library, the residential or base population may be subtracted from the population served by that library if these persons are served by an institutional or base library. If the institution or military installation does not have a library that provides general library services, the population will not be subtracted.

(10) When a library believes that the acceptance of county funding would result in the assignment of an unrealistic population figure, it may request in writing that the Library Systems Act Advisory Board approve an exception to the population served methodology. The board will use its discretion to devise a method by which data from the Bureau of the Census will be used to calculate the assignment of population served.

§1.72. Public Library Service.

(a) Library services for the general public must be provided without charge or deposit to all persons residing in the local political subdivisions which provide monetary support to the library. These li-

brary services include the dissemination of materials or information by the library to the general public during the hours of operations of all library facilities. In this context, library services include the circulation of any type of materials, reference services [(~~locating and interpreting information~~)], use of computers to access information sources, databases, or other similar services, and admissions to the facility or any programs sponsored or conducted by the library.

(b) The following charges are permitted at the discretion of the library's governing authority: reserving library materials; use of facilities [~~meeting rooms~~]; replacement of lost borrower cards; fines for overdue, lost, or damaged materials in accordance with local library policies; postage; in-depth reference services on a contractual basis; photocopying; printing; telefacsimile services; library parking; service to nonresidents; sale of publications; rental and deposits on equipment; and charges for the use of materials and machine-readable data bases not owned by the library[~~, major resource center, or regional library system~~] for which the vendor or supplier has charged a borrowing fee.

(c) Fees may not be charged for library services on the library premises by individuals or organizations other than the library unless the charges are permitted by subsection (b) of this section.

(d) As permitted by §1.73 of this subchapter, relating to Public Library: Legal Establishment, non profit corporations may enter into a contract with a school district to provide library services to the general public residing in the district. This public library service must be in addition to that provided to school students, faculty, and staff. Public library services must be provided at least the required number of hours all weeks of the year, except those weeks with national or state holidays. The number of hours is specified in §1.81 of this subchapter, relating to Quantitative Standards for Accreditation of Library.

§1.77 Public Library: Local Government Support.

(a) At least half of the annual local operating expenditures required to meet the minimum level of per capita support for accreditation must be from local government sources. Local government sources are defined as money appropriated by library districts, by school districts, or by city or county governments. Exemption: A public library that expends at least $17.50 per capita is exempt from this membership criterion if it shows evidence of some library expenditures from local government sources and is open to citizens under identical conditions without charge. [~~At least half of the annual local operating expenditures required to meet the minimum level of per capita support for accreditation must be from local government sources. A public library that expends at least $13.50 per capita is exempt from this membership criterion if it shows evidence of some library expenditures from local government sources and is open to citizens under identical conditions without charge. Local government sources are defined as money appropriated by library districts, by school districts, or by city or county governments.~~]

(b) If a currently accredited library is closed by action of its governing body, the commission, following a public hearing, may revoke that library's current membership in the state library system. This section will not apply if only the library building is temporarily closed because of natural or man-made disasters, or building construction, renovation, or maintenance. The library may be re-accredited as a member in the state library system during the next regular accreditation process, assuming that, by July 31, the library reports data showing that it currently meets all of the appropriate minimum requirements for membership in the state library system (as listed in §1.74 of this subchapter, related to Local Operating Expenditures; §1.75 of this subchapter, related to Nondiscrimination; §1.81 of this subchapter, related to Quantitative Standards for Accreditation of Library; §1.83 of this subchapter, related to Other Requirements; and §1.84 of this subchapter, related to Professional Librarian).

(c) If a currently accredited library suffers a funding reduction that causes the library to reduce its hours, staffing, or budget below its appropriate minimum requirements for membership in the state library system (as listed in §1.81 of this subchapter, related to Quantitative Standards for Accreditation of Library), the commission, following a public hearing, may revoke that library's current membership in the state library system. The library may be re-accredited as a member in the state library system during the next regular accreditation process, assuming that, by July 31, the library reports data showing that it currently meets all of the appropriate minimum requirements for membership in the state library system (as listed in §1.74 of this subchapter, related to Local Operating Expenditures; §1.75 of this subchapter, related to Nondiscrimination; §1.81 of this subchapter, related to Quantitative Standards for Accreditation of Library; §1.83 of this subchapter, related to Other Requirements; and §1.84 of this subchapter, related to Professional Librarian).

§1.83. Other Requirements.

Each public library applying for membership in the Texas Library System must meet the following requirements:

(1) The library must have a website and a telephone with a published [~~listed~~] number.

(2) The library must have available both a photocopier and a computer with Internet access for use by the library staff and at least one computer with Internet access and printing/copying capabilities for the general public.

(3) The library must offer to borrow materials via the interlibrary loan resource sharing service for persons residing in the library's designated service area. A library must also participate in the interlibrary loan resource sharing service by lending its materials to other libraries, as requested. The library governing board may adopt policies regarding materials available for loan and the length of the loan, the good standing of the borrower, and other relevant issues; these policies must be available for the public [~~posted on the library system's web site~~].

(4) The library director must have a minimum of ten hours of continuing education credits annually. Continuing education activities must be instructional and may include workshops, appropriate sessions at library association conferences, instructional webinars, and distance education courses. Board [~~Library system meetings, board~~] meetings, public hearings, other business meetings, author luncheons, and other non-instructional sessions are not considered continuing education activities. The director must maintain appropriate documentation of participation, duration, and relevance to the operation of a library.

(5) The library must have a catalog of its holdings available to the public that is electronically searchable, [~~either manually or electronically,~~] at a minimum by author, title, and subject.

(6) The library must have a long-range plan that is approved by its governing board. This plan must be reviewed and updated at least every five years and must include a collection development element and a technology element. [~~Library systems must provide public libraries with the consulting and continuing education services necessary to develop these plans as part of the services provided under §1.47 of this title (relating to Consulting and Continuing Education Services).~~]

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

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Edward Seidenberg
Deputy Director
Texas State Library and Archives Commission
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13 TAC §1.74, §1.81

(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 State Library and Archives Commission or in the Texas Register office, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Texas State Library and Archives Commission proposes to repeal 13 TAC §1.74 and §1.81 regarding minimum standards for accreditation of libraries. The proposed repealed rules would be replaced by new rules with new and changed criteria regarding the standards for "Local Operating Expenditures and Quantitative Standards."

Deborah Littrell, Director, Library Development and Networking, has determined that for the first five years after the repeal is in effect there will be no fiscal implications for state or local governments as a result of the repeal of the rules. Ms. Littrell does not anticipate either a loss of, or an increase in, revenue to state or local government as a result of the proposed repeal. The public benefit of the proposed repealed sections is to clarify the current standards and better reflect current practices in librarianship to strengthen local libraries. There will be no impact on small businesses, micro-businesses, or individuals as a result of the repeal of the rules.

Written comments on this proposal may be submitted to Deborah Littrell, Director, Library Development and Networking Division, Texas State Library, Box 12927, Austin, Texas 78711; by fax to (512) 936-2306; or by e-mail to dlittrell@tsl.texas.gov.

The repeal of the sections is proposed under the authority of Government Code §441.127, that provides the Commission authority to establish accreditation standards for system membership.

The proposed repeals affect the Government Code §441.127.

§1.74. Local Operating Expenditures.

§1.81. Quantitative Standards for Accreditation of Library.

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

Filed with the Office of the Secretary of State on August 11, 2014.

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Edward Seidenberg
Deputy Director
Texas State Library and Archives Commission
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For further information, please call: (512) 463-5459

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13 TAC §1.74, §1.81

The Texas State Library and Archives Commission proposes new 13 TAC §1.74 and §1.81 regarding minimum standards for accreditation of libraries to replace the current sections which are being repealed simultaneously. The proposed new rules would establish new and changed criteria, especially raising the minimum local expenditures, for the standards regarding "Local Operating Expenditures and Quantitative Standards."

Deborah Littrell, Director, Library Development and Networking, has determined that for the first five years the new sections are in effect there will be no fiscal implications for state or local governments as a result of enforcing or administering the new sections. Ms. Littrell does not anticipate either a loss of, or an increase in, revenue to state or local government as a result of the proposed changes. The public benefit of the proposed new sections is to clarify the current standards and better reflect current practices in librarianship to strengthen local libraries. There will be no impact on small businesses, micro-businesses, or individuals as a result of enforcing the new sections.

Written comments on this proposal may be submitted to Deborah Littrell, Director, Library Development and Networking Division, Texas State Library, Box 12927, Austin, Texas 78711; by fax to (512) 936-2306; or by e-mail to dlittrell@tsl.texas.gov.

The new sections are proposed under the authority of Government Code §441.225(b), which authorizes the commission to adopt rules to govern the operation of the consortium.

No other codes or statutes are affected by the proposal.

§1.74. Local Operating Expenditures.

(a) A public library must demonstrate local effort on an annual basis by maintaining or increasing local operating expenditures or per capita local operating expenditures. Expenditures for the current reporting year will be compared to the average of the total local operating expenditures or to the average of the total per capita local operating expenditures for the three preceding years.

(b) A public library must have minimum total local expenditures of $10,650 in local fiscal years 2013, 2014, 2015; $15,000 in local fiscal years 2016, 2017, 2018; $18,000 in local fiscal years 2019, 2020, 2021; and $21,000 in local fiscal years 2022, 2023, 2024.

(c) Exemption: Libraries that expend at least $17.50 per capita and at least $150,000 of local funds are exempt from this membership criterion.

§1.81. Quantitative Standards for Accreditation of Library.

(a) The definition of "local fiscal year" is the fiscal year in which January 1 of that year falls.

(b) The following are the minimum requirements for membership in the state library system:

(1) A library serving a population of at least 500,001 persons must:

(A) have local expenditures amounting to at least $13.82 per capita in local fiscal years 2013, 2014, 2015; $13.89 per capita in local fiscal years 2016, 2017, 2018; $13.96 per capita in local fiscal years 2019, 2020, 2021; $14.03 per capita in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 64 hours per week;

(E) employ a library director for at least 40 hours per week in library duties; and

(F) employ twelve full-time equivalent professional librarians, with one additional full-time equivalent professional librarian for every 50,000 persons above 500,000.

(2) A library serving a population of 200,001 - 500,000 persons must:

(A) have local expenditures amounting to at least $11.95 per capita in local fiscal years 2013, 2014, 2015; $12.01 per capita in local fiscal years 2016, 2017, 2018; $12.07 per capita in local fiscal years 2019, 2020, 2021; $12.13 per capita in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 64 hours per week;

(E) employ a library director for at least 40 hours per week in library duties; and

(F) employ six full-time equivalent professional librarians, with one additional full-time equivalent professional librarian for every 50,000 persons above 200,000.

(3) A library serving a population of 100,001 - 200,000 persons must:

(A) have local expenditures amounting to at least $9.60 per capita in local fiscal years 2013, 2014, 2015; $9.79 per capita in local fiscal years 2016, 2017, 2018; $9.98 per capita in local fiscal years 2019, 2020, 2021; $10.18 per capita in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 54 hours per week;

(E) employ a library director for at least 40 hours per week in library duties; and

(F) employ four full-time equivalent professional librarians, with one additional full-time equivalent professional librarian for each 50,000 persons above 100,000.

(4) A library serving a population of 50,001 - 100,000 persons must:

(A) have local expenditures amounting to at least $8.00 per capita in local fiscal years 2013, 2014, 2015; $8.16 per capita in local fiscal years 2016, 2017, 2018; $8.32 per capita in local fiscal years 2019, 2020, 2021; at least $8.48 per capita in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 48 hours per week;

(E) employ a library director for at least 40 hours per week in library duties; and

(F) employ at least two full-time equivalent professional librarians.

(5) A library serving a population of 25,001 - 50,000 persons must:

(A) have local expenditures of at least $5.31 per capita in local fiscal years 2013, 2014, 2015; $5.42 per capita in local fiscal years 2016, 2017, 2018; $5.52 per capita in local fiscal years 2019, 2020, 2021; $5.63 per capita in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 40 hours per week;

(E) employ a library director for at least 40 hours per week in library duties; and

(F) employ at least one full-time equivalent professional librarian.

(6) A library serving a population of 10,001 - 25,000 persons must:

(A) have local expenditures of at least $4.25 per capita in local fiscal years 2013, 2014, 2015; $4.34 per capita in local fiscal years 2016, 2017, 2018; $4.42 per capita in local fiscal years 2019, 2020, 2021; $4.51 per capita in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials, provided that in either case a minimum of 7,500 items are held;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 30 hours per week; and

(E) employ a library director for at least 30 hours per week in library duties.

(7) A library serving a population of 5,001 - 10,000 must:

(A) have local expenditures of at least $3.97 per capita in local fiscal years 2013, 2014, 2015; $4.05 per capita in local fiscal years 2016, 2017, 2018; $4.13 per capita in local fiscal years 2019, 2020, 2021; $4.21 per capita in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials; provided that in either case a minimum of 7,500 items are held;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 20 hours per week; and

(E) employ a library director for at least 20 hours per week in library duties.

(8) A library serving a population of 5,000 or fewer persons must:

(A) have local per capita expenditures or minimum total local expenditures, whichever is greater, of $3.70 per capita or $10,650 in local fiscal years 2013, 2014, 2015; $3.77 per capita or $15,000 total

in local fiscal years 2016, 2017, 2018; $3.85 per capita or $18,000 total in local fiscal years 2019, 2020, 2021; $3.92 per capita or $21,000 in local fiscal years 2022, 2023, 2024;

(B) have at least one item of library materials per capita or expend at least 15% of the local expenditures on the purchase of library materials, provided that in either case a minimum of 7,500 items are held;

(C) have at least 1% of total items in collection published in the last five years;

(D) be open for service not less than 20 hours per week; and

(E) employ a library director for at least 20 hours per week in library duties.

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

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Edward Seidenberg
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CHAPTER 2. GENERAL POLICIES AND PROCEDURES

SUBCHAPTER C. GRANT POLICIES

DIVISION 1. GENERAL GRANT GUIDELINES

13 TAC §2.118

The Texas State Library and Archives Commission proposes an amendment to 13 TAC §2.118, regarding the decision making process for competitive grants. The amendment raises the minimum score that competitive grant applications must attain to be eligible for funding from the Library and Archives Commission.

Deborah Littrell, Director, Library Development and Networking Division, has determined that for each year of the first five years after the amended section is in effect there may be fiscal implications for state or local governments. Ms. Littrell anticipates a small, but undeterminable, potential loss of revenue to state or local government as a result of the proposed amendment. The public benefit of the proposed amendment is that it will establish a higher minimum standard for grant funding, and therefore public funds will be better spent. There will be no impact on small businesses, micro-businesses, or individuals as a result of enforcing the amendments.

Written comments on this proposal may be submitted to Deborah Littrell, Director, Library Development and Networking Division, Texas State Library, Box 12927, Austin, Texas 78711-2927; by fax to (512) 936-2306; or by e-mail to dlittrell@tsl.texas.gov.

This amendment is proposed under the authority of Government Code §441.123 that directs the commission to establish and develop a state library system and §441.136 that authorizes the director and librarian to propose rules necessary for the administration of the program.

No other codes or statutes are affected by the proposal.

§2.118. Decision Making Process.

To be considered eligible for funding by the commission, any application must receive a minimum adjusted mean score of more than 60 [~~50~~] percent of the maximum points available. To reduce the impact of scores that are exceedingly high or low, or otherwise outside the range of scores from other reviewers, agency staff will tabulate the panel's work using calculations such as an adjusted mean score.

(1) Applications will be ranked in priority order by score for consideration by the commission.

(2) If insufficient funds remain to fully fund the next application, the staff will negotiate a reduced grant with the next ranked applicant.

(3) If the panel recommends funding an application that, for legal, fiscal, or other reasons, is unacceptable to the staff, a contrary recommendation will be made. The applicant will be informed of this situation prior to presentation to the commission and may negotiate a revision to the application. A positive recommendation to the commission will be contingent upon successfully completing these negotiations prior to the commission meeting.

(4) If the panel is unable to produce a set of recommendations for funding, the agency staff will use the same evaluation procedures to develop recommendations to the commission.

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

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CHAPTER 8. TEXSHARE LIBRARY CONSORTIUM

13 TAC §8.1

The Texas State Library and Archives Commission proposes to amend 13 TAC §8.1, regarding the definition for libraries of clinical medicine in the TexShare Consortium. The proposed revision to §8.1(7) would update the definition of "Extensive library services" and "Extensive collections in the fields of clinical medicine and the history of medicine."

Deborah Littrell, Director, Library Development and Networking, has determined that for the first five years the section is in effect there will be no fiscal implications for state or local governments as a result of enforcing or administering the amended rule. Ms. Littrell does not anticipate either a loss of, or an increase in, revenue to state or local government as a result of the proposed changes. The public benefit of the proposed amended section is to establish a more precise definition for the TexShare membership category, "libraries of clinical medicine" and better reflect current practices in medical librarianship. There will be no impact on small businesses, micro-businesses, or individuals as a result of enforcing the amendments.

Written comments on this proposal may be submitted to Deborah Littrell, Director, Library Development and Networking Division, Texas State Library, Box 12927, Austin, Texas 78711; by fax to (512) 936-2306; or by e-mail to dlittrell@tsl.texas.gov.

The amendment is proposed under the authority of Government Code §441.225(b), which authorizes the commission to adopt rules to govern the operation of the consortium.

No other codes or statutes are affected by the proposal.

§8.1. Definitions.

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

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

(7) Library of clinical medicine has the meaning assigned to Non-Profit Corporation by Government Code, §441.221.

(A) Extensive library services are defined as: [~~those services set forth in §1.81(b)(4)(C) and (D) of this title (relating to Quantitative Standards for Accreditation of Library).~~]

(i) Library is open and staffed a minimum of 45 hours per week; and

(ii) Staff includes a minimum of one full-time equivalent professional librarian (as defined in 13 TAC §1.84, relating to Professional Librarian); and

(iii) Library employs a library director for at least 40 hours per week in library duties; and

(iv) Services include circulation of materials, reference services, use of computers to access information sources, databases, or other similar services; and

(v) An institutionally-approved collection development policy updated at least every five years.

(B) Extensive collections in the fields of clinical medicine and the history of medicine is defined as follows: [~~Medicine--A minimum of 10,000 library resources in print and in electronic format, comprised of books, journal titles, technical reports, and databases on clinical medicine and the history of medicine.~~]

(i) Clinical medicine is defined as materials in the "W" category of the National Library of Medicine (NLM) classification scheme (www.nlm.nih.gov/clas/index.html).

(ii) History of Medicine is defined as:

(I) Materials fitting the scope of the NLM classification scheme (www.nlm.nih.gov/clas/index.html) under WZ-History of Medicine, Misc or in the NLM classification scheme under history of a particular medical subject (e.g. history of surgery (WO 11), history of dermatology (WR 11), history of gynecology (WP 11), etc.); or

(II) Unique archival materials (print materials, historical artifacts, and other unique resources) related to institutional history, or reflecting historically significant contributions of persons or institutions, or history of a particular area of health care.

(iii) "Extensive collections" is defined as a minimum of 12,000 library resources in the field of clinical medicine and history of medicine, in print and in electronic formats, comprised of books, journal titles, technical reports, videos, or databases.

(8) - (16) (No change.)

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

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TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 26. SUBSTANTIVE RULES APPLICABLE TO TELECOMMUNICATIONS SERVICE PROVIDERS

SUBCHAPTER E. CERTIFICATION, LICENSING AND REGISTRATION

16 TAC §26.111

The Public Utility Commission of Texas (commission) proposes an amendment to §26.111, relating to Certificate of Operating Authority (COA) and Service Provider Certificate of Operating Authority (SPCOA) Criteria. The proposed amendment will clarify the applicability of requirements in the rule to deregulated companies holding a COA or to an Exempt Carrier as defined in §26.5(89). In addition, the amendment will further amend §26.111 to conform to 2013 legislation, specifically the implementation of Senate Bill 259 of the 83rd Legislature, Regular Session. Project Number 42477 is assigned to this proceeding.

Meena Thomas, Senior Market Economist in the Competitive Markets Division, has determined that for each year of the first five-year period the proposed section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Ms. Thomas has determined that for each year of the first five years the proposed section is in effect the public benefit anticipated as result of enforcing the section will be improved clarity and applicability of §26.111. There will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing this section. Therefore, no regulatory flexibility analysis is required. There is no anticipated economic cost to persons who are required to comply with the section as proposed.

Ms. Thomas has also determined that for each year of the first five years the proposed section is in effect 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.

Comments on the proposed amendment may be submitted to the Filing Clerk, Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326, within 10 days after publication. Reply comments may be submitted within 18 days after publication. Sixteen copies of com-

ments to the proposed amendment 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 the proposed rule. The commission invites specific comments regarding the costs associated with, and benefits that will be gained by, implementation of the proposed section. The commission will consider the costs and benefits in deciding whether to adopt the section. All comments should refer to Project No. 42477.

This amendment is proposed under the Public Utility Regulatory Act, Texas Utilities Code Annotated §14.002 (West 2007 and Supp. 2013) (PURA), which provides the Public Utility Commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction; and specifically, PURA §52.154, which precludes the commission from adopting a rule or regulatory practice that would impose a greater burden on a nondominant telecommunications utility than is imposed on a holder of a certificate of convenience and necessity serving the same area or on certain deregulated incumbent local exchange carriers (ILECs), and PURA §65.102, which specifies the requirements applicable to a deregulated ILEC that holds a COA.

Cross Reference to Statutes: Public Utility Regulatory Act §§14.002, 52.154, and 65.102.

§26.111. Certificate of Operating Authority (COA) and Service Provider Certificate of Operating Authority (SPCOA) Criteria.

(a) - (d) (No change.)

(e) Standards for granting certification to COA and SPCOA applicants. The commission may grant a COA or SPCOA to an applicant that demonstrates that it is eligible under subsection (c) of this section, has the technical and financial qualifications specified in this section, has the ability to meet the commission's quality of service requirements to the extent required by PURA and this title, and it and its executive officers and principals do not have a history of violations of rules or misconduct such that granting the application would be inconsistent with the public interest. In determining whether to grant a certificate, the commission shall consider whether the applicant satisfactorily provided all of the information required in the application for a COA or SPCOA.

(f) (No change.)

(g) Technical and managerial requirements. To obtain COA or SPCOA certification, an applicant must have and maintain the technical and managerial resources and ability to provide continuous and reliable service in accordance with PURA, commission rules, and other applicable laws.

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

(4) Quality of service and customer protection.

(A) The applicant must affirm that it will meet the commission's applicable quality-of-service standards as listed on the quality of service questionnaire contained in the application. The quality-of-service standards include E9-1-1 compliance and local number portability capability. Data-only providers are not subject to the requirements for E9-1-1 and local number portability compliance as applicable to switched voice services.

(B) The applicant must affirm that it is aware of and will comply with the applicable customer protection rules and disclosure requirements as set forth in Chapter 26, Subchapter B, of this title (relating to Customer Service and Protection).

(5) (No change.)

(h) (No change.)

(i) Amendment of a COA or SPCOA Certificate.

(1) A person or entity granted a COA or SPCOA by the commission shall file an application to amend the COA or an SPCOA in a commission approved format in order to:

(A) - (D) (No change.)

(E) Discontinuation of service and relinquishment of certificate, or discontinuation of optional services.

(i) A deregulated company holding a certificate of operating authority or an Exempt Carrier shall provide the information in subclauses (I) - (III) of this clause for the discontinuation of its service and relinquishment of its certificate. The requirements for the discontinuation of optional services do not apply to a deregulated company holding a certificate of operating authority or an Exempt Carrier.

(I) Certification that the carrier will send customers whose service is being discontinued a notification letter providing a minimum of 61 days of notice of termination of service and clearly stating the date of termination of service;

(II) A statement regarding the disposition of customer credits and deposits; and

(III) Certification that the carrier will comply with §26.24 of this title (relating to Credit Requirements and Deposits).

(ii) For all other carriers, such [~~Such~~] an application is subject to subsections (m) and (n) of this section.

(2) - (5) (No change.)

(j) (No change.)

(k) Renewal of certificates. Each COA and SPCOA holder is required to file with the commission a renewal of its certification once every ten years. The commission may, prior to the ten year renewal requirement, require each COA and SPCOA holder to file, the following year, a renewal of its certification.

(1) The certification renewal will consist of:

(A) - (B) (No change.)

(C) the most recent version of the annual report the commission requires the certificate holder to submit to comply with subsection (l)(1) of this section, to the extent required by PURA and this title.

(2) - (7) (No change.)

(l) Reporting Requirements.

(1) - (4) (No change.)

(5) A certificate holder shall file all reports to the extent required by PURA and this title, including but not limited to: §26.51 of this title (relating to Reliability of Operations of Telecommunications Providers); §26.76 of this title (relating to Gross Receipts Assessment Report); §26.80 of this title (relating to Annual Report on Historically Underutilized Businesses); §26.85 of this title (relating to Report of Workforce Diversity and Other Business Practices); §26.89 of this title (relating to Information Regarding Rates and Services of Nondominant Carriers); §26.465 of this title (relating to Methodology for Counting Access Lines and Reporting Requirements for Certified Telecommunications Providers); and §26.467 of this title (relating to Rates, Allocation, Compensation, Adjustments and Reporting).

(m) Standards for discontinuation of service and relinquishment of certification. A COA or SPCOA holder may cease operations

in the state only if commission authorization to cease operations has been obtained. A COA or SPCOA holder that ceases operations and relinquishes its certification shall comply with PURA §54.253 (relating to Discontinuation of Service by Certain Certificate Holders). This section does not apply to a deregulated company holding a certificate of operating authority or to an Exempt Carrier.

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

(n) Standards for discontinuing optional services. A COA or SPCOA holder discontinuing optional services shall comply with PURA §54.253. This section does not apply to a deregulated company holding a certificate of operating authority or to an Exempt Carrier.

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

(o) Revocation or suspension. A certificate granted pursuant to this section is subject to amendment, suspension, or revocation by the commission for violation of PURA or commission rules or if the holder of the certificate does not meet the requirements under this section to the extent required by PURA and this title to operate as a COA or SPCOA. A suspension of a COA or SPCOA certificate requires the cessation of all COA or SPCOA activities associated with obtaining new customers in the state of Texas. A revocation of a COA or SPCOA certificate requires the cessation of all COA or SPCOA activities in the state of Texas, pursuant to commission order. The commission may also impose an administrative penalty on a person for violations of law within its jurisdiction. The commission staff or any affected person may bring a complaint seeking to amend, suspend, or revoke a COA or SPCOA's certificate. Grounds for initiating an investigation that may result in the suspension or revocation include the following:

(1) - (4) (No change.)

(5) Failure to meet commission reporting requirements to the extent required by PURA and this title;

(6) - (16) (No change.)

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

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Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
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For further information, please call: (512) 936-7223

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TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 21. STUDENT SERVICES

SUBCHAPTER E. TEXAS B-ON-TIME LOAN PROGRAM

19 TAC §21.136

The Texas Higher Education Coordinating Board (Coordinating Board) proposes new §21.136, regarding the Texas B-On-Time Loan program, to reflect provisions of Senate Bill 215, passed by the 83rd Texas Legislature, Regular Session. The statute requires the Board, by rule, to establish and publish financial aid program allocation methodologies and develop procedures to verify the accuracy of the application of those methodologies by Board staff. Additionally, the statute requires the Board to engage institutions of higher education in a negotiated rulemaking process described in Subchapter 2008 of the Government Code in the development of such rules.

The statute also states that tuition set asides collected by public institutions of higher education shall be allocated only to those institutions. This proposed new section was drafted and approved by the Negotiated Rulemaking Committee on B-On-Time (Tuition Set-Asides) on August 4, 2014. The report of the Negotiated Rulemaking Committee is available at the offices of the Texas Higher Education Coordinating Board located at 1200 E. Anderson Lane, Austin, Texas.

Section 21.136(a) states that funds will be allocated to participating (public) institutions in proportion to the amount of tuition set-asides collected by each of those institutions for the preceding academic year. Section 21.136(b) states that details of the preliminary allocations will be shared with institutions for verification and comment before final allocations are posted on the Board's web site. Section 21.136(c) provides a specific deadline, March 15 at 11:59 p.m., for institutions to encumber program funds. Funds that are not encumbered as of that date are released for reallocation by the Board to other institutions. Section 21.136(d) describes the reallocation methodology, which is in keeping with the initial allocation methodology.

Ms. Lesa Moller, Interim Assistant Commissioner for State Financial Aid Programs, has determined that for each year of the first five years the new section is in effect, there will be no significant fiscal implications to state or local government as a result of enforcing or administering the rule.

Ms. Moller has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of administering the new section will be a clearer understanding of calculations for Texas B-On-Time Loan Program allocations for public institutions. Additionally, the rule establishes the opportunity for institutions to review and comment on any possible discrepancies between institutional tuition set aside records and Coordinating Board records before final allocations are published. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Lesa Moller, P.O. Box 12788, Austin, Texas 78711, (512) 427-6366, or Lesa.Moller@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

The new section is proposed under the Texas Education Code, Subchapter Q, §56.453, which authorizes the Coordinating Board to adopt rules to administer the Texas B-On-Time Loan Program.

The new section affects Texas Education Code, §§56.451 - 56.465.

§21.136. Allocation and Reallocation of Funds for Eligible Public Institutions of Higher Education.

(a) Funds in the Texas B-On-Time student loan account, other than money appropriated to the account exclusively for loans to stu-

dents attending private or independent institutions of higher education, shall be allocated to eligible public institutions in proportion to the amount of tuition set-aside collected by each of those institutions under Texas Education Code, §56.465 for the preceding academic year.

(b) Preliminary institutional allocations, each institution's percentage of the total allocation, and each institution's tuition set aside for the preceding academic year upon which the B-On-Time allocation is based under Texas Education Code, §56.465 will be shared with all participating public institutions of higher education for comment and verification before posting of the final allocations on the Board's website. Institutions will have 10 working days, beginning the day of the notice's distribution and excluding State holidays, to confirm that the amount of tuition set aside by the institution for BOT is accurately reflected on the preliminary allocation table or to advise Board staff of any inaccuracies.

(c) Institutions will have until March 15 at 11:59 p.m. (Central Time) or the first business day thereafter if it falls on a weekend or holiday to encumber the program funds that have been allocated to them. On the next business day, institutions lose claim to any funds not yet encumbered from the Board and the funds released in this manner are available to the Board for reallocation to other institutions.

(d) Funds available for any reallocation shall be distributed to eligible public institutions requesting reallocations in proportion to the amount of tuition set asides collected by each of the requesting institutions under Texas Education Code, §56.465 for the preceding academic year. No institution will receive more funds than it requested. If necessary for ensuring the full use of funds, subsequent reallocations may be scheduled until all funds are disbursed.

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

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403668
Bill Franz
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: October 23, 2014
For further information, please call: (512) 427-6114

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TITLE 22. EXAMINING BOARDS

PART 7. STATE COMMITTEE OF EXAMINERS IN THE FITTING AND DISPENSING OF HEARING INSTRUMENTS

CHAPTER 141. FITTING AND DISPENSING OF HEARING INSTRUMENTS

22 TAC §§141.2, 141.3, 141.6, 141.9, 141.11, 141.13, 141.16 - 141.18, 141.20, 141.28, 141.30, 141.31

The State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments (committee), proposes amendments to §§141.2, 141.3, 141.6, 141.9, 141.11, 141.13, 141.16 - 141.18, 141.20, and 141.28 and new §141.30 and §141.31, concerning the licensing and regulation of fitters and dispensers of hearing instruments.

BACKGROUND AND PURPOSE

The amendments to §141.28 are necessary to implement the requirements of SB 162 and House Bill (HB) 2254, 83rd Legislature, Regular Session, 2013, relating to requirements for licensure of military service members, military veterans, and military spouses.

New §141.30 is necessary to implement the requirements of Senate Bill (SB) 312, 83rd Legislature, Regular Session, 2013, which added Texas Occupations Code, §402.1023, for the committee to jointly adopt rules, with the assistance of the Department of State Health Services (department), with the State Board of Examiners for Speech-Language Pathology and Audiology (board) to establish requirements for the fitting and dispensing of hearing instruments by telepractice.

New §141.31 will initiate rulemaking in response to a petition submitted to the committee on behalf of a fitting and dispensing business requesting adoption of a rule establishing procedures for rulemaking petitions. The new rule will prescribe the content and procedural requirements for petitioning the committee for the adoption of rules, as required under Government Code, §2001.051.

Amendments to the following rules are proposed to clarify, correct, or update various rules to improve licensee understanding of the rules and the use of consistent terminology, and to accommodate evolving licensing processes and procedures, as further described in the summary for each section: §§141.2, 141.3, 141.6, 141.9, 141.11, 141.13, 141.16, 141.17, 141.18, and 141.20.

SECTION-BY-SECTION SUMMARY

The amendments to §141.2 are proposed to refine and clarify the definition of certain terms used in the chapter, and to improve consistency with standard usage within the profession.

The amendments to §141.3 are proposed to improve consistency in terminology used within the chapter.

The amendments to §141.6 will specify only those licensure examination fees collected by the committee to cover the costs of administering the licensing and regulatory program for fitters and dispensers of hearing instruments. Under existing rule, a single examination fee of $250 is specified, without distinguishing between the written and practical examination, or an initial or retake examination. The third party administrator for the written portion of the required examination has collected the $250 fee and returned $100 to the committee for its administration of the practical portion of the required licensure examination. If only the written or practical examination had to be re-taken, the applicant sent the third party written examination administrator or the committee, which administers the practical retake examination, the entire rule examination fee of $250 for the applicable examination being retaken.

As amended, the rule will specify only fees the committee will collect from applicants for the practical examination that it administers. Examination charges assessed by the third party administrator for the required written examination will continue to be assessed by, and paid directly to, the examination administrator. The amended rule will also separate the practical examination fees for an initial examination for $100 and a retake examination for $125, which will assess fees more equitably among applicants according to which examinations they are actually required to take for licensure and make retake practical examination fees proportionate to that portion of the examination being

retaken. Separating the fees in this manner will also allow for greater flexibility in examination administration.

Additionally, §141.6 will establish a fee for issuing a verification letter for a permit or license, which will increase consistency across professional licensing programs administered by, or with boards administratively attached to, the department, many of which contain fees for licensure verification letters, and will cover administrative and overhead costs associated with producing a licensure verification letter when online verification does not meet an individual's needs.

The amendments to §141.9 are proposed to improve consistency in terminology used within the chapter.

The amendment to §141.11 is proposed to reflect the spelling variant, i.e., "judgments," that generally predominates in the United States.

The amendments to §141.13 are proposed for consistency with the requirements of Texas Occupations Code, §55.002, and to reflect more specifically certain application requirements.

The amendments to §141.16 revise the title of the rule, correct the use of acronyms according to whether they are subsequently re-used in the section, and omit subsection (e), which has been moved to §141.17.

The amendments to §141.17(i) incorporate text moved from §141.16, with related language revisions to improve consistency and correct internal references.

The amendment to §141.18 is proposed to improve consistency in terminology used within the chapter.

The amendments to §141.20 are proposed to provide additional information to the complainant in an informal conference notice.

The amendments to §141.28 are proposed to comply with SB 162 and HB 2254, relating to requirements for licensure of military service members, military veterans, and military spouses.

New §141.30 is proposed to be jointly adopted with the State Board of Examiners for Speech-Language Pathology and Audiology to establish requirements for the fitting and dispensing of hearing instruments by telepractice, as required by SB 312.

New §141.31 is proposed to establish procedures relating to a petition for rulemaking.

FISCAL NOTE

Stewart Myrick, Interim Executive Director, has determined that for each year of the first five years the sections are in effect, there will be fiscal implications to state government as a result of enforcing or administering the sections as proposed. The effect on state government will be an estimated net decrease in state revenue of approximately $4,200 per year. The $100 fee collected by the committee for the initial practical examination under the amended rule will be consistent with the amount it has historically received back from the third party administrator of the written examination for the practical portion of the required licensure examination administered by the committee. The separation of the initial and retake examination fees for the practical examination will result in an estimated decrease in state revenue of approximately $5,000 per year, based on an average of 40 license applicants who will have to retake the practical examination per year at the proposed retake examination fee of $125 for the practical examination, rather than at the full examination fee of $250 paid under existing rule if someone has to retake only the practical examination, but will reduce the cost differential between the initial and retake practical examination for applicants retaking the examination.

Partially offsetting this decrease is an estimated increase in revenue to the state by a rounded estimate of $800 per year. The estimated increase is based on an average of 16 licensees per year who will be required to pay a late fee for the renewal of their licenses. Under §141.13(c)(10) and (11) (relating to Renewal of License), which is based on Texas Occupations Code, §402.301(d)(Relating to License Renewal), and not proposed for amendment, late renewal fees are charged at either half of, or an amount equal to, the amount of the fee for the examination required for licensure, which includes both a written and practical component. The combined cost for the applicant of the required written and practical examination is anticipated to be $325, consisting of an anticipated charge of $225 by the third party written examination administrator and the $100 to be assessed under the amended rule for the practical portion of the required licensure examination administered by the committee. This is a cost increase of $75 over the examination fee of $250 specified under existing rule for the required examination The rounded estimate for the increase in state revenue from late renewal fees, which is tied to the fee for the examination required for licensure, is $800, based on the average number of licensees who will be required to pay a late renewal fee, apportioned between the estimated number of licensees required to pay the full anticipated written and practical examination fee total and those paying half that total, depending on the period of time by which the renewal application is late.

Given the historically low volume of requests for license verification letters, any gain of revenue from the implementation of the fee is not expected to significantly affect the estimated decreases in revenue. Furthermore, the decrease in revenue to the committee for its practical examination administration, based on separating the initial and retake fee for the practical examination will not prevent the committee from producing sufficient revenue to cover the costs of administering the licensing and regulatory program for fitters and dispensers of hearing instruments. Implementation of the proposed amendments and new rules will not result in any fiscal implications for local governments.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Mr. Myrick has also determined that there will be no adverse economic impact to small businesses or micro-businesses required to comply with the sections 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 anticipated economic costs to persons who are required to comply with the sections as proposed, which will vary by individual applicant or licensee. Licensees who request a written verification of their license, which is a rare occurrence, will be required to remit $10.

Initial licensure examination is expected to cost applicants approximately $75 more in the aggregate, due to separation of payment for the initial written and practical examinations. The $100 the committee has historically received back from the third party administrator from the total examination fee of $250 specified under existing rule and paid by applicants to the third party written examination administrator will not increase, but the third party administrator is expected to charge $225 for the written

portion of the examination, resulting in an aggregate increase in cost of $75 to the applicant to take both the written and practical examinations required for licensure. Retaking both the written and practical examinations, for which applicants will separately pay the third party administrator for the written examination and the committee, as specified in the amended rule, for the retake practical examination, will also increase the applicants' cost, but having to retake both portions of the examination is expected to be a rare occurrence. Retaking either the written or practical examination only, which is more common, is expected to result in a cost savings to applicants in either case, since they will pay only for the exam portion they are required to retake. Retaking only the practical examination, which the committee administers, will save applicants $125 due to the separation of practical examination fees from written examination fees under the proposed amendments to §141.6 (relating to Application Procedures). Licensees who submit a renewal application less than 90 days after the expiration of their license are expected to have to pay a late fee of $162.50, based upon half of the combined cost of the written and practical portions of the examination required for licensure, and licensees who submit a renewal application more than 90 days but less than two years after the expiration of their license will have to pay a late fee of $325, based upon that full examination cost. These late renewal fees for applicants under the amended rule constitute an increase of $37.50 and $75, respectively, from late fees under current rules. The aggregate cost or savings to individual applicants or licensees required to comply with the sections as proposed will vary according to which fees apply to the individual in a given year. There is no anticipated impact on local employment.

PUBLIC BENEFIT

Mr. Myrick has also determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the proposed rule amendments and new rules. The public benefit anticipated as a result of enforcing or administering the sections will be to ensure the effective regulation of licensed hearing instrument dispensers, apprentice permit holders, and temporary training permit holders in Texas, which will protect and promote public health, safety, and welfare. In addition, adoption of the proposed rule amendments, and new rules will facilitate the occupational licensing of applicants with applicable military experience and of qualified military spouses.

REGULATORY ANALYSIS

The committee 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 committee 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 Stewart Myrick, Interim Executive Director, State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments, Mail Code 1982, P.O. Box 149347, Austin, Texas 78714-9347. Comments may also be sent through email to fdhi@dshs.state.tx.us. Please write "Comments on Proposed Rules" in the subject line. 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' legal authority to adopt.

STATUTORY AUTHORITY

The amendments and new rules are proposed under Texas Occupations Code, §402.102, which authorizes the committee, with the approval of the Executive Commissioner of the Health and Human Services Commission, to adopt procedural rules necessary for the performance of the committee's duties; §402.1023, which requires the committee and the State Board of Examiners for Speech-Language Pathology and Audiology, with the assistance of the department, to jointly adopt rules to establish requirements for the fitting and dispensing of hearing instruments by the use of telepractice; and §402.354, which authorizes the committee to adopt rules consistent with those joint rules, including rules that establish the qualifications and duties of license holders who use telepractice; under Texas Occupations Code, Chapter 55, which provides certain rulemaking authority and requirements for state licensing agencies; and under Government Code §2001.051, which requires that the committee adopt rules governing the form and procedure for petitioning the committee for the adoption of rules.

The amendments and new rules affect Texas Occupations Code, Chapters 55 and 402; and Government Code Chapter 2001.

§141.2. Definitions.

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

(1) - (4) (No change.)

(5) Apprentice permit--A permit issued by the committee to a person who meets the qualifications established by [~~requirements of~~] Texas Occupations Code, §402.207 and this chapter, and which authorizes the permit holder to fit and dispense hearing instruments under appropriate supervision from a person who holds a current, renewable license to fit and dispense hearing instruments without supervision under Texas Occupations Code, Chapter 401, which does not include an individual licensed under §401.311 or §401.312, or under Texas Occupations Code, Chapter 402.

(6) - (18) (No change.)

(19) Manufacturer--The term includes a person who applies to be a continuing education sponsor who is employed by, compensated by, or represents an entity, business, or corporation engaged in any of the activities described in this paragraph. An entity, business, or corporation that:

(A) - (C) (No change.)

[~~(D) is engaged in assembling hearing instruments for sale to the public;~~]

(D) [~~(E)~~] is a subsidiary of, or held by, an entity that is engaged in manufacturing, producing, or assembling hearing instruments as described above;

(E) [~~(F)~~] holds an entity, business, or corporation engaged in manufacturing, producing, or assembling hearing instruments as described above; or

(F) [~~(G)~~] serves as a buying group for an entity, business, or corporation engaged in manufacturing, producing, or assembling hearing instruments as described above.

(20) - (28) (No change.)

(29) Temporary training permit--A permit issued by the committee to a person who meets the qualifications established by Texas Occupations Code, Chapter 402, Subchapter F, and this chapter, to authorize the permit holder [~~persons authorized~~] to fit and dispense hearing instruments only under the direct or indirect supervision, as required and as appropriate, of a person who holds a current, renewable [~~valid~~] license to fit and dispense hearing instruments without supervision under Texas Occupations Code, Chapter 401, which does not include [~~or 402, other than~~] an individual licensed under §401.311 or §401.312, or under Texas Occupations Code, Chapter 402 [~~and meets the qualifications established by Texas Occupations Code, §402.255 and this chapter~~].

(30) - (32) (No change.)

§141.3. The Committee.

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

(c) Agendas.

(1) The executive director shall be responsible for preparing and submitting an agenda to each member of the board prior to each meeting which includes items requested by members, items required by law, and other matters of committee business which have been approved for discussion by the presiding officer [~~president~~].

(2) (No change.)

(d) Minutes.

(1) The minutes of a committee meeting are official only when affixed with the original signatures of the presiding officer [~~president~~] and the executive director.

(2) - (3) (No change.)

(e) - (m) (No change.)

§141.6. Application Procedures.

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

(f) The fees for administering the Act and this chapter shall be as follows:

(1) (No change.)

(2) initial practical examination fee--$100 [~~$250~~];

(3) retake practical examination fee--$125;

(4) [~~(3)~~] apprentice permit--$205;

(5) [~~(4)~~] licensure fee--$205;

(6) [~~(5)~~] a license issued or renewed for a one-year term--$205;

(7) [~~(6)~~] a license issued or renewed for a two-year term--$405;

(8) [~~(7)~~] duplicate document fee--$25;

(9) [~~(8)~~] continuing education sponsor fee--$500 annually;

(10) permit or license verification letter--$10;

(11) [~~(9)~~] reinstatement fee for a license that was suspended for failure to pay child support--$55; and

(12) [~~(10)~~] criminal history evaluation letter fee--$50.

§141.9. Issuance of Licenses.

(a) (No change.)

(b) License certificate. Upon receiving the licensure form and fee, the committee shall issue a license certificate which indicates the licensee's name and license number.

(1) Regular licenses shall bear the signature of the committee presiding officer [~~president~~].

(2) Temporary training permits and apprentice permits shall bear the signatures of the committee presiding officer [~~president~~].

(3) (No change.)

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

§141.11. Filing of a Bond.

(a) A sole proprietor, partnership, corporation, or other legal entity engaged in the fitting and dispensing of hearing instruments shall file a bond or a surety in lieu of a bond in the amount of $10,000 with the committee conditioned on the promise to pay all:

(1) (No change.)

(2) judgments [~~judgements~~] that the sole proprietor, partnership, corporation, or other legal entity may be required to pay for negligently or improperly dispensed hearing instruments or for breaching a contract relating to the dispensing of hearing instruments.

(b) - (e) (No change.)

§141.13. Renewal of License.

(a) General.

(1) - (2) (No change.)

(3) Each person who holds a regular license is responsible for renewing the license and shall not be excused from paying late renewal fees or renewal penalty fees, unless the individual establishes to the satisfaction of the committee or its staff or designee that the individual failed to renew the license in a timely manner because, on the deadline for timely submission of a renewal application, the individual was on active duty in the United States armed forces serving outside of Texas.

(4) The committee shall deny the renewal of the license of a licensee who is in violation of Texas Occupations Code, §402.501 [~~(Act)~~] or this chapter at the time of application for renewal.

(5) A person whose license has expired shall return his or her license certificate to the committee office.

(6) - (9) (No change.)

(b) (No change.)

(c) License renewal.

(1) (No change.)

(2) A paper or electronic license renewal form shall be made available to licensees eligible for renewal. The form shall require the licensee to provide:

(A) (No change.)

(B) telephone numbers; [and]

(C) information regarding continuing education that has been completed; and[.]

(D) information regarding calibration of all testing equipment.

(3) - (16) (No change.)

§141.16. Conditions of Sales [~~Condition of Sale~~].

(a) Compliance with other state and federal regulations.

(1) A licensee or permit holder shall adhere to the Federal Food and Drug Administration regulations in accordance with 21 Code of Federal Regulations [~~(CFR)~~] §801.420 and §801.421.

(2) - (4) (No change.)

(b) Audiometers and audiometric testing devices shall meet the current standards of the American National Standards Institute (ANSI) or the International Electrotechnical Commission [~~(IEC)~~].

(c) Audiometric testing not conducted in a stationary acoustical enclosure.

(1) A notation shall be made on the hearing test if testing was not done in a stationary acoustical enclosure and sound-level measurements must be conducted at the time of the testing to ensure that ambient noise levels meet permissible standards for testing threshold to 20 dB based on the most current ANSI [~~American National Standards Institute~~] "ear covered" octave band criteria for Permissible Ambient Noise Levels During Audiometric Testing, or the test environment shall have a maximum allowable ambient noise level of 42 dBA.

(2) (No change.)

(d) (No change.)

~~[(e) Committee-Ordered Refund. The committee may order a license holder to pay a refund to a consumer who returns a hearing instrument during the 30-day trial period described in the Act and in this section.]~~

§141.17. Complaints and Violations.

(a) - (h) (No change.)

(i) Committee-Ordered Refund. The committee may order a licensee or permit holder to pay a refund to a consumer who returns a hearing instrument(s) during the 30-day trial period described in the Act and in this chapter.

§141.18. Formal Hearings.

(a) - (g) (No change.)

(h) Final orders or decisions.

(1) - (2) (No change.)

(3) All final orders shall be signed by the presiding officer [~~president~~] of the committee; however, interim orders may be issued by the Administrative Law Judge.

(4) (No change.)

(i) - (j) (No change.)

§141.20. Informal Disposition.

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

(f) The notice of the conference shall be sent to the complainant at his or her last known address or personally delivered to the complainant. The complainant shall be informed that the complainant and the licensee [~~he or she~~] may appear and testify or that either [~~he or she~~] may submit a written statement for consideration at the conference.

(g) - (w) (No change.)

§141.28. Licensing of Military Service Members, Military Veterans, and Military Spouses [~~of Members of the Military~~].

(a) This section sets out licensing procedures for military service members, military veterans, and military spouses required under Occupations Code, Chapter 55 (relating to Licensing of Military Service Members, Military Veterans, and Military Spouses). For purposes of this section: [~~the alternative license procedure for military spouse required under Occupations Code, Chapter 55 (relating to License While on Military Duty and for Military Spouse).~~]

(1) "Military service member" means a person who is currently serving in the armed forces of the United States, in a reserve component of the armed forces of the United States, including the National Guard, or in the state military service of any state.

(2) "Military spouse" means a person who is married to a military service member who is currently on active duty.

(3) "Military veteran" means a person who has served in the army, navy, air force, marine corps, or coast guard of the United States, or in an auxiliary service of one of those branches of the armed forces.

(b) An applicant shall provide documentation of the applicant's status as a military service member, military veteran, or military spouse. Acceptable documentation includes, but is not limited to, copies of official documents such as military service orders, marriage licenses, and military discharge records. The application of a person who fails to provide documentation of his or her status shall not be processed under the requirements of this section.

(c) Upon request, an applicant shall provide acceptable proof of current licensure issued by another jurisdiction. Upon request, the applicant shall provide proof that the licensing requirements of that jurisdiction are substantially equivalent to the licensing requirements of this state.

(d) The committee's authority to require an applicant to undergo a criminal history background check, and the timeframes associated with that process, are not affected by the requirements of this section.

(e) For an application for a license submitted by a verified military service member or military veteran, the applicant shall receive credit towards any licensing requirements, except an examination requirement, for verified military service, training, or education that is relevant to the occupation, unless he or she holds a restricted license issued by another jurisdiction or if he or she has an unacceptable criminal history as described by the Act and this chapter.

(f) An applicant who is a military spouse who holds a current license issued by another jurisdiction that has substantially equivalent licensing requirements shall complete and submit an application form and fee. The committee shall issue a license to a qualified applicant who holds such a license as soon as practicable and the renewal of the license shall be in accordance with subsection (i) of this section.

(g) In accordance with Texas Occupations Code, §55.004(c), the executive director may waive any prerequisite to obtaining a license after reviewing the applicant's credentials and determining that the applicant holds a license issued by another jurisdiction that has licensing requirements substantially equivalent to those of this state.

(h) A military spouse who within the five years preceding the application date held the license in this state that expired while the applicant lived in another state for at least six months is qualified for licensure based on the previously held license, if there are no unresolved complaints against the applicant and if there is no other bar to licensure, such as criminal background or non-compliance with a committee order.

(i) If the committee issues an initial license to an applicant who is a military spouse in accordance with subsection (f) of this section, the committee shall assess whether the applicant has met all licensing requirements of this state by virtue of the current license issued by another jurisdiction. The committee shall provide this assessment in writing to the applicant at the time the license is issued. If the applicant has not met all licensing requirements of this state, the applicant must provide proof of completion at the time of the first application for license renewal. A license shall not be renewed, shall be allowed to expire, and shall become ineffective if the applicant does not provide proof of completion at the time of the first application for licensure renewal.

~~[(b) The spouse of a person serving on active duty as a member of the armed forces of the United States who holds a current license issued by another state that has licensing requirements shall complete and submit an application form and fee to the department. In accordance with Occupations Code, §55.004(c), the executive director may waive any prerequisite to obtaining a license after reviewing the applicant's credentials and determining that the applicant holds a license issued by another jurisdiction that has licensing requirements substantially equivalent to those of this state.]~~

~~[(c) The spouse of a person serving on active duty as a member of the armed forces of the United States who within the five years preceding the application date held the license in this state that expired while the applicant lived in another state for at least six months is qualified for licensure based on the previously held license, if there are no unresolved complaints against the applicant and if there is no other bar to licensure, such as criminal background or non-compliance with a committee order.]~~

§141.30. Joint Rule Regarding the Fitting and Dispensing of Hearing Instruments by Telepractice.

(a) Pursuant to Texas Occupations Code, §402.1023 and §401.2022, the Committee and the State Board of Examiners for Speech Language Pathology and Audiology, with the assistance of the department, are to adopt rules jointly to establish requirements for the fitting and dispensing of hearing instruments through the use of telepractice. This section contains joint rules that set forth the requirements for the fitting and dispensing of hearing instruments through the use of telepractice.

(b) Definitions. Unless the context clearly indicates otherwise, the following words and terms, when used in this section, shall have the following meanings:

(1) Acts--Texas Occupations Code, Chapter 402, relating to Hearing Instrument Fitters and Dispensers, and Chapter 401, relating to Speech-Language Pathologists and Audiologists.

(2) Board--The State Board of Examiners for Speech-Language Pathology and Audiology.

(3) Client--A consumer or proposed consumer of services.

(4) Client site--The site at which the client is physically located.

(5) Facilitator--The individual at the client site who assists with the delivery of telehealth services.

(6) Hearing instrument--Any wearable instrument or device designed for, or represented as, aiding, improving or correcting defective human hearing. This includes the instrument's parts and any attachment, including an earmold, or accessory to the instrument. The term does not include a battery or cord.

(7) Provider--An individual who holds a current, renewable, unrestricted license under Texas Occupations Code, Chapter 402, that authorizes the individual to fit and dispense hearing instruments without supervision; an individual who holds a current, renewable, unrestricted license under Texas Occupations Code, §401.302; or an individual who holds an audiology intern license under Texas Occupations Code, §401.311.

(8) Provider site--The physical location of the provider of telehealth services which is distant or remote from the client site.

(9) Telecommunications--Interactive communication at a distance by concurrent two-way transmission, using telecommunications technology, of information, including, without limitation, sound, visual images, and/or computer data, between the client site and the provider site, and required to occur without a change in the form or content of the information, as sent and received, other than through encoding or encryption of the transmission itself for purposes of and to protect the transmission.

(10) Telecommunications technology--Computers and equipment, other than telephone, email or facsimile technology and equipment, used or capable of use for purposes of telecommunications. For purposes of this section, the term includes, without limitation:

(A) compressed digital interactive video, audio, or data transmission;

(B) clinical data transmission using computer imaging by way of still-image capture and storage and forward; and

(C) other technology that facilitates the delivery of telehealth services.

(11) Telehealth services--The fitting and dispensing of hearing instruments through telepractice to a client who is physically located at a site other than the site where the provider is located.

(12) Telepractice--The use of telecommunications technology for the fitting and dispensing of hearing instruments.

(c) Unless otherwise legally authorized to do so, an individual shall not render telehealth services from the State of Texas or to a client in the state of Texas, unless the individual qualifies as a provider as that term is defined in this section and renders only those telehealth services that are within the course and scope of the provider's licensure and competence, and delivered in accordance with the requirements of that licensure and pursuant to the terms and conditions set forth in this section.

(d) The provider shall use only telecommunications technology that meets the definition of that term, as defined in this section, to render telehealth services. Modes of communication that do not utilize such telecommunications technology, including telephone, facsimile, and email, may be used only as adjuncts.

(e) Subject to the requirements and limitations of this section, a provider may utilize a facilitator at the client site to assist the provider in rendering telehealth services.

(f) The provider shall be present at the provider site and shall be visible and audible to, and able to see and hear the client and the facilitator via telecommunications technology in synchronous, real-time interactions, even when receiving or sending data and other telecommunication transmissions in carrying out the telehealth services. The

provider is responsible for the actions of the facilitator and shall monitor the client and oversee and direct the facilitator at all times during the telehealth session.

(g) The provider of telehealth services, prior to allowing a facilitator to assist the provider in rendering telehealth services, shall verify and document the facilitator's qualifications, training, and competence in each task the provider directs the facilitator to perform at the client site, and in the methodology and equipment the facilitator is to use at the client site.

(h) The facilitator may perform at the client site only the following tasks:

(1) those physical, administrative, and other tasks for which the provider has trained the facilitator in connection with the fitting or dispensing of hearing instruments for which no form of license, permit, authorization or exemption under either of the Acts is required; and

(2) a task for which the facilitator holds and acts in accordance with any license, permit, or other form of authorization or exemption required under either of the Acts.

(i) A provider shall not render telehealth services to a client in those situations in which the presence of a facilitator is required for safe and effective service to the client and no qualified facilitator is available to the client during the telepractice session.

(j) The scope, nature, and quality of the telehealth services provided, including the assistance provided by the facilitator, shall be commensurate with the services the provider renders in person at the same physical location as the client.

(k) The provider shall not render telehealth services unless the telecommunications technology and equipment located at the client site and at the provider site are appropriate to the telehealth services to be rendered; are properly calibrated and in good working order; and are of sufficient quality to allow the provider to deliver equivalent fitting and dispensing service and quality to the client as if those services were provided in person at the same physical location. The provider shall only utilize telecommunications technology and other equipment for the provider's telepractice which the provider is competent to use.

(l) The initial professional contact between the provider and client shall be at the same physical location.

(m) Providers and facilitators involved in the provider's delivery of telehealth services shall comply with all laws, rules, and regulations governing the maintenance of client records, including client confidentiality requirements. Documentation of telehealth services shall include documentation of the date and nature of services performed by the provider by telepractice and of the assistive tasks of the facilitator.

(n) Except to the extent it imposes additional or more stringent requirements, this section does not affect the applicability of any other requirement or provision of law to which an individual is otherwise subject under this chapter or other law.

§141.31. Petition for Adoption of a Rule.

(a) To request adoption of a rule, a person shall submit a written petition for adoption of the rule to the committee. The petition shall contain the following:

(1) the petitioner's name, address, and telephone number;

(2) a brief explanation of, and justification for, the proposed rule;

(3) the text of the proposed rule prepared in a manner to indicate the words to be added or deleted from the current text, if any;

(4) a statement of the statutory or other authority or mandate under which the rule is to be adopted; and

(5) a statement of the public benefit anticipated as a result of adopting the rule or the anticipated injury or inequity which could result from the failure to adopt the proposed rule.

(b) The petition shall be submitted to the executive director.

(c) The executive director shall submit a petition that complies with subsection (a) of this section to the committee for its consideration.

(d) Within 60 days after the executive director's receipt of a complete petition, the committee shall either:

(1) deny the petition;

(2) initiate rulemaking proceedings in accordance with the Administrative Procedure Act; or

(3) deny parts of the petition and initiate rulemaking proceedings on parts of the petition.

(e) If the committee denies all or part of the petition, the executive director, within 60 days after receipt of the petition, shall give the petitioner written notice of the board's denial, including the reason for the denial.

(f) If the committee initiates rulemaking proceedings, the version of the rule which the committee proposes or adopts may differ from the version proposed by the petitioner.

(g) All petitions for the adoption of a rule shall be presented to and decided by the committee in accordance with the provisions of this section.

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

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403766
William McCrae
Chair
State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 776-6972

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PART 9. TEXAS MEDICAL BOARD

CHAPTER 185. PHYSICIAN ASSISTANTS

22 TAC §185.16, §185.18

The Texas Medical Board (Board) proposes amendments to §185.16, concerning Employment Guidelines, and §185.18, concerning Discipline of Physician Assistants.

The amendments to §185.16 delete language related to limits on the number of physician assistants (PAs) that may be supervised by a physician. The amendments relate to general supervision only. The amendments are not intended to change laws related to limits on the numbers of PAs that may have prescriptive delegation authority.

The amendment to §185.18 changes the word "shall" to "may" in subsection (a) to reflect that the PA Board has the authority to enter non-disciplinary remedial plans to resolve certain matters.

Scott Freshour, General Counsel for the Board, has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing this proposal will be to provide physicians greater flexibility to determine appropriate supervision ratios of PAs at the practice level, which will improve the physicians and PAs' ability in Texas to work to the fullest extent of licensure and expertise and improve Texans' access to healthcare. Further, removing strict numerical limits related to general supervision of PAs will better align board regulations with other laws related to general supervision of advance practice registered nurses and to have rules that are accurate and that are consistent with other laws.

Mr. Freshour has also determined that for the first five-year period the sections are in effect there will be no fiscal implication to state or local government as a result of enforcing the sections as proposed. There will be no effect to individuals required to comply with the rules as proposed. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Rita Chapin, P.O. Box 2018, Austin, Texas 78768-2018 or emailed to: rules.development@tmb.state.tx.us. A public hearing will be held at a later date.

The amendments are proposed under the authority of the Texas Occupations Code Annotated, §204.101, which provides authority for the Board to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§185.16. Employment Guidelines.

[(a) Supervision Limited to Five Physician Assistants. Except as otherwise provided in this section, a physician may supervise up to five physician assistants, or their full-time equivalents. "Full time" shall mean no more than 50 hours per week.]

[(b)] Billing. A physician assistant may not independently bill patients for the services provided by the physician assistant except where provided by law.

[(c) Except at a site serving medically underserved populations as defined by Sec. 157.052 of the Tex. Occ. Code, a physician assistant shall not practice at a site where that physician assistant's supervising physician is not present at least 10 percent of the site's listed business hours. This provision shall not be interpreted to prevent a physician who has delegated prescriptive authority to a PA or APN pursuant to Chapter 157 of the Tex. Occ. Code from applying for a waiver in accordance with Sec. 157.0542 of the Tex. Occ. Code and §193.6(i) of this title (relating to Waivers).]

[(d) Supervision Requirements for Preventive Medical Services. A physician who provides medical services in preventive medicine, disease management, health and wellness education, or similar services in an accredited academic/teaching institution listed in paragraphs (1) - (3) of this subsection, or its affiliates, may be denoted as the supervising physician for more than five physician assistants in that institution or its affiliates, provided the supervising physician determines that the physician assistants are properly trained to deliver the services, that the services are of such a nature that they may be safely and competently delivered by the supervised physician assistants, and the proper paperwork has been filed with the Medical Board. The supervision of physician assistants must comply with all institutional rules and there must be accurate and timely internal institutional records, which are available upon request within 24 hours to the Medical Board, which list the name and license number of the physician who is specifically assigned to actively supervise each physician assistant at one of the following institutions:]

[(1) a school of medicine in this state accredited by the Liaison Committee on Medical Education or the American Osteopathic Association of Professional Education;]

[(2) the University of Texas Health Science Center at Tyler; or]

[(3) the University of Texas M.D. Anderson Cancer Center.]

[(e) Supervision Requirements for Licensed Hospitals. A physician who holds the position of Medical Director, Chief of Staff, or Emergency Room Department Chair at a licensed hospital may be denoted as the supervising physician for more than five physician assistants for the purpose of staffing a hospital emergency room. This physician may then delegate the direct supervision of the physician assistant to staff physicians providing medical services within the emergency room, provided that the supervising physician determines that the physician assistants are properly trained to deliver services, that the services are of such a nature that they may be safely and competently delivered by the supervised physician assistants, and that the proper paperwork has been filed with the Medical Board. The supervision of physician assistants must comply with all institutional rules and there must be accurate and timely internal institutional records, which are available upon request within 24 hours to the Texas Medical Board, which list the name and license number of the physician who is specifically assigned to actively supervise each physician assistant.]

[(f) Prescription Delegation. The provisions of subsections (a), (d), and (e) of this section relating to the number of physician assistants authorized to be supervised shall not be interpreted to change or modify rules or statutes relating to the number of physician assistants to whom prescriptive authority may be delegated, including delegating prescriptive authority to up to six physician assistants or advanced practice nurses if granted approval through a Board waiver under §193.6(i) of this title (relating to Waivers).]

§185.18. Discipline of Physician Assistants.

(a) The board, upon finding a physician assistant has committed any of the acts set forth in §185.17 of this title (relating to Grounds for Denial of Licensure and for Disciplinary Action), may [shall] enter an order imposing one or more of the allowable actions set forth under §204.301 of the Act.

(b) (No change.)

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

Filed with the Office of the Secretary of State on August 8, 2014.

TRD-201403596
Mari Robinson, J.D.
Executive Director
Texas Medical Board
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 305-7016

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PART 32. STATE BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

CHAPTER 741. SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS SUBCHAPTER P. JOINT RULES FOR FITTING AND DISPENSING OF HEARING INSTRUMENTS BY TELEPRACTICE

22 TAC §§741.231 - 741.233

The State Board of Examiners for Speech-Language Pathology and Audiology (board) proposes new §§741.231 - 741.233, concerning the regulation and licensure of speech-language pathologists and audiologists.

BACKGROUND AND PURPOSE

The new rules are necessary to comply with Section 2 of Senate Bill (SB) 312, 83rd Legislature, Regular Session, 2013, which adds new §401.2022, to the Texas Occupations Code, requiring the board and the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments (committee) to jointly adopt rules, with the assistance of the Department of State Health Services (department), to establish requirements for the fitting and dispensing of hearing instruments by the use of telepractice.

The proposed new rules in Subchapter P are proposed under Texas Occupations Code, §401.2022, which, together with a corresponding new rule proposed for 22 TAC §141.30, pursuant to Texas Occupations Code, §402.1023, were jointly approved by the board and committee for publication as proposed new joint rules for the fitting and dispensing of hearing instruments by telepractice. The rules being proposed in new Subchapter P are in the format jointly approved for publication by the board and committee, and previously published by the board in the June 6, 2014, issue of the *Texas Register* (39 TexReg 4387). The board has withdrawn the previously published proposed Subchapter P rules and is now re-publishing these rules in coordination with publication of the corresponding proposed new joint rule 22 TAC §140.30 under Texas Occupations Code, §402.1023, to allow for all comments on the proposed new joint rules, whether submitted to the board or to the committee, based upon their respective publication of proposed new joint rules in 22 TAC Chapter 741, Subchapter P, or in 22 TAC §141.30, to be considered before the board and committee each act to jointly adopt rules establishing requirements for the fitting and dispensing of hearing instruments by telepractice. Comments submitted in response to publication of the same proposed new joint rules on June 6, 2014, may be resubmitted for consideration during the comment period for this re-published proposed new joint rule.

SECTION-BY-SECTION SUMMARY

New §741.231 sets forth the purpose of the joint rules between the board and the committee regarding the fitting and dispensing of hearing instruments by telepractice.

New §741.232 defines the terms applicable to the rules in new Subchapter P.

New §741.233 sets forth the requirements for the fitting and dispensing of hearing instruments using telepractice.

FISCAL NOTE

Stewart Myrick, Interim Executive Director, has determined that for each year of the first five years the sections are in effect, there will be no fiscal implications to state or local governments as a result of enforcing or administering the sections as proposed.

SMALL AND MICRO-BUSINESS ECONOMIC STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

Mr. Myrick has also determined that there will be no adverse economic impact to small businesses or micro-businesses required to comply with the sections 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. Therefore, an economic impact statement and regulatory flexibility analysis for small businesses and micro-businesses is not required.

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. The new rules do not impose additional fees. There is no anticipated impact on local employment.

PUBLIC BENEFIT

Mr. Myrick has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the sections will be to ensure the effective and consistent regulation of the fitting and dispensing of hearing instruments by telepractice from, or to a person in Texas, which will protect and promote public health, safety, and welfare when telepractice is used for the fitting and dispensing of hearing instruments.

REGULATORY ANALYSIS

The board 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 board 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 Stewart Myrick, Interim Executive Director, State Board of Examiners for Speech-Language Pathology and Audiology, Mail Code 1982, P.O. Box 149347, Austin, Texas 78714-9347. Comments may also be sent through email to speech@dshs.state.tx.us. Please write "Comments on Proposed Rules" in the subject line. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

STATUTORY AUTHORITY

The new rules are authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; as well as Texas Occupations Code, §401.2022, which specifically authorizes and requires the board to jointly adopt, with the committee, and with the assistance of the department, rules establishing requirements for the fitting and dispensing of hearing instruments using telepractice.

The new rules affect Texas Occupations Code, Chapter 401.

§741.231. Purpose.

Pursuant to Texas Occupations Code, §401.2022 and §402.1023, the State Board of Examiners for Speech-Language Pathology and Audiology (board) and the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments (committee), with the assistance of the department, are to adopt rules jointly to establish requirements for the fitting and dispensing of hearing instruments through the use of telepractice. The rules in this subchapter contain joint rules that set forth the requirements for the fitting and dispensing of hearing instruments through the use of telepractice.

§741.232. Definitions.

Unless the context clearly indicates otherwise, the following words and terms, when used in this subchapter, shall have the following meanings:

(1) Acts--Texas Occupations Code, Chapter 401, relating to Speech-Language Pathologists and Audiologists, and Texas Occupations Code, Chapter 402, relating to Hearing Instrument Fitters and Dispensers.

(2) Board--The State Board of Examiners for Speech-Language Pathology and Audiology.

(3) Client--A consumer or proposed consumer of services.

(4) Client site--The site at which the client is physically located.

(5) Committee--The State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments.

(6) Facilitator--The individual at the client site who assists with the delivery of telehealth services.

(7) Fitting and dispensing hearing instruments--The measurement of human hearing by the use of an audiometer or other means to make selections, adaptations, or sales of hearing instruments. The term includes the making of impressions for earmolds to be used as a part of the hearing instruments and any necessary post fitting counseling for the purpose of fitting and dispensing hearing instruments.

(8) Hearing instrument--Any wearable instrument or device designed for, or represented as, aiding, improving or correcting defective human hearing. This includes the instrument's parts and any attachment, including an earmold, or accessory to the instrument. The term does not include a battery or cord.

(9) Provider--An individual who holds a current, renewable, unrestricted audiology license under Texas Occupations Code, §401.302 and §401.304; an individual who holds an audiology intern license under Texas Occupations Code, §401.311; or an individual who holds a current, renewable, unrestricted license under Texas Occupations Code, Chapter 402, that authorizes the individual to fit and dispense hearing instruments without supervision.

(10) Provider site--The physical location of the provider of telehealth services which is distant or remote from the client site.

(11) Telecommunications--Interactive communication at a distance by concurrent two-way transmission, using telecommunications technology, of information, including, without limitation, sound, visual images, and/or computer data, between the client site and the provider site, and required to occur without a change in the form or content of the information, as sent and received, other than through encoding or encryption of the transmission itself for purposes of and to protect the transmission.

(12) Telecommunications technology--Computers and equipment, other than telephone, email or facsimile technology and equipment, used or capable of use for purposes of telecommunications. For purposes of this subchapter, the term includes, without limitation:

(A) compressed digital interactive video, audio, or data transmission;

(B) clinical data transmission using computer imaging by way of still-image capture and storage and forward; and

(C) other technology that facilitates the delivery of telehealth services.

(13) Telehealth services--The fitting and dispensing of hearing instruments through telepractice to a client who is physically located at a site other than the site where the provider is located.

(14) Telepractice--The use of telecommunications technology for the fitting and dispensing of hearing instruments.

§741.233. Requirements for Providing Telehealth Services for the Fitting and Dispensing of Hearing Instruments.

(a) Unless otherwise legally authorized to do so, an individual shall not render telehealth services from the State of Texas or to a client in the State of Texas, unless the individual qualifies as a provider as that term is defined in this subchapter and renders only those telehealth services that are within the course and scope of the provider's licensure and competence, and delivered in accordance with the requirements of that licensure and pursuant to the terms and conditions set forth in this section.

(b) The provider shall use only telecommunications technology that meets the definition of that term, as defined in this subchapter, to render telehealth services. Modes of communication that do not utilize such telecommunications technology, including telephone, facsimile, and email, may be used only as adjuncts.

(c) Subject to the requirements and limitations of this section, a provider may utilize a facilitator at the client site to assist the provider in rendering telehealth services.

(d) The provider shall be present at the provider site and shall be visible and audible to, and able to see and hear the client and the facilitator via telecommunications technology in synchronous, real-time interactions, even when receiving or sending data and other telecommunication transmissions in carrying out the telehealth services. The provider is responsible for the actions of the facilitator and shall monitor the client and oversee and direct the facilitator at all times during the telehealth session.

(e) The provider of telehealth services, prior to allowing a facilitator to assist the provider in rendering telehealth services, shall verify and document the facilitator's qualifications, training, and competence in each task the provider directs the facilitator to perform at the client site, and in the methodology and equipment the facilitator is to use at the client site.

(f) The facilitator may perform at the client site only the following tasks:

(1) those physical, administrative, and other tasks for which the provider has trained the facilitator in connection with the fitting or dispensing of hearing instruments for which no form of license, permit, authorization or exemption under either of the Acts is required; and

(2) a task for which the facilitator holds and acts in accordance with any license, permit, authorization or exemption required under either of the Acts to perform the task.

(g) A provider shall not render telehealth services to a client in those situations in which the presence of a facilitator is required for safe and effective service to the client and no qualified facilitator is available to the client during the telepractice session.

(h) The scope, nature, and quality of the telehealth services provided, including the assistance provided by the facilitator, shall be commensurate with the services the provider renders in person at the same physical location as the client.

(i) The provider shall not render telehealth services unless the telecommunications technology and equipment located at the client site and at the provider site are appropriate to the telehealth services to be rendered; are properly calibrated and in good working order; and are of sufficient quality to allow the provider to deliver equivalent fitting and dispensing service and quality to the client as if those services were provided in person at the same physical location. The provider shall only utilize telecommunications technology and other equipment for the provider's telepractice which the provider is competent to use.

(j) The initial professional contact between the provider and client shall be at the same physical location.

(k) Providers and facilitators involved in the provider's delivery of telehealth services shall comply with all laws, rules, and regulations governing the maintenance of client records, including client confidentiality requirements. Documentation of telehealth services shall include documentation of the date and nature of services performed by the provider by telepractice and of the assistive tasks of the facilitator.

(l) Except to the extent it imposes additional or more stringent requirements, this section does not affect the applicability of any other requirement or provision of law to which an individual is otherwise subject under this chapter or other law.

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

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403772

Vickie Dionne, Au.D.

Presiding Officer

State Board of Examiners for Speech-Language Pathology and Audiology

Earliest possible date of adoption: September 21, 2014

For further information, please call: (512) 776-6972

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PART 40. ADVISORY BOARD OF ATHLETIC TRAINERS

CHAPTER 871. ATHLETIC TRAINERS

SUBCHAPTER A. GENERAL GUIDELINES AND REQUIREMENTS

22 TAC §871.12, §871.20

The Advisory Board of Athletic Trainers (board) proposes an amendment to §871.12 and new §871.20, concerning the licensure and regulation of athletic trainers.

BACKGROUND AND PURPOSE

The proposed amendments increase the continuing education requirement for renewal of a license and specify the level of emergency cardiac care certification required for renewal, and to be maintained throughout each licensure period, in order to ensure training adequate to the needs and context of Athletic Trainers' professional practice, and consistent with the level required for national certification.

The proposed new rule implements the requirements of Senate Bill (SB) 162 and House Bill (HB) 2254, 83rd Legislature, Regular Session, 2013, which amended Texas Occupations Code, Chapter 55, which addresses the licensing of military service members, military veterans, and military spouses.

SECTION-BY-SECTION SUMMARY

The amendments to §871.12 propose an increase in the number of continuing education hours required to renew a license on or after September 1, 2015, from twenty to forty, which is more closely aligned to national continuing education standards for Athletic Trainers and better ensures that licensees will remain knowledgeable of current trends and developments in the industry and keep their practices aligned with current industry standards. The amendments also describe with greater specificity the level of emergency cardiac care certification required for renewal of the license, and to be maintained throughout each licensure period, in order to ensure training adequate to the needs and context of Athletic Trainers' professional practice, and consistent with the level required for national certification.

New §871.20 is proposed to implement the requirements of SB 162 and HB 2254, relating to the occupational licensing of spouses of members of the military and the eligibility requirements for certain occupational licenses issued to applicants with military experience, and apprenticeship requirements for occupational licenses issued to applicants with military experience.

FISCAL NOTE

Stewart Myrick, Program Director, 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 the sections as proposed.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Mr. Myrick has also determined that there will be no effect on small businesses or micro-businesses required to comply with the sections as proposed. This was determined by interpretation of the rules that small businesses and micro-business will not be required to alter their business practices in order to comply with the sections.

ECONOMIC COST 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. Although the number of continuing education hours required for renewal is being increased, there are sufficient continuing education resources available at no cost for any licensee who chooses to fulfill the requirement without additional cost to do so. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

In addition, Mr. Myrick has also determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. The public benefit anticipated as a result of enforcing or administering the sections is that licensees will be better informed concerning current trends and developments in the industry and better prepared to keep their practices aligned with current industry standards as a result of the increased continuing education requirements. In addition, the application of more flexible standards to members of the military, their spouses, and veterans holds the potential of increasing the availability of licensed athletic trainers to the public.

REGULATORY ANALYSIS

The board 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 specially intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The board 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 Stewart Myrick, Program Director, Advisory Board of Athletic Trainers, Mail Code 1982, P.O. Box 149347, Austin, Texas 78714-9347 or by email to at@dshs.state.tx.us. When emailing comments, please indicate "Comments on Proposed Rules" in the subject line. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

STATUTORY AUTHORITY

The amendment and new rule are proposed under Texas Occupations Code, §451.103, which authorizes the board to adopt rules necessary for the performance of its duties; under Texas Occupations Code, Chapter 55, which authorizes rulemaking regarding certain licensing provisions for military service members, military veterans, and military spouses; and under SB 162, 83rd Legislature, Regular Session, 2013, which authorizes rulemaking regarding certain licensing provisions for military spouses.

The amendment and new rule affect Texas Occupations Code, Chapter 451, and Texas Occupations Code, Chapter 55.

§871.12. Continuing Education Requirements.

(a) (No change.)

(b) To renew a license that expires on or after September 1, 2015, a [~~Hours required for continuing education. A~~] licensee must have completed 40 [~~complete 20~~] clock-hours of continuing education during the previous [~~each~~] two-year period. To renew a license that expires prior to September 1, 2015, a licensee must have completed 20 clock-hours of continuing education during the previous two-year period. The continuing education must include 2 clock-hours of training in concussion management. In addition to the number of [~~20~~] clock-hours of continuing education required under this subsection, a licensee must also show proof of current Emergency Cardiac Care certification at the Basic Life Support for Healthcare Providers/Professional Rescuers and Healthcare Providers level or beyond, which shall be maintained throughout [~~successfully complete a cardiopulmonary resuscitation (CPR) techniques course and an automated external defibrillation course during~~] each two-year period. The two-year period begins on the first day following the license issuance month and ends upon the expiration date of the license.

(c) - (j) (No change.)

§871.20. Licensing of Military Service Members, Military Veterans, and Military Spouses.

(a) This section sets out licensing procedures for military service members, military veterans, and military spouses required under Occupations Code, Chapter 55 (relating to Licensing of Military Service Members, Military Veterans, and Military Spouses). For purposes of this section:

(1) "Military service member" means a person who is currently serving in the armed forces of the United States, in a reserve component of the armed forces of the United States, including the National Guard, or in the state military service of any state.

(2) "Military spouse" means a person who is married to a military service member who is currently on active duty.

(3) "Military veteran" means a person who has served in the army, navy, air force, marine corps, or coast guard of the United States, or in an auxiliary service of one of those branches of the armed forces.

(b) An applicant shall provide documentation of the applicant's status as a military service member, military veteran, or military spouse. Acceptable documentation includes, but is not limited to, copies of official documents such as military service orders, marriage licenses, and military discharge records. The application of a person who fails to provide documentation of his or her status shall not be processed under the requirements of this section.

(c) Upon request, an applicant shall provide acceptable proof of current licensure issued by another jurisdiction. Upon request, the applicant shall provide proof that the licensing requirements of that jurisdiction are substantially equivalent to the licensing requirements of this state.

(d) The board's authority to require an applicant to undergo a criminal history background check, and the timeframes associated with that process, are not affected by the requirements of this section.

(e) For an application for a license submitted by a verified military service member or military veteran, the applicant shall receive credit towards any licensing or apprenticeship requirements, except an examination requirement, for verified military service, training, or education that is relevant to the occupation, unless he or she holds a restricted license issued by another jurisdiction or if he or she has an unacceptable criminal history as described by the Act and this chapter.

(f) An applicant who is a military spouse who holds a current license issued by another jurisdiction that has substantially equivalent licensing requirements shall complete and submit an application form and fee. The board shall issue a license to a qualified applicant who holds such a license as soon as practicable and the renewal of the license shall be in accordance with subsection (i) of this section.

(g) In accordance with Occupations Code, §55.004(c), the program director may waive any prerequisite to obtaining a license after reviewing the applicant's credentials and determining that the applicant holds a license issued by another jurisdiction that has licensing requirements substantially equivalent to those of this state.

(h) A military spouse who within the five years preceding the application date held the license in this state that expired while the applicant lived in another state for at least six months is qualified for licensure based on the previously held license, if there are no unresolved complaints against the applicant and if there is no other bar to licensure, such as criminal background or non-compliance with a board order.

(i) If the board issues an initial license to an applicant who is a military spouse in accordance with subsection (f) of this section, the board shall assess whether the applicant has met all licensing requirements of this state by virtue of the current license issued by another jurisdiction. The board shall provide this assessment in writing to the applicant at the time the license is issued. If the applicant has not met all licensing requirements of this state, the applicant must provide proof of completion at the time of the first application for license renewal. A license shall not be renewed, shall be allowed to expire, and shall become ineffective if the applicant does not provide proof of completion at the time of the first application for licensure renewal.

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

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403770
David Weir
Chair
Advisory Board of Athletic Trainers
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 776-6972

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER J. RULES TO IMPLEMENT THE AMUSEMENT RIDE SAFETY INSPECTION AND INSURANCE ACT

28 TAC §5.9003

The Texas Department of Insurance proposes amending 28 TAC §5.9003. This section concerns the payment of annual fees by persons operating amusement rides. The amendments are necessary to provide additional payment options for owners and operators of amusement rides and to clarify the administration of fees.

The proposed amendments to §5.9003 provide for the option of paying required fees online through the Texas OnLine Project. The Texas OnLine Project is the common electronic infrastructure established by Government Code §2054.252 for state agencies and local governments, including licensing entities. The proposed new language specifies that TDI authorizes online or electronic transactions, and persons must pay the fee associated with the transaction as directed by TDI or the Texas OnLine Authority. The website for payment is www.texas.gov. The proposed amendments also allow amusement ride owners and operators to remit fees by personal check, in addition to cashier's check. Finally, the proposed amendments also clarify that fees are nonrefundable and nontransferable.

FISCAL NOTE. Sam Nelson, director of the Inspections Office, Property and Casualty Section, has determined that for each year of the first five years the proposed section will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT/COST NOTE. Mr. Nelson has also determined that for each year of the first five years the proposed amendment is in effect, the public benefit anticipated as a result of the proposal is the more efficient administration of Occupations Code Chapter 2151 and increased access to state government over the Internet for the public. The cost to persons required to comply with the proposal varies. Owners and operators of amusement rides electing to use the optional electronic transaction available online at www.texas.gov must pay additional charges. The website www.texas.gov adds $2 and an additional 2.25 percent for each transaction. For a single amusement ride inspection certificate fee costing $40, the price on www.texas.gov would be $42.90. Owners and operators of amusement rides are not required to pay online, and the proposed amendments do not impose other new requirements. All of the costs in this cost note are equally applicable to small or micro businesses. TDI anticipates that the proposed amendments will not substantively affect persons who do not choose to use the optional online payment method.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. As required by Government Code §2006.002(c), TDI has determined that the proposal will not have an adverse economic effect on small or micro businesses because the proposed rule may not apply to any small or micro businesses. Instead, the rule provides an additional option for the payment of annual fees. In accord with Government Code §2006.002(c), TDI has determined that a regulatory flexibility analysis is not required.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, as a result, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. To have your written comments on the proposal considered, you must submit them no later than 5:00 p.m., Central time on September 22, 2014. Send your comments to the chief clerk by email at chiefclerk@tdi.texas.gov or by mail to Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. You must simultaneously submit your comments by email to Sam Nelson at sam.nelson@tdi.texas.gov or by mail to Sam Nelson, Inspections Office, Mail Code 103-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. You must submit any request for a public hearing separately to the chief clerk by email at chiefclerk@tdi.texas.gov or by mail to Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 before the close of the public comment period. If TDI holds a hearing, written comments and testimony presented at the hearing will also be considered.

STATUTORY AUTHORITY. The amendments are proposed under Title 13, Occupations Code, Chapter 2151 and Insurance Code §36.001. Occupations Code §2151.052 provides that the commissioner may establish reasonable and necessary fees, in an amount not to exceed $40 per year, for each amusement ride covered by this chapter. Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state. Government Code §2054.252(g) requires TDI to increase licensing fees in an amount sufficient to cover TDI's Texas OnLine Project subscription fee cost.

CROSS REFERENCE TO STATUTE. The proposal affects Title 13, Occupations Code, Chapter 2151 and Government Code §2054.252.

§5.9003. Administration and Enforcement.

The Texas Department of Insurance is required by the Act to administer and enforce the Act. Owners/operators operating amusement rides must pay a fee of $40 per year for each amusement ride subject to the Act. [~~The fee payment shall accompany the insurance policy and amusement ride inspection certificate (TDI Form AR-100, Amusement Ride Certificate of Inspection/Re-Inspection, Revised Effective October, 2005) required by the Act and by §5.9004 of this title (relating to Amusement Ride Operation Requirements).~~] The fees must [~~shall~~] be paid by [~~certified~~] check or money order made payable to the Texas Department of Insurance; or if paying over the Internet, the fee must be submitted through the Texas OnLine Project, as directed by the Texas OnLine Authority, which may add a surcharge for the online transaction. Except for overpayments resulting from mistakes of law or fact, all fees are nonrefundable and nontransferable. [~~The applicant shall attach the certified check or money order to the inspection certificate (TDI Form AR-100, Revised Effective October, 2005). The certified check or money order may be one check or money order for the total amount of fees for all rides or a separate check for each ride.~~]

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

Filed with the Office of the Secretary of State on August 5, 2014.

TRD-201403542
Sara Waitt
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 463-6327

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CHAPTER 19. AGENTS' LICENSING
SUBCHAPTER S. FORMS TO REQUEST PRIOR AUTHORIZATION

The Texas Department of Insurance proposes new Subchapter S, §§19.1801 - 19.1804 and 19.1810, in 28 TAC Chapter 19, Agents' Licensing, concerning Forms to Request Prior Authorization. Subchapter S will prescribe a prior authorization request form for health care services that will be accepted and used by health benefit plan issuers, and the agents of health benefit plan issuers that manage or administer issuers' health care services benefits, when a provider or facility submits the form to request prior authorization of a health care service for which an issuer's plan requires prior authorization.

Background and Justification.

Senate Bill 1216, 83rd Legislature, Regular Session (2013) amended Insurance Code Title 8, Subtitle A, to add Chapter 1217 to require the commissioner of insurance to prescribe by rule a single, standard form for requesting prior authorization of health care services. SB 1216 also requires an issuer and its agents to accept and use the form for all prior authorizations of health care services for which the issuer's plan requires prior authorization, and it requires the department and the issuer and its agents to make the form available in paper form and electronically on their websites. The proposed rule addresses these requirements.

SB 1216 also directed the commissioner to develop the form with input from an advisory committee and to consider prior authorization forms now used widely in Texas, used by the department, or established by the Centers for Medicare and Medicaid Services, and to consider national standards or draft standards on electronic prior authorization of benefits.

In compliance with new Insurance Code §1217.005, the commissioner appointed an advisory committee composed as required by §1217.005(c). Agency staff met with the advisory committee on April 22, 2014, May 14, 2014, and June 10, 2014, and consulted the committee by email to get the committee's input, which was used to create the form in this rule proposal.

Description of Proposed Rule.

In addition to SB 1216, the 83rd Legislature (Regular Session) passed SB 644, which directs the commissioner to prescribe by rule a single, standard form for requesting prior authorization of prescription drug benefits.

Because the prior authorization rules implementing SB 1216 and SB 644 are closely linked, both rules will be included in Subchapter S. Although this proposal addresses only the prior authorization request form for health care services mandated by SB 1216, some provisions of this rule will also apply to the prior authorization request form for prescription drug benefits when the rule adopting that form is added.

Division 1, §§19.1801 - 19.1804, includes sections common to both rules. Section 19.1801 lists the health benefit plans, coverages, and programs to which the subchapter applies. Section 19.1802 lists the health benefit plans, coverages, and policies excepted from the rules. Section 19.1803 defines terms also defined in SB 1216 or SB 644 or used in the prescribed forms. Section 19.1804 is a severability provision.

Division 2, §19.1810, is specific to SB 1216. Section 19.1810(a) adopts the form by reference and lists several ways to find and get the form. Subsection (a) also contains a description of the form sufficiently specific to provide the substantive detail about the form, as prescribed by 28 TAC §1.203(b)(2). Section 19.1810(b) states that issuers are required to accept and use the form when submitted by a provider seeking prior authorization of a health care service for which the issuer requires prior authorization. This subsection also lists purposes for which the form may not be used. Section 19.1810(c) states the rule's effective date. Section 19.1810(d) directs both the health benefit plan issuer and the agent of a health benefit plan issuer that manages or administers the issuer's health care services benefits to make the form available both on paper and on its website.

FISCAL NOTE. Patricia Brewer, special advisor for policy development in the Life, Accident, and Health Section, has determined

that for each year of the first five years the proposed new sections will be in effect, there will be no fiscal impact to state or local governments resulting from enforcement or administration of the rule. The proposal will have no measurable effect on local employment or on the local economy.

PUBLIC BENEFIT AND COST NOTE. Ms. Brewer has also determined that for each year of the first five years the proposed new sections are in effect, the rules' anticipated public benefits include reduced administrative time spent by physicians, hospitals, and other health care providers identifying and completing each issuer's prior authorization form or forms; easy provider access to the standard prior authorization form on the department's and the issuers' and agents' websites; and expedited delivery of health care services to consumers.

The costs to persons who must comply with the proposed sections, for each year of the first five years they would be in effect, result from the enactment of SB 1216, and not from the adoption, enforcement, or administration of the proposed sections. SB 1216 explicitly prohibits the department from declining to prescribe the form. The department is unable to determine the actual cost for issuers and providers to adopt and use the form when adopted, as those costs will vary based on each entity's administrative processes. However, as required by SB 1216, the department developed the proposed form with input from an advisory committee in which issuer representatives and health care provider and facility representatives, among others, participated. After extensively discussing the form's elements with the advisory committee, the department does not anticipate that issuers or their agents or providers and facilities will incur undue material costs due to the particular elements of the proposed form. The agency does not anticipate a difference in the cost of compliance between small and large businesses.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. In compliance with Government Code §2006.002(c), the department has determined that the proposed new sections that require issuers and their agents to use and accept the standard prior authorization request form and to make the form available in paper form and electronically on their respective websites will not have an adverse economic effect on small or micro businesses required to comply with the proposed rule. The proposal does not impose on businesses any requirements or costs other than those required by SB 1216. Costs to persons required to comply with the proposed new sections result from the enactment of SB 1216, and not from the adoption, enforcement, or administration of the proposal. Therefore, the department has determined that a regulatory flexibility analysis is not required because the proposal will not have an adverse impact on small or micro businesses. It is not possible both to provide flexibility for small or micro businesses and to comply with the Legislature's mandate in SB 1216 to create a single, standard prior authorization request form for Texas. Permitting small or micro businesses to refuse to accept the adopted form, and instead require providers to use a form specific to or created by individual small or micro businesses, would increase, rather than decrease, providers' confusion.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal. This proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and so does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. The department invites comments on the proposed rules. If you wish to comment on this proposal, your comments must be postmarked no later than 5:00 p.m., Central time, on September 22, 2014. Please send comments by mail to Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or by email to chiefclerk@tdi.texas.gov. Please simultaneously submit an additional copy of the comments by mail to Patricia Brewer, Special Advisor for Policy Development, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or by email to lhlcomments@tdi.texas.gov. You must submit any request for a public hearing separately to the Office of Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or by email to chiefclerk@tdi.texas.gov before the close of the public comment period. If there is a hearing on this proposal, you may present written comment and public testimony at the hearing.

DIVISION 1. TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORMS

28 TAC §§19.1801 - 19.1804

STATUTORY AUTHORITY. The department proposes the new sections under Insurance Code §§1217.001, 1217.002, 1217.003, 1217.004, 1217.006, and 36.001. Section 1217.001 provides definitions for insurance code Chapter 1217. Section 1217.002 states applicability of Insurance Code Chapter 1217. Section 1217.003 states exceptions to the applicability of Insurance Code Chapter 1217. Section 1217.004 requires the commissioner to adopt a rule to prescribe a single, standard form for requesting prior authorization of health care services; to require an issuer to use the form for all prior authorizations of health care services for which the issuer's plan requires prior authorization; and to require the department and the issuer to make the form available in paper form and electronically on their websites. Section 1217.006 states that nothing in Chapter 1217 may be construed to authorize the commissioner to decline to prescribe the form required by §1217.004. Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. All statutes cited below are in the Insurance Code unless otherwise noted. The following statutes are affected by this proposal: Insurance Code §§1217.001, 1217.002, 1217.003, 1217.004, 1217.006, and 36.001.

§19.1801. Applicability.

(a) Applicable health benefit plans. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement holding a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation holding a certificate of authority under Chapter 844.

(b) Other applicable coverages and programs.

(1) This subchapter applies to group health coverage made available by a school district under Education Code §22.004.

(2) This subchapter applies to:

(A) a basic coverage plan under Chapter 1551;

(B) a basic plan under Chapter 1575;

(C) a primary care coverage plan under Chapter 1579; and

(D) basic coverage under Chapter 1601.

(3) This subchapter applies to coverage under the child health program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code.

(4) This subchapter applies to a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

§19.1802. Exception.

This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) only for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by §1882, Social Security Act (42 U.S.C. §1395ss);

(3) medical payment insurance coverage provided under a motor vehicle insurance policy;

(4) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by §1217.002; or

(5) a workers' compensation insurance policy.

§19.1803. Definitions.

The following words and terms, when used in this subchapter, have the following meanings:

(1) CDT--Current Dental Terminology code set maintained by the American Dental Association.

(2) CPT--Current Procedural Terminology code set maintained by the American Medical Association.

(3) Department--Texas Department of Insurance.

(4) Form--In Division 2 of this subchapter, the Texas Standardized Prior Authorization Request Form for Health Care Services.

(5) HCPCS--Healthcare Common Procedure Coding System.

(6) Health benefit plan--

(A) a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document offered by a health benefit plan issuer.

(B) Health benefit plan also includes:

(i) group health coverage made available by a school district in accord with Education Code §22.004;

(ii) coverage under the child health program in Chapter 62 Health and Safety Code, or the health benefits plan for children in Chapter 63 Health and Safety Code;

(iii) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code;

(iv) a basic coverage plan under Chapter 1551;

(v) a basic plan under Chapter 1575;

(vi) a primary care coverage plan under Chapter 1579; and

(vii) basic coverage under Chapter 1601.

(7) Health benefit plan issuer--An entity authorized under the Texas Insurance Code or another insurance law of this state that delivers or issues for delivery a health benefit plan or other coverage described in Insurance Code §1217.002.

(8) Health care service--A service to diagnose, prevent, alleviate, cure, or heal a human illness or injury, which is provided by a physician or other health care provider. The term includes medical or health care treatments, consultations, procedures, drugs, supplies, imaging and diagnostic services, inpatient and outpatient care, medical devices, and durable medical equipment. The term does not include prescription drugs as defined by Occupations Code §551.003.

(9) Issuer--A health benefit plan issuer and the agent of a health benefit plan issuer that manages or administers the issuer's health care services or prescription drug benefits.

(10) NPI number--A provider's or facility's National Provider Identifier.

(11) Prescription drug--Has the meaning assigned by Occupations Code §551.003.

§19.1804. Severability.

If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applica-

tions of this subchapter that can be given effect without the invalid provision or application, and to this end, the provisions of this subchapter are severable.

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

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TRD-201403647
Sara Waitt
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 463-6327

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DIVISION 2. TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

28 TAC §19.1810

STATUTORY AUTHORITY. The department proposes the new section under Insurance Code §§1217.001, 1217.002, 1217.003, 1217.004, 1217.006, and 36.001. Section 1217.001 provides definitions for insurance code Chapter 1217. Section 1217.002 states applicability of Insurance Code Chapter 1217. Section 1217.003 states exceptions to the applicability of Insurance Code Chapter 1217. Section 1217.004 requires the commissioner to adopt a rule to prescribe a single, standard form for requesting prior authorization of health care services; to require an issuer to use the form for all prior authorizations of health care services for which the issuer's plan requires prior authorization; and to require the department and the issuer to make the form available in paper form and electronically on their websites. Section 1217.006 states that nothing in Chapter 1217 may be construed to authorize the commissioner to decline to prescribe the form required by §1217.004. Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. All statutes cited below are in the Insurance Code unless otherwise noted. The following statutes are affected by this proposal: Insurance Code §§1217.001, 1217.002, 1217.003, 1217.004, 1217.006, and 36.001.

§19.1810. Prior Authorization Request Form for Health Care Services, Required Acceptance, and Use.

(a) Form requirements. The commissioner adopts by reference the Prior Authorization Request Form for Health Care Services, to be accepted and used by an issuer in compliance with subsection (b) of this section. The form and its instruction sheet are posted on the department's website at www.tdi.texas.gov/forms/form10.html; or the form and its instruction sheet can be requested by mail from the Texas Department of Insurance, Rate and Form Review Office, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104. The form must be reproduced without changes. The form provides space for the following information:

(1) the plan issuer's name, telephone number, and facsimile (fax) number;

(2) the date the request is submitted;

(3) the type of review, whether:

(A) nonurgent; or

(B) urgent. An urgent review should only be requested for a patient with a life-threatening condition or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. A provider or facility may also request an urgent review to authorize treatment of an acute injury or illness if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health;

(4) the type of request (whether an initial request or an extension, renewal, or amendment of a previous authorization);

(5) the patient's name, date of birth, sex, contact telephone number, and identifying insurance information;

(6) the requesting provider's or facility's name, NPI number, specialty, telephone and fax numbers, contact person's name and telephone number, and the requesting provider's signature and date, if required (if a signature is required, a signature stamp may not be used);

(7) the service provider's or facility's name, NPI number, specialty, and telephone and fax numbers;

(8) the primary care provider's name and telephone and fax numbers, if the patient's plan requires the patient to have a primary care provider and that provider is not the requesting provider;

(9) the planned services or procedures and the associated CPT, CDT, or HCPCS codes, and the planned start and end dates of the services or procedures;

(10) the diagnosis description, ICD version number (if more than one version is allowed by the U.S. Department of Health and Human Services), and ICD code;

(11) identification of the treatment location (inpatient, outpatient, provider office, observation, home, day surgery, or other specified location);

(12) if requesting prior authorization for therapy, information about the duration and frequency of treatment sessions for physical, occupational, or speech therapy, cardiac rehabilitation, mental health, or substance abuse;

(13) if requesting prior authorization for home health care, information about the requested number of home health visits and their duration and frequency, and an indication whether a physician's signed order or a nursing assessment is attached;

(14) if requesting prior authorization for durable medical equipment, an indication of whether a physician's signed order is attached, a description of requested equipment or supplies with associated HCPCS codes, duration, and, if the patient is a Medicaid beneficiary, an indication of whether a Title 19 Certification is attached;

(15) a place for the requester to include a brief narrative of medical necessity or other clinical documentation. A requesting provider or facility may also attach a narrative of medical necessity and supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.); and

(16) a place to list a direct telephone number for the requesting provider or facility the issuer can call to ask for additional or missing information to process the request. Such a call is not a peer-to-peer discussion afforded by a utilization review agent before issuing an adverse determination required by 28 TAC §19.1710.

(b) Acceptance and use of the form.

(1) If a provider or facility submits the form to request prior authorization of a health care service for which the issuer's plan requires prior authorization, the issuer must accept and use the form for that purpose. An issuer may also have on its website another electronic process a provider or facility may use to request prior authorization of a health care service.

(2) This form may not be used by a provider or facility:

(A) to request an appeal;

(B) to confirm eligibility;

(C) to verify coverage;

(D) to ask whether a service requires prior authorization;

(E) to request prior authorization of a prescription drug; or

(F) to request a referral to an out of network physician facility or other health care provider.

(c) Effective date. An issuer must accept a request for prior authorization of health care services made by a provider or facility using the form on or after September 1, 2015.

(d) Availability of the form.

(1) A health benefit plan issuer must make the form available on paper and electronically on its website.

(2) A health benefit plan issuer's agent that manages or administers health care services benefits must make the form available on paper and electronically on its website.

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

Filed with the Office of the Secretary of State on August 11, 2014.

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Sara Waitt
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 463-6327

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 335. INDUSTRIAL SOLID WASTE AND MUNICIPAL HAZARDOUS WASTE

The Texas Commission on Environmental Quality (TCEQ, agency, commission) proposes amendments to §§335.1, 335.29, 335.155, 335.211, 335.261, 335.431, 335.503, and 335.504.

Background and Summary of the Factual Basis for the Proposed Rules

The federal hazardous waste program is authorized under the Resource Conservation and Recovery Act of 1976 (RCRA), §3006. States may obtain authorization from the United States Environmental Protection Agency (EPA) to administer the hazardous waste program. State authorization is a rulemaking process through which EPA delegates the primary responsibility of implementing the RCRA hazardous waste program to individual states in lieu of EPA. This process ensures national consistency and minimum standards while providing flexibility to states in implementing rules. State RCRA programs must always be at least as stringent as the federal requirements.

Since the beginning of the federal hazardous waste program, Texas has continuously participated in the EPA's authorization program. To maintain RCRA authorization, the commission must adopt regulations to meet the minimum standards of federal programs administered by EPA. Because the federal regulations undergo regular revision, the commission adopts new regulations regularly to meet the changing federal regulations.

Texas received authorization of its hazardous waste "base program" under the RCRA on December 26, 1984. Texas received authorization for revisions to its base hazardous waste program on February 17, 1987 (Clusters I and II). Texas submitted further revisions to its hazardous waste program and received final authorization of those revisions on March 15, 1990, July 23, 1990, October 21, 1991, December 4, 1992, June 27, 1994, November 26, 1997, October 18, 1999, September 11, 2000, June 14, 2005 (parts of Clusters III - X), March 5, 2009 (parts of Clusters XI - XV) and May 7, 2012 (parts of Clusters IX and XV - XVIII). In addition, Texas submitted an authorization package to EPA for parts of Clusters XIX, XX, and XXI in March 2013. EPA is currently reviewing this authorization package.

The commission proposes in this rulemaking certain parts of RCRA Rule Clusters XXI, XXII, and XXIII that implement revisions to the federal hazardous waste program which EPA made between June 1, 2011, and July 31, 2013. The commission proposes to adopt optional federal rule changes in these clusters. Although not necessary in order to maintain RCRA authorization, EPA recommends that the optional federal rule changes be incorporated into the state rules. Establishing equivalency with federal regulations will enable Texas to operate all aspects of the federal hazardous waste program in lieu of the EPA. All proposed rule changes are discussed further in the Section by Section Discussion portion of this preamble.

Section by Section Discussion

The commission proposes administrative changes throughout the proposed rulemaking to reflect the agency's current practices and to conform to *Texas Register* and agency guidelines. These changes include updating references to Texas State Agencies, updating cross-references, and correcting typographical, spelling, and grammatical errors.

§335.1, Definitions

The commission proposes renumbering of definitions at §335.1 to add four new definitions.

The commission proposes to amend §335.1(16) to conform to federal regulations promulgated in the January 3, 2014, issue of the *Federal Register* (79 FR 350). Specifically, this amendment would add the definition of "Carbon dioxide stream" so that it is consistent with the EPA definition in 40 Code of Federal Regulations (CFR) §260.10.

The commission proposes to amend §335.1(104) to conform to federal regulations promulgated in the July 31, 2013, issue of the *Federal Register* (78 FR 46448). Specifically, this amendment

would add the definition of "No free liquids" so that it is consistent with the EPA definition in 40 CFR §260.10.

The commission proposes to amend §335.1(141) to conform to federal regulations promulgated in the July 31, 2013, issue of the *Federal Register* (78 FR 46448). Specifically, this amendment would add the definition of "Solvent-contaminated wipe" so that it is consistent with the EPA definition in 40 CFR §260.10.

The commission proposes to amend §335.1(174) to conform to federal regulations promulgated in the July 31, 2013, issue of the *Federal Register* (78 FR 46448). Specifically, this amendment would add the definition of "Wipe" so that it is consistent with the EPA definition in 40 CFR §260.10.

§335.29, Adoption of Appendices by Reference

The commission proposes to amend §335.29(3) to conform to federal regulations previously promulgated in the December 17, 2010, issue of the *Federal Register* (75 FR 78918). This amendment removes saccharin and its salts from the lists of hazardous constituents and commercial chemical products which are hazardous wastes when discarded or intended to be discarded. This exclusion was adopted in a previous rulemaking, but the correct amendment date and federal register page was inadvertently not updated.

§335.155, Additional Reports

The commission proposes to amend §335.155(1) to correct a typographical error. Specifically, this amendment would correct a citation from 40 CFR §264.56(j) to 40 CFR §264.56(i).

§335.211, Applicability

The commission proposes to amend §335.211(b) to conform to federal regulations promulgated in the April 13, 2012, issue of the *Federal Register* (77 FR 22229). Specifically, this amendment would make a conforming change to alert certain recycling facilities that they have existing certification and notification requirements under the Land Disposal Restrictions (LDR) regulations.

§335.261, Universal Waste Rule

The commission proposes to amend §335.261(b)(15) to correct two typographical errors. Specifically, this amendment would correct a reference from 40 CFR §273.8(a)(1) to 40 CFR §273.8(a)(2) and correct a reference from 40 CFR §261.4(b)(1) to 40 CFR §261.5.

§335.431, Purpose, Scope and Applicability

The commission proposes to amend §335.431 to conform to federal regulations promulgated in the June 13, 2011, issue of the *Federal Register* (76 FR 34147). Specifically, this amendment would revise the Land Disposal Restrictions (LDR) treatment standards for hazardous wastes from the production of carbamates and carbamate commercial chemical products, and off-specification or manufacturing chemical intermediates and container residues that become hazardous wastes when they are discarded or intended to be discarded. Currently, under the LDR program, most carbamate wastes must meet numeric concentration limits before they can be land disposed. However, the lack of readily available analytical standards makes it difficult for a generator to measure whether the numeric LDR concentration limits have been met. Therefore, this amendment would provide as an alternative standard the use of the best demonstrated available technologies (BDAT) for treating these wastes. In addition, this amendment would remove carbamate Regulated Constituents from the table of Universal Treatment Standards.

§335.503, Waste Classification and Waste Coding Required

The commission proposes to amend §335.503(b)(8) to correct a typographical error. Specifically, this amendment would correct a citation from §335.10(g) to §335.10(e).

§335.504, Hazardous Waste Determination

The commission proposes to amend §335.504(1) to conform to federal regulations promulgated in the July 31, 2013, issue of the *Federal Register* (78 FR 46448). Specifically, this amendment would revise the definition of "Solid waste" to conditionally exclude solvent-contaminated wipes that are cleaned and reused and revises the definition of "Hazardous waste" to conditionally exclude solvent-contaminated wipes that are disposed. The purpose of this proposed amendment is to provide a consistent regulatory framework that is appropriate to the level of risk posed by solvent-contaminated wipes in a way that maintains protection of human health and the environment, while reducing overall compliance costs for industry, many of which are small businesses.

The commission proposes to amend §335.504(1) to conform to federal regulations promulgated in the January 3, 2014, issue of the *Federal Register* (79 FR 350). Specifically, this amendment would conditionally exclude carbon dioxide (CO_2) streams that are hazardous from the definition of "Hazardous waste", provided the generator captures these hazardous CO_2 streams from emission sources, injects the CO_2 streams into Underground Injection Control (UIC) Class VI wells for purposes of geologic sequestration (GS), and meets certain other conditions. The management of these CO_2 streams, when meeting certain conditions, does not present a substantial risk to human health or the environment, and therefore additional regulation pursuant to hazardous waste regulations is unnecessary. This amendment will substantially reduce the uncertainty associated with identifying these CO_2 streams under Subtitle C of RCRA and will also facilitate the deployment of GS by providing additional regulatory certainty.

The commission proposes to amend §335.504(3) to conform to federal regulations promulgated in the April 13, 2012, issue of the *Federal Register* (77 FR 22229). Specifically, this amendment would correct a typographical error in the entry "K107" in the table listing hazardous wastes from specific sources at 40 CFR §261.32.

Fiscal Note: Costs to State and Local Government

Nina Chamness, Analyst in the Chief Financial Officer Division, has determined that, for the first five-year period the proposed rules are in effect, no significant fiscal implications are anticipated for the agency as a result of administration or enforcement of the proposed rules. The proposed rules impact certain types of businesses generating and disposing of wastes and would not have fiscal impacts on other units of state or local government.

The proposed rules would incorporate, by reference, specific federal RCRA (the federal hazardous waste program) rule changes regarding the management of carbamate wastes, CO_2 wastes, and wastes from solvent contaminated wipes made by the EPA between June 2011 and July 2013. The proposed rules also incorporate technical corrections and clarifications to existing rule language in Chapter 335 that would have no fiscal impact to regulated parties.

Revision of the Land Disposal Treatment Standards for Carbamate Wastes

The proposed rules would provide an alternative standard that uses the BDAT for treating hazardous wastes from the production of carbamates and carbamate commercial chemical products. The EPA has determined that this alternative standard would have no fiscal impact on regulated entities.

Revisions to Definitions for Solid Waste and Hazardous Waste Regarding Solvent-Contaminated Wipes

The proposed rules revise the definition of solid waste to conditionally exclude solvent contaminated wipes that are cleaned and reused. The revision of this definition clarifies current agency policy regarding reusable wipes and is not expected to have a significant fiscal impact on businesses. The proposed rules also revise the definition of hazardous waste to conditionally exclude solvent-contaminated wipes that are disposable. This change is less stringent than current state rules.

Exclusion of Hazardous CO_2 Streams

The proposed rules would exclude hazardous CO_2 streams from the definition of hazardous waste provided they are captured from emission sources and injected into UIC Class VI wells for purposes of GS. These amendments are less stringent than current state rules.

Impacts to the Agency and Other Governmental Entities

The TCEQ would not experience significant fiscal impacts under the proposed rules since current agency resources would be used to implement any changes to policy or procedures. The proposed rules would have no fiscal impacts on units of local governments or other state agencies since these governmental entities do not typically generate or treat these types of waste for disposal.

Public Benefits and Costs

Ms. Chamness also determined that for each year of the first five years the proposed rules are in effect, the public benefit anticipated from the changes seen in the proposed rules will be consistency with federal regulations and continued protection of the environment and the public's health and safety. Although the federal regulations may be less stringent than current state rules, they will provide greater flexibility for managing carbamate wastes, CO_2 waste streams, and wastes from solvent contaminated wipes which would encourage proper treatment and disposal. The proposed rules would not have a significant fiscal impact on individuals, and adoption of federal rules would not create a special group of affected persons.

Revisions to Definitions for Solid Waste and Hazardous Waste Regarding Solvent-Contaminated Wipes

The TCEQ estimates that there may be as many as 558 facilities owned by businesses statewide that generate, treat, store, or dispose of solvent contaminated wipes. Of these facilities, 300 are large quantity generators, 228 are small quantity generators, and 30 are handling facilities. There are two types of solvent contaminated wipes: reusable wipes and disposable wipes.

Disposable Wipes

For disposable wipes, the proposed rule is expected to produce a net savings for generators and handling facilities. If a business complies with the proposed rules, disposable wipes could be treated as a solid waste instead of a hazardous waste. The significance of any cost savings would depend on the operating environment and business practice of each facility. Net savings for a large quantity generator using disposable wipes could be as much as $31,000 per year per facility; a small quantity generator could save as much as $4,000 per year per facility; and a handling facility could save as much as $200 per year. The majority of estimated savings would result from the payment of lower solid waste disposal fees as opposed to higher hazardous waste disposal fees. Some savings could also be attributed to the fact that there will be no hazardous waste manifest costs or other record keeping requirements. If a small quantity generator is reclassified as a conditionally exempt small quantity generator, it would also have lower costs due to fewer recordkeeping and reporting requirements.

Reusable Wipes

The proposed rules clarify current waste management practices for reusable wipes. Some requirements, such as container and labeling requirements, are more specific under the proposed rules, but any increased compliance costs are not expected to have a significant impact on generators or handling facilities on an annual basis (less than $378 per facility for a large quantity generator, less than $91 per facility for a small quantity generator, and less than $40 for a handling facility).

CO_2 Waste Streams

The proposed rules regarding CO_2 streams are less stringent than current rules and could lower costs for gas processing facilities when they begin injection into Class VI UIC wells. However, these types of injections are not expected to occur until fiscal year 2030, and no immediate cost savings are projected in this fiscal note for the five gas processing facilities in the Val Verde area of Texas that currently capture CO_2 for operations in the Sharon Ridge oilfield.

Small Business and Micro-Business Assessment

No adverse fiscal implications are anticipated for small or micro-businesses under the proposed rules. The proposed rules would either have no significant fiscal impact on a small business or generate cost savings for those small businesses that opt to comply with the proposed rules. It is not known how many generators or handling facilities are owned or operated by small businesses. A small business is expected to experience the same fiscal impact as a large business under the proposed rules.

Small Business Regulatory Flexibility Analysis

The commission has reviewed this proposed rulemaking and determined that a small business regulatory flexibility analysis is not required because the proposed rules comply with federal regulations and do not adversely affect a small or micro-business in a material way for the first five years that the proposed rules are in effect.

Local Employment Impact Statement

The commission has reviewed this proposed rulemaking and determined that a local employment impact statement is not required because the proposed rules do not adversely affect a local economy in a material way for the first five years that the proposed rules are in effect.

Draft Regulatory Impact Analysis Determination

The commission reviewed the proposed rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to Texas Government Code, §2001.0225 because it does not meet

the definition of a "major environmental rule" as defined in that statute. Although the intent of the rulemaking is to protect the environment and reduce the risk to human health from environmental exposure, the rulemaking is not a major environmental rule because it will not 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 the state or a sector of the state. There is no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions under 42 United States Code (USC), §6926(g), which already imposes the more stringent federal requirements on the regulated community under the Hazardous and Solid Waste Amendments of 1984. Likewise, there would be no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions outside 42 USC, §6926(g), because either the changes are not substantive, or the regulated community would benefit from the greater flexibility and reduced compliance burden. The regulated community must comply with the more stringent federal requirements beginning on the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal rules, equivalent state rules would not cause any adverse effects. There is no adverse effect in a material way on the environment, or the public health and safety of the state or a sector of the state because the rulemaking is designed to protect the environment, the public health, and the public safety of the state and all sectors of the state. Because the proposed rulemaking does not have an adverse material impact on the economy, the rulemaking does not meet the definition of a major environmental rule. Furthermore, the rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). First, the proposed rulemaking does not exceed a standard set by federal law because the commission proposes this rulemaking to implement revisions to the federal hazardous waste program. The commission must meet the minimum standards and mandatory requirements of the federal program to maintain authorization of the state hazardous waste program. The other proposed changes do not alter substantive requirements although various changes may increase flexibility for the regulated community. Second, although the rulemaking proposes some requirements that are more stringent than existing state rules, federal law requires the commission to promulgate rules that are as stringent as federal law for the commission to maintain authorization of the state hazardous waste program. Third, the rulemaking does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government, where the delegation agreement or contract is to implement a state and federal program. On the contrary, the commission must undertake the waste program. And fourth, the rulemaking does not seek to adopt a rule solely under the general powers of the agency instead of under a specific state law. The commission proposes this rulemaking under Texas Water Code, §5.103 and §5.105 and under Texas Health and Safety Code, §361.017 and §361.024.

Written comments on the draft regulatory impact analysis determination may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Takings Impact Assessment

The commission evaluated the rulemaking and performed an assessment of whether Texas Government Code, Chapter 2007 applies. The commission's assessment indicates that Texas Government Code, Chapter 2007 does not apply to the proposed rulemaking because this action is reasonably taken to fulfill an obligation mandated by federal law; therefore, this action is exempt under Texas Government Code, §2007.003(b)(4). The specific purpose of the rulemaking is to maintain state RCRA authorization by adopting state hazardous waste rules that are equivalent to the federal regulations. The rulemaking substantially advances this purpose by adopting rules that incorporate and refer to the federal regulations. Promulgation and enforcement of the rules is not a statutory or constitutional taking of private real property. Specifically, the proposed rulemaking does not affect a landowner's rights in private real property because this rulemaking does not constitutionally burden the owner's right to property, does not restrict or limit the owner's right to property, and does not reduce the value of property by 25% or more beyond that which will otherwise exist in the absence of the regulations. The rulemaking seeks to meet the minimum standards of federal RCRA regulations that are already in place. 42 USC, §6926(g) imposes on the regulated community any federal requirements that are more stringent than current state rules. The regulated community must already have complied with the more stringent federal requirements as of the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal regulations, promulgating equivalent state rules does not burden, restrict, or limit the owner's right to property and does not reduce the value of property by 25% or more. Likewise, the regulated community is not unduly burdened by those revisions providing greater flexibility, reduced recordkeeping, reporting, inspection, and sampling requirements.

Consistency with the Coastal Management Program

The commission reviewed the proposed rulemaking and found that the proposal is subject to the Texas Coastal Management Program (CMP) in accordance with the Coastal Coordination Act, Texas Natural Resources Code, §§33.201 *et seq.,* and therefore must be consistent with all applicable CMP goals and policies. The commission conducted a consistency determination for the proposed rules in accordance with Coastal Coordination Act Implementation Rules, 31 TAC §505.22 and found the proposed rulemaking is consistent with the applicable CMP goals and policies. The CMP goal applicable to the rulemaking is to protect, preserve, restore and enhance the diversity, quality, quantity, functions and values of coastal natural resource areas (CNRAs). Applicable policies are construction and operation of solid waste treatment, storage, and disposal facilities, such that new solid waste facilities and areal expansions of existing solid waste facilities shall be sited, designed, constructed, and operated to prevent releases of pollutants that may adversely affect CNRAs and, at a minimum, comply with standards established under the Solid Waste Disposal Act, 42 USC, §§6901 *et seq.* Promulgation and enforcement of these rules are consistent with the applicable CMP goals and policies because the rulemaking would update and enhance the commission's rules concerning hazardous waste facilities. In addition, the rules would not violate any applicable provisions of the CMP's stated goals and policies.

Written comments on the consistency of this rulemaking may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Announcement of Hearing

The commission will hold a public hearing on this proposal in Austin on September 16, 2014, at 10:00 A.M., in Building E, Room 201S, at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members 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 Sandy Wong, Office of Legal Services, at (512) 239-1802. Requests should be made as far in advance as possible.

Submittal of Comments

Written comments may be submitted to Bruce McAnally, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 or faxed to (512) 239-4808. Electronic comments may be submitted at: *http://www5.tceq.texas.gov/rules/ecomments/*. File size restrictions may apply to comments being submitted via the eComments system. All comments should reference Rule Project Number 2014-019-335-WS. The comment period closes on September 22, 2014. Copies of the proposed rulemaking can be obtained from the commission's Web site at *http://www.tceq.texas.gov/nav/rules/propose_adopt.html*. For further information, please contact Cynthia Palomares, P.G., P.E., Industrial & Hazardous Waste Permits Section, (512) 239-6079.

SUBCHAPTER A. INDUSTRIAL SOLID WASTE AND MUNICIPAL HAZARDOUS WASTE IN GENERAL

30 TAC §335.1, §335.29

Statutory Authority

The amendments are proposed under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The proposed amendments implement THSC, Chapter 361.

§335.1. Definitions.

In addition to the terms defined in Chapter 3 of this title (relating to Definitions), the following words and terms, when used in this chapter, have the following meanings.

(1) Aboveground tank--A device meeting the definition of tank in this section and that is situated in such a way that the entire surface area of the tank is completely above the plane of the adjacent surrounding surface and the entire surface area of the tank (including the tank bottom) is able to be visually inspected.

(2) Act--Texas Health and Safety Code, Chapter 361.

(3) Active life--The period from the initial receipt of hazardous waste at the facility until the executive director receives certification of final closure.

(4) Active portion--That portion of a facility where processing, storage, or disposal operations are being or have been conducted after November 19, 1980, and which is not a closed portion. *(See* also "closed portion" and "inactive portion.")

(5) Activities associated with the exploration, development, and production of oil or gas or geothermal resources--Activities associated with:

(A) the drilling of exploratory wells, oil wells, gas wells, or geothermal resource wells;

(B) the production of oil or gas or geothermal resources, including:

(i) activities associated with the drilling of injection water source wells that penetrate the base of usable quality water;

(ii) activities associated with the drilling of cathodic protection holes associated with the cathodic protection of wells and pipelines subject to the jurisdiction of the commission to regulate the production of oil or gas or geothermal resources;

(iii) activities associated with gasoline plants, natural gas or natural gas liquids processing plants, pressure maintenance plants, or repressurizing plants;

(iv) activities associated with any underground natural gas storage facility, provided the terms "natural gas" and "storage facility" shall have the meanings set out in the Texas Natural Resources Code, §1.173;

(v) activities associated with any underground hydrocarbon storage facility, provided the terms "hydrocarbons" and "underground hydrocarbon storage facility" shall have the meanings set out in the Texas Natural Resources Code, §91.201; and

(vi) activities associated with the storage, handling, reclamation, gathering, transportation, or distribution of oil or gas prior to the refining of such oil or prior to the use of such gas in any manufacturing process or as a residential or industrial fuel;

(C) the operation, abandonment, and proper plugging of wells subject to the jurisdiction of the commission to regulate the exploration, development, and production of oil or gas or geothermal resources; and

(D) the discharge, storage, handling, transportation, reclamation, or disposal of waste or any other substance or material associated with any activity listed in subparagraphs (A) - (C) of this paragraph, except for waste generated in connection with activities associated with gasoline plants, natural gas or natural gas liquids processing plants, pressure maintenance plants, or repressurizing plants if that waste is a hazardous waste as defined by the administrator of the United States Environmental Protection Agency in accordance with the Federal Solid Waste Disposal Act, as amended (42 United States Code, §§6901 *et seq.)*.

(6) Administrator--The administrator of the United States Environmental Protection Agency or his designee.

(7) Ancillary equipment--Any device that is used to distribute, meter, or control the flow of solid waste or hazardous waste from its point of generation to a storage or processing tank(s), between solid waste or hazardous waste storage and processing tanks to a point of disposal on site, or to a point of shipment for disposal off site. Such

devices include, but are not limited to, piping, fittings, flanges, valves, and pumps.

(8) Aquifer--A geologic formation, group of formations, or part of a formation capable of yielding a significant amount of groundwater to wells or springs.

(9) Area of concern--Any area of a facility under the control or ownership of an owner or operator where a release to the environment of hazardous wastes or hazardous constituents has occurred, is suspected to have occurred, or may occur, regardless of the frequency or duration.

(10) Authorized representative--The person responsible for the overall operation of a facility or an operation unit (i.e., part of a facility), e.g., the plant manager, superintendent, or person of equivalent responsibility.

(11) Battery--As defined in §335.261 of this title (relating to Universal Waste Rule).

(12) Boiler--An enclosed device using controlled flame combustion and having the following characteristics:

(A) the unit must have physical provisions for recovering and exporting thermal energy in the form of steam, heated fluids, or heated gases;

(B) the unit's combustion chamber and primary energy recovery section(s) must be of integral design. To be of integral design, the combustion chamber and the primary energy recovery section(s) (such as waterwalls and superheaters) must be physically formed into one manufactured or assembled unit. A unit in which the combustion chamber and the primary energy recovery section(s) are joined only by ducts or connections carrying flue gas is not integrally designed; however, secondary energy recovery equipment (such as economizers or air preheaters) need not be physically formed into the same unit as the combustion chamber and the primary energy recovery section. The following units are not precluded from being boilers solely because they are not of integral design:

(i) process heaters (units that transfer energy directly to a process stream); and

(ii) fluidized bed combustion units;

(C) while in operation, the unit must maintain a thermal energy recovery efficiency of at least 60%, calculated in terms of the recovered energy compared with the thermal value of the fuel; and

(D) the unit must export and utilize at least 75% of the recovered energy, calculated on an annual basis. In this calculation, no credit shall be given for recovered heat used internally in the same unit. (Examples of internal use are the preheating of fuel or combustion air, and the driving of induced or forced draft fans or feedwater pumps); or

(E) the unit is one which the executive director has determined, on a case-by-case basis, to be a boiler, after considering the standards in §335.20 of this title (relating to Variance To Be Classified as a Boiler).

(13) Captive facility--A facility that accepts wastes from only related (within the same corporation) off-site generators.

(14) Captured facility--A manufacturing or production facility that generates an industrial solid waste or hazardous waste that is routinely stored, processed, or disposed of on a shared basis in an integrated waste management unit owned, operated by, and located within a contiguous manufacturing complex.

(15) Captured receiver--A receiver that is located within the property boundaries of the generators from which it receives waste.

(16) Carbon dioxide stream--Carbon dioxide that has been captured from an emission source (e.g., power plant), plus incidental associated substances derived from the source materials and the capture process, and any substances added to the stream to enable or improve the injection process.

(17) [~~(16)~~] Carbon regeneration unit--Any enclosed thermal treatment device used to regenerate spent activated carbon.

(18) [~~(17)~~] Cathode ray tube or CRT--A vacuum tube, composed primarily of glass, which is the visual or video display component of an electronic device. A used, intact CRT means a CRT whose vacuum has not been released. A used, broken CRT means its glass has been removed from its housing, or casing whose vacuum has been released.

(19) [~~(18)~~] Certification--A statement of professional opinion based upon knowledge and belief.

(20) [~~(19)~~] Class 1 wastes--Any industrial solid waste or mixture of industrial solid wastes which because of its concentration, or physical or chemical characteristics, is toxic, corrosive, flammable, a strong sensitizer or irritant, a generator of sudden pressure by decomposition, heat, or other means, or may pose a substantial present or potential danger to human health or the environment when improperly processed, stored, transported, or disposed of or otherwise managed, as further defined in §335.505 of this title (relating to Class 1 Waste Determination).

(21) [~~(20)~~] Class 2 wastes--Any individual solid waste or combination of industrial solid waste which cannot be described as hazardous, Class 1, or Class 3 as defined in §335.506 of this title (relating to Class 2 Waste Determination).

(22) [~~(21)~~] Class 3 wastes--Inert and essentially insoluble industrial solid waste, usually including, but not limited to, materials such as rock, brick, glass, dirt, and certain plastics and rubber, etc., that are not readily decomposable, as further defined in §335.507 of this title (relating to Class 3 Waste Determination).

(23) [~~(22)~~] Closed portion--That portion of a facility which an owner or operator has closed in accordance with the approved facility closure plan and all applicable closure requirements. *(See* also "active portion" and "inactive portion.")

(24) [~~(23)~~] Closure--The act of permanently taking a waste management unit or facility out of service.

(25) [~~(24)~~] Commercial hazardous waste management facility--Any hazardous waste management facility that accepts hazardous waste or polychlorinated biphenyl compounds for a charge, except a captured facility or a facility that accepts waste only from other facilities owned or effectively controlled by the same person.

(26) [~~(25)~~] Component--Either the tank or ancillary equipment of a tank system.

(27) [~~(26)~~] Confined aquifer--An aquifer bounded above and below by impermeable beds or by beds of distinctly lower permeability than that of the aquifer itself; an aquifer containing confined groundwater.

(28) [~~(27)~~] Consignee--The ultimate treatment, storage, or disposal facility in a receiving country to which the hazardous waste will be sent.

(29) [~~(28)~~] Container--Any portable device in which a material is stored, transported, processed, or disposed of, or otherwise handled.

(30) [~~(29)~~] Containment building--A hazardous waste management unit that is used to store or treat hazardous waste under the provisions of §335.152(a)(19) or §335.112(a)(21) of this title (relating to Standards).

(31) [~~(30)~~] Contaminant--Includes, but is not limited to, "solid waste," "hazardous waste," and "hazardous waste constituent" as defined in this subchapter; "pollutant" as defined in Texas Water Code (TWC), §26.001, and Texas Health and Safety Code (THSC), §361.401; "hazardous substance" as defined in THSC, §361.003; and other substances that are subject to the Texas Hazardous Substances Spill Prevention and Control Act, TWC, §§26.261 - 26.267.

(32) [~~(31)~~] Contaminated medium/media--A portion or portions of the physical environment to include soil, sediment, surface water, groundwater or air, that contain contaminants at levels that pose a substantial present or future threat to human health and the environment.

(33) [~~(32)~~] Contingency plan--A document setting out an organized, planned, and coordinated course of action to be followed in case of a fire, explosion, or release of hazardous waste or hazardous waste constituents which could threaten human health or the environment.

(34) [~~(33)~~] Control--To apply engineering measures such as capping or reversible treatment methods and/or institutional measures such as deed restrictions to facilities or areas with wastes or contaminated media which result in remedies that are protective of human health and the environment when combined with appropriate maintenance, monitoring, and any necessary further corrective action.

(35) [~~(34)~~] Corrosion expert--A person who, by reason of his knowledge of the physical sciences and the principles of engineering and mathematics, acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks. Such a person must be certified as being qualified by the National Association of Corrosion Engineers or be a registered professional engineer who has certification or licensing that includes education and experience in corrosion control on buried or submerged metal piping systems and metal tanks.

(36) [~~(35)~~] Cathode Ray Tube collector--A person who receives used, intact Cathode Ray Tubes for recycling, repair, resale, or donation.

(37) [~~(36)~~] Cathode Ray Tube glass manufacturer--An operation or part of an operation that uses a furnace to manufacture Cathode Ray Tube glass.

(38) [~~(37)~~] Cathode Ray Tube processing--Conducting all of the following activities:

(A) Receiving broken or intact Cathode Ray Tubes (CRTs);

(B) Intentionally breaking intact CRTs or further breaking or separating broken CRTs; and

(C) Sorting or otherwise managing glass removed from CRT monitors.

(39) [~~(38)~~] Decontaminate--To apply a treatment process(es) to wastes or contaminated media whereby the substantial present or future threat to human health and the environment is eliminated.

(40) [~~(39)~~] Designated facility--A hazardous waste treatment, storage, or disposal facility which: has received a permit (or interim status) in accordance with the requirements of 40 Code of Federal Regulations (CFR) Parts 270 and 124; has received a permit (or interim status) from a state authorized in accordance with 40 CFR Part 271; or is regulated under 40 CFR §261.6(c)(2) or 40 CFR Part 266, Subpart F and has been designated on the manifest by the generator pursuant to 40 CFR §262.20. For hazardous wastes, if a waste is destined to a facility in an authorized state which has not yet obtained authorization to regulate that particular waste as hazardous, then the designated facility must be a facility allowed by the receiving state to accept such waste. For Class 1 wastes, a designated facility is any treatment, storage, or disposal facility authorized to receive the Class 1 waste that has been designated on the manifest by the generator. Designated facility also means a generator site designated on the manifest to receive its waste as a return shipment from a facility that has rejected the waste in accordance with §335.12 of this title (relating to Shipping Requirements Applicable to Owners or Operators of Treatment, Storage, or Disposal Facilities).

(41) [~~(40)~~] Destination facility--Has the definition adopted under §335.261 of this title (relating to Universal Waste Rule).

(42) [~~(41)~~] Dike--An embankment or ridge of either natural or man-made materials used to prevent the movement of liquids, sludges, solids, or other materials.

(43) [~~(42)~~] Dioxins and furans (D/F)--Tetra, penta, hexa, hepta, and octa-chlorinated dibenzo dioxins and furans.

(44) [~~(43)~~] Discharge or hazardous waste discharge--The accidental or intentional spilling, leaking, pumping, pouring, emitting, emptying, or dumping of waste into or on any land or water.

(45) [~~(44)~~] Disposal--The discharge, deposit, injection, dumping, spilling, leaking, or placing of any solid waste or hazardous waste (whether containerized or uncontainerized) into or on any land or water so that such solid waste or hazardous waste or any constituent thereof may enter the environment or be emitted into the air or discharged into any waters, including groundwaters.

(46) [~~(45)~~] Disposal facility--A facility or part of a facility at which solid waste is intentionally placed into or on any land or water, and at which waste will remain after closure. The term "disposal facility" does not include a corrective action management unit into which remediation wastes are placed.

(47) [~~(46)~~] Drip pad--An engineered structure consisting of a curbed, free-draining base, constructed of non-earthen materials and designed to convey preservative kick-back or drippage from treated wood, precipitation, and surface water run-on to an associated collection system at wood preserving plants.

(48) [~~(47)~~] Elementary neutralization unit--A device which:

(A) is used for neutralizing wastes which are hazardous only because they exhibit the corrosivity characteristic defined in 40 Code of Federal Regulations (CFR) §261.22, or are listed in 40 CFR Part 261, Subpart D, only for this reason; or is used for neutralizing the pH of non-hazardous industrial solid waste; and

(B) meets the definition of tank, tank system, container, transport vehicle, or vessel as defined in this section.

(49) [~~(48)~~] United States Environmental Protection Agency (EPA) acknowledgment of consent--The cable sent to EPA from the United States Embassy in a receiving country that acknowledges the written consent of the receiving country to accept the hazardous waste and describes the terms and conditions of the receiving country's consent to the shipment.

(50) [~~(49)~~] United States Environmental Protection Agency (EPA) hazardous waste number--The number assigned by the EPA to each hazardous waste listed in 40 Code of Federal Regulations (CFR) Part 261 [~~261~~], Subpart D and to each characteristic identified in 40 CFR Part 261 [~~261~~], Subpart C.

(51) [~~(50)~~] United States Environmental Protection Agency (EPA) identification number--The number assigned by the EPA or the commission to each generator, transporter, and processing, storage, or disposal facility.

(52) [~~(51)~~] Essentially insoluble--Any material, which if representatively sampled and placed in static or dynamic contact with deionized water at ambient temperature for seven days, will not leach any quantity of any constituent of the material into the water in excess of current United States Public Health Service or United States Environmental Protection Agency limits for drinking water as published in the Federal Register.

(53) [~~(52)~~] Equivalent method--Any testing or analytical method approved by the administrator under 40 Code of Federal Regulations §260.20 and §260.21.

(54) [~~(53)~~] Existing portion--That land surface area of an existing waste management unit, included in the original Part A permit application, on which wastes have been placed prior to the issuance of a permit.

(55) [~~(54)~~] Existing tank system or existing component--A tank system or component that is used for the storage or processing of hazardous waste and that is in operation, or for which installation has commenced on or prior to July 14, 1986. Installation will be considered to have commenced if the owner or operator has obtained all federal, state, and local approvals or permits necessary to begin physical construction of the site or installation of the tank system and if either:

(A) a continuous on-site physical construction or installation program has begun; or

(B) the owner or operator has entered into contractual obligations--which cannot be canceled or modified without substantial loss--for physical construction of the site or installation of the tank system to be completed within a reasonable time.

(56) [~~(55)~~] Explosives or munitions emergency--A situation involving the suspected or detected presence of unexploded ordnance, damaged or deteriorated explosives or munitions, an improvised explosive device, other potentially explosive material or device, or other potentially harmful military chemical munitions or device, that creates an actual or potential imminent threat to human health, including safety, or the environment, including property, as determined by an explosives or munitions emergency response specialist. These situations may require immediate and expeditious action by an explosives or munitions emergency response specialist to control, mitigate, or eliminate the threat.

(57) [~~(56)~~] Explosives or munitions emergency response--All immediate response activities by an explosives and munitions emergency response specialist to control, mitigate, or eliminate the actual or potential threat encountered during an explosives or munitions emergency, subject to the following:

(A) an explosives or munitions emergency response includes in-place render-safe procedures, treatment or destruction of the explosives or munitions and/or transporting those items to another location to be rendered safe, treated, or destroyed;

(B) any reasonable delay in the completion of an explosives or munitions emergency response caused by a necessary, unforeseen, or uncontrollable circumstance will not terminate the explosives or munitions emergency; and

(C) explosives and munitions emergency responses can occur on either public or private lands and are not limited to responses at hazardous waste facilities.

(58) [~~(57)~~] Explosives or munitions emergency response specialist--An individual trained in chemical or conventional munitions or explosives handling, transportation, render-safe procedures, or destruction techniques, including United States Department of Defense (DOD) emergency explosive ordnance disposal, technical escort unit, and DOD-certified civilian or contractor personnel; and, other federal, state, or local government, or civilian personnel similarly trained in explosives or munitions emergency responses.

(59) [~~(58)~~] Extrusion--A process using pressure to force ground poultry carcasses through a decreasing-diameter barrel or nozzle, causing the generation of heat sufficient to kill pathogens, and resulting in an extruded product acceptable as a feed ingredient.

(60) [~~(59)~~] Facility--Includes:

(A) all contiguous land, and structures, other appurtenances, and improvements on the land, used for storing, processing, or disposing of municipal hazardous waste or industrial solid waste. A facility may consist of several treatment, storage, or disposal operational units (e.g., one or more landfills, surface impoundments, or combinations of them);

(B) for the purpose of implementing corrective action under §335.167 of this title (relating to Corrective Action for Solid Waste Management Units) or §335.602(a)(5) of this title (relating to Standards), all contiguous property under the control of the owner or operator seeking a permit for the treatment, storage, and/or disposal of hazardous waste. This definition also applies to facilities implementing corrective action under Texas Water Code, §7.031 (Corrective Action Relating to Hazardous Waste).

(61) [~~(60)~~] Final closure--The closure of all hazardous waste management units at the facility in accordance with all applicable closure requirements so that hazardous waste management activities under Subchapter E of this chapter (relating to Interim Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities) and Subchapter F of this chapter (relating to Permitting Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities) are no longer conducted at the facility unless subject to the provisions in §335.69 of this title (relating to Accumulation Time).

(62) [~~(61)~~] Food-chain crops--Tobacco, crops grown for human consumption, and crops grown for feed for animals whose products are consumed by humans.

(63) [~~(62)~~] Freeboard--The vertical distance between the top of a tank or surface impoundment dike, and the surface of the waste contained therein.

(64) [~~(63)~~] Free liquids--Liquids which readily separate from the solid portion of a waste under ambient temperature and pressure.

(65) [~~(64)~~] Gasification--For the purpose of complying with 40 Code of Federal Regulations §261.4(a)(12)(i), gasification is a process, conducted in an enclosed device or system, designed and operated to process petroleum feedstock, including oil-bearing hazardous secondary materials through a series of highly controlled steps utilizing thermal decomposition, limited oxidation, and gas cleaning to yield a synthesis gas composed primarily of hydrogen and carbon monoxide gas.

(66) [~~(65)~~] Generator--Any person, by site, who produces municipal hazardous waste or industrial solid waste; any person who possesses municipal hazardous waste or industrial solid waste to be shipped to any other person; or any person whose act first causes the solid waste to become subject to regulation under this chapter. For the purposes of this regulation, a person who generates or possesses Class 3 wastes only shall not be considered a generator.

(67) [~~(66)~~] Groundwater--Water below the land surface in a zone of saturation.

(68) [~~(67)~~] Hazardous industrial waste--Any industrial solid waste or combination of industrial solid wastes identified or listed as a hazardous waste by the administrator of the United States Environmental Protection Agency in accordance with the Resource Conservation and Recovery Act of 1976, §3001 (42 United States Code, §6921). The administrator has identified the characteristics of hazardous wastes and listed certain wastes as hazardous in 40 Code of Federal Regulations Part 26l. The executive director will maintain in the offices of the commission a current list of hazardous wastes, a current set of characteristics of hazardous waste, and applicable appendices, as promulgated by the administrator.

(69) [~~(68)~~] Hazardous substance--Any substance designated as a hazardous substance under 40 Code of Federal Regulations Part 302.

(70) [~~(69)~~] Hazardous waste--Any solid waste identified or listed as a hazardous waste by the administrator of the United States Environmental Protection Agency in accordance with the federal Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act, 42 United States Code, §§6901 *et seq.*

(71) [~~(70)~~] Hazardous waste constituent--A constituent that caused the administrator to list the hazardous waste in 40 Code of Federal Regulations (CFR) Part 261, Subpart D or a constituent listed in Table 1 of 40 CFR §261.24.

(72) [~~(71)~~] Hazardous waste management facility--All contiguous land, including structures, appurtenances, and other improvements on the land, used for processing, storing, or disposing of hazardous waste. The term includes a publicly- or privately-owned hazardous waste management facility consisting of processing, storage, or disposal operational hazardous waste management units such as one or more landfills, surface impoundments, waste piles, incinerators, boilers, and industrial furnaces, including cement kilns, injection wells, salt dome waste containment caverns, land treatment facilities, or a combination of units.

(73) [~~(72)~~] Hazardous waste management unit--A landfill, surface impoundment, waste pile, industrial furnace, incinerator, cement kiln, injection well, container, drum, salt dome waste containment cavern, or land treatment unit, or any other structure, vessel, appurtenance, or other improvement on land used to manage hazardous waste.

(74) [~~(73)~~] In operation--Refers to a facility which is processing, storing, or disposing of solid waste or hazardous waste.

(75) [~~(74)~~] Inactive portion--That portion of a facility which is not operated after November 19, 1980. *(See* also "active portion" and "closed portion.")

(76) [~~(75)~~] Incinerator--Any enclosed device that:

(A) uses controlled flame combustion and neither meets the criteria for classification as a boiler, sludge dryer, or carbon regeneration unit, nor is listed as an industrial furnace; or

(B) meets the definition of infrared incinerator or plasma arc incinerator.

(77) [~~(76)~~] Incompatible waste--A hazardous waste which is unsuitable for:

(A) placement in a particular device or facility because it may cause corrosion or decay of containment materials (e.g., container inner liners or tank walls); or

(B) commingling with another waste or material under uncontrolled conditions because the commingling might produce heat or pressure, fire or explosion, violent reaction, toxic dusts, mists, fumes, or gases, or flammable fumes or gases.

(78) [~~(77)~~] Individual generation site--The contiguous site at or on which one or more solid waste or hazardous wastes are generated. An individual generation site, such as a large manufacturing plant, may have one or more sources of solid waste or hazardous waste, but is considered a single or individual generation site if the site or property is contiguous.

(79) [~~(78)~~] Industrial furnace--Includes any of the following enclosed devices that use thermal treatment to accomplish recovery of materials or energy:

(A) cement kilns;

(B) lime kilns;

(C) aggregate kilns;

(D) phosphate kilns;

(E) coke ovens;

(F) blast furnaces;

(G) smelting, melting, and refining furnaces (including pyrometallurgical devices such as cupolas, reverberator furnaces, sintering machines, roasters, and foundry furnaces);

(H) titanium dioxide chloride process oxidation reactors;

(I) methane reforming furnaces;

(J) pulping liquor recovery furnaces;

(K) combustion devices used in the recovery of sulfur values from spent sulfuric acid;

(L) halogen acid furnaces for the production of acid from halogenated hazardous waste generated by chemical production facilities where the furnace is located on the site of a chemical production facility, the acid product has a halogen acid content of at least 3.0%, the acid product is used in a manufacturing process, and, except for hazardous waste burned as fuel, hazardous waste fed to the furnace has a minimum halogen content of 20% as generated; and

(M) other devices the commission may list, after the opportunity for notice and comment is afforded to the public.

(80) [~~(79)~~] Industrial solid waste--Solid waste resulting from or incidental to any process of industry or manufacturing, or mining or agricultural operation, which may include hazardous waste as defined in this section.

(81) [~~(80)~~] Infrared incinerator--Any enclosed device that uses electric powered resistance heaters as a source of radiant heat followed by an afterburner using controlled flame combustion and which is not listed as an industrial furnace.

(82) [~~(81)~~] Inground tank--A device meeting the definition of tank in this section whereby a portion of the tank wall is situated to any degree within the ground, thereby preventing visual inspection of that external surface area of the tank that is in the ground.

(83) [~~(82)~~] Injection well--A well into which fluids are injected. *(See* also "underground injection.")

(84) [~~(83)~~] Inner liner--A continuous layer of material placed inside a tank or container which protects the construction materials of the tank or container from the contained waste or reagents used to treat the waste.

(85) [~~(84)~~] Installation inspector--A person who, by reason of his knowledge of the physical sciences and the principles of engineering, acquired by a professional education and related practical experience, is qualified to supervise the installation of tank systems.

(86) [~~(85)~~] International shipment--The transportation of hazardous waste into or out of the jurisdiction of the United States.

(87) [~~(86)~~] Lamp--Has the definition adopted under §335.261 of this title (relating to Universal Waste Rule).

(88) [~~(87)~~] Land treatment facility--A facility or part of a facility at which solid waste or hazardous waste is applied onto or incorporated into the soil surface and that is not a corrective action management unit; such facilities are disposal facilities if the waste will remain after closure.

(89) [~~(88)~~] Landfill--A disposal facility or part of a facility where solid waste or hazardous waste is placed in or on land and which is not a pile, a land treatment facility, a surface impoundment, an injection well, a salt dome formation, a salt bed formation, an underground mine, a cave, or a corrective action management unit.

(90) [~~(89)~~] Landfill cell--A discrete volume of a solid waste or hazardous waste landfill which uses a liner to provide isolation of wastes from adjacent cells or wastes. Examples of landfill cells are trenches and pits.

(91) [~~(90)~~] Leachate--Any liquid, including any suspended components in the liquid, that has percolated through or drained from solid waste or hazardous waste.

(92) [~~(91)~~] Leak-detection system--A system capable of detecting the failure of either the primary or secondary containment structure or the presence of a release of solid waste or hazardous waste or accumulated liquid in the secondary containment structure. Such a system must employ operational controls (e.g., daily visual inspections for releases into the secondary containment system of aboveground tanks) or consist of an interstitial monitoring device designed to detect continuously and automatically the failure of the primary or secondary containment structure or the presence of a release of solid waste or hazardous waste into the secondary containment structure.

(93) [~~(92)~~] Licensed professional geoscientist--A geoscientist who maintains a current license through the Texas Board of Professional Geoscientists in accordance with its requirements for professional practice.

(94) [~~(93)~~] Liner--A continuous layer of natural or man-made materials, beneath or on the sides of a surface impoundment, landfill, or landfill cell, which restricts the downward or lateral escape of solid waste or hazardous waste, hazardous waste constituents, or leachate.

(95) [~~(94)~~] Management or hazardous waste management--The systematic control of the collection, source separation, storage, transportation, processing, treatment, recovery, and disposal of solid waste or hazardous waste.

(96) [~~(95)~~] Manifest--The waste shipping document, United States Environmental Protection Agency (EPA) Form 8700-22 (including, if necessary, EPA Form 8700-22A), originated and signed by the generator or offeror in accordance with the instructions in §335.10 of this title and the applicable requirements of 40 Code of Federal Regulations [~~CFR~~] Parts 262 - 265.

(97) [~~(96)~~] Manifest tracking number--The alphanumeric identification number (i.e., a unique three-letter suffix preceded by nine numerical digits), which is pre-printed in Item 4 of the manifest by a registered source.

(98) [~~(97)~~] Military munitions--All ammunition products and components produced or used by or for the Department of Defense (DOD) or the United States Armed Services for national defense and security, including military munitions under the control of the DOD, the United States Coast Guard, the United States Department of Energy (DOE), and National Guard personnel. The term "military munitions":

(A) includes confined gaseous, liquid, and solid propellants, explosives, pyrotechnics, chemical and riot control agents, smokes, and incendiaries used by DOD components, including bulk explosives and chemical warfare agents, chemical munitions, rockets, guided and ballistic missiles, bombs, warheads, mortar rounds, artillery ammunition, small arms ammunition, grenades, mines, torpedoes, depth charges, cluster munitions and dispensers, demolition charges, and devices and components thereof; and

(B) includes non-nuclear components of nuclear devices, managed under DOE's nuclear weapons program after all required sanitization operations under the Atomic Energy Act of 1954, as amended, have been completed; but

(C) does not include wholly inert items, improvised explosive devices, and nuclear weapons, nuclear devices, and nuclear components thereof.

(99) [~~(98)~~] Miscellaneous unit--A hazardous waste management unit where hazardous waste is stored, processed, or disposed of and that is not a container, tank, surface impoundment, pile, land treatment unit, landfill, incinerator, boiler, industrial furnace, underground injection well with appropriate technical standards under Chapter 331 of this title (relating to Underground Injection Control), corrective action management unit, containment building, staging pile, or unit eligible for a research, development, and demonstration permit or under Chapter 305, Subchapter K of this title (relating to Research, Development, and Demonstration Permits).

(100) [~~(99)~~] Movement--That solid waste or hazardous waste transported to a facility in an individual vehicle.

(101) [~~(100)~~] Municipal hazardous waste--A municipal solid waste or mixture of municipal solid wastes which has been identified or listed as a hazardous waste by the administrator of the United States Environmental Protection Agency.

(102) [~~(101)~~] Municipal solid waste--Solid waste resulting from or incidental to municipal, community, commercial, institutional, and recreational activities; including garbage, rubbish, ashes, street cleanings, dead animals, abandoned automobiles, and all other solid waste other than industrial waste.

(103) [~~(102)~~] New tank system or new tank component--A tank system or component that will be used for the storage or processing of hazardous waste and for which installation has commenced after July 14, 1986; except, however, for purposes of 40 Code of Federal Regulations (CFR) §264.193(g)(2) (incorporated by reference at §335.152(a)(8) of this title (relating to Standards)) and 40 CFR §265.193(g)(2) (incorporated by reference at §335.112(a)(9) of this title (relating to Standards)), a new tank system is one for which construction commences after July 14, 1986. *(See* also "existing tank system.")

(104) No free liquids--As used in 40 Code of Federal Regulations (CFR) §261.4(a)(26) and (b)(18), means that solvent-contaminated wipes may not contain free liquids as determined by Method 9095B (Paint Filter Liquids Test), included in "Test Methods for Evaluating Solid Waste, Physical/Chemical Methods" (EPA Publication SW-846), which is incorporated by reference, and that there is no free liquid in the container holding the wipes.

(105) [~~(103)~~] Off-site--Property which cannot be characterized as on-site.

(106) [~~(104)~~] Onground tank--A device meeting the definition of tank in this section and that is situated in such a way that the bottom of the tank is on the same level as the adjacent surrounding surface so that the external tank bottom cannot be visually inspected.

(107) [~~(105)~~] On-Site--The same or geographically contiguous property which may be divided by public or private rights-of-way, provided the entrance and exit between the properties is at a cross-roads intersection, and access is by crossing, as opposed to going along, the right-of-way. Noncontiguous properties owned by the same person but connected by a right-of-way which he controls and to which the public does not have access, is also considered on-site property.

(108) [~~(106)~~] Open burning--The combustion of any material without the following characteristics:

(A) control of combustion air to maintain adequate temperature for efficient combustion;

(B) containment of the combustion-reaction in an enclosed device to provide sufficient residence time and mixing for complete combustion; and

(C) control of emission of the gaseous combustion products. *(See* also "incineration" and "thermal treatment.")

(109) [~~(107)~~] Operator--The person responsible for the overall operation of a facility.

(110) [~~(108)~~] Owner--The person who owns a facility or part of a facility.

(111) [~~(109)~~] Partial closure--The closure of a hazardous waste management unit in accordance with the applicable closure requirements of Subchapters E and F of this chapter (relating to Interim Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities; and Permitting Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities) at a facility that contains other active hazardous waste management units. For example, partial closure may include the closure of a tank (including its associated piping and underlying containment systems), landfill cell, surface impoundment, waste pile, or other hazardous waste management unit, while other units of the same facility continue to operate.

(112) [~~(110)~~] PCBs or polychlorinated biphenyl compounds--Compounds subject to 40 Code of Federal Regulations Part 761.

(113) [~~(111)~~] Permit--A written permit issued by the commission which, by its conditions, may authorize the permittee to construct, install, modify, or operate a specified municipal hazardous waste or industrial solid waste treatment, storage, or disposal facility in accordance with specified limitations.

(114) [~~(112)~~] Personnel or facility personnel--All persons who work at, or oversee the operations of, a solid waste or hazardous waste facility, and whose actions or failure to act may result in noncompliance with the requirements of this chapter.

(115) [~~(113)~~] Pesticide--Has the definition adopted under §335.261 of this title (relating to Universal Waste Rule).

(116) [~~(114)~~] Petroleum substance--A crude oil or any refined or unrefined fraction or derivative of crude oil which is a liquid at standard conditions of temperature and pressure.

(A) Except as provided in subparagraph (C) of this paragraph for the purposes of this chapter, a "petroleum substance" shall be limited to a substance in or a combination or mixture of substances within the following list (except for any listed substance regulated as a hazardous waste under the federal Solid Waste Disposal Act, Subtitle C (42 United States Code (USC), §§6921, *et seq.))* and which is liquid at standard conditions of temperature (20 degrees Centigrade) and pressure (1 atmosphere):

(i) basic petroleum substances--i.e., crude oils, crude oil fractions, petroleum feedstocks, and petroleum fractions;

(ii) motor fuels--a petroleum substance which is typically used for the operation of internal combustion engines and/or motors (which includes, but is not limited to, stationary engines and engines used in transportation vehicles and marine vessels);

(iii) aviation gasolines--i.e., Grade 80, Grade 100, and Grade 100-LL;

(iv) aviation jet fuels--i.e., Jet A, Jet A-1, Jet B, JP-4, JP-5, and JP-8;

(v) distillate fuel oils--i.e., Number 1-D, Number 1, Number 2-D, and Number 2;

(vi) residual fuel oils--i.e., Number 4-D, Number 4-light, Number 4, Number 5-light, Number 5-heavy, and Number 6;

(vii) gas-turbine fuel oils--i.e., Grade O-GT, Grade 1-GT, Grade 2-GT, Grade 3-GT, and Grade 4-GT;

(viii) illuminating oils--i.e., kerosene, mineral seal oil, long-time burning oils, 300 oil, and mineral colza oil;

(ix) lubricants--i.e., automotive and industrial lubricants;

(x) building materials--i.e., liquid asphalt and dust-laying oils;

(xi) insulating and waterproofing materials--i.e., transformer oils and cable oils; and

(xii) used oils--See definition for "used oil" in this section.

(B) For the purposes of this chapter, a "petroleum substance" shall include solvents or a combination or mixture of solvents (except for any listed substance regulated as a hazardous waste under the federal Solid Waste Disposal Act, Subtitle C (42 USC, §§6921, *et seq.))* and which is liquid at standard conditions of temperature (20 degrees Centigrade) and pressure (1 atmosphere) i.e., Stoddard solvent, petroleum spirits, mineral spirits, petroleum ether, varnish makers' and painters' naphthas, petroleum extender oils, and commercial hexane.

(C) The following materials are not considered petroleum substances:

(i) polymerized materials, i.e., plastics, synthetic rubber, polystyrene, high and low density polyethylene;

(ii) animal, microbial, and vegetable fats;

(iii) food grade oils;

(iv) hardened asphalt and solid asphaltic materials--i.e., roofing shingles, roofing felt, hot mix (and cold mix); and

(v) cosmetics.

(117) [~~(115)~~] Pile--Any noncontainerized accumulation of solid, nonflowing solid waste or hazardous waste that is used for processing or storage, and that is not a corrective action management unit or a containment building.

(118) [~~(116)~~] Plasma arc incinerator--Any enclosed device using a high intensity electrical discharge or arc as a source of heat followed by an afterburner using controlled flame combustion and which is not listed as an industrial furnace.

(119) [~~(117)~~] Post-closure order--An order issued by the commission for post-closure care of interim status units, a corrective action management unit unless authorized by permit, or alternative corrective action requirements for contamination commingled from Resource Conservation and Recovery Act and solid waste management units.

(120) [~~(118)~~] Poultry--Chickens or ducks being raised or kept on any premises in the state for profit.

(121) [~~(119)~~] Poultry carcass--The carcass, or part of a carcass, of poultry that died as a result of a cause other than intentional slaughter for use for human consumption.

(122) [~~(120)~~] Poultry facility--A facility that:

(A) is used to raise, grow, feed, or otherwise produce poultry for commercial purposes; or

(B) is a commercial poultry hatchery that is used to produce chicks or ducklings.

(123) [~~(121)~~] Primary exporter--Any person who is required to originate the manifest for a shipment of hazardous waste in accordance with the regulations contained in 40 Code of Federal Regulations Part 262, Subpart B, which are in effect as of November 8, 1986, or equivalent state provision, which specifies a treatment, storage, or disposal facility in a receiving country as the facility to which the hazardous waste will be sent and any intermediary arranging for the export.

(124) [~~(122)~~] Processing--The extraction of materials, transfer, volume reduction, conversion to energy, or other separation and preparation of solid waste for reuse or disposal, including the treatment or neutralization of solid waste or hazardous waste, designed to change the physical, chemical, or biological character or composition of any solid waste or hazardous waste so as to neutralize such waste, or so as to recover energy or material from the waste or so as to render such waste nonhazardous, or less hazardous; safer to transport, store or dispose of; or amenable for recovery, amenable for storage, or reduced in volume. The transfer of solid waste for reuse or disposal as used in this definition does not include the actions of a transporter in conveying or transporting solid waste by truck, ship, pipeline, or other means. Unless the executive director determines that regulation of such activity is necessary to protect human health or the environment, the definition of processing does not include activities relating to those materials exempted by the administrator of the United States Environmental Protection Agency in accordance with the federal Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act, 42 United States Code, §§6901 *et seq.,* as amended.

(125) [~~(123)~~] Publicly-owned treatment works (POTW)--Any device or system used in the treatment (including recycling and reclamation) of municipal sewage or industrial wastes of a liquid nature which is owned by a state or municipality (as defined by the Clean Water Act, §502(4)). The definition includes sewers, pipes, or other conveyances only if they convey wastewater to a POTW providing treatment.

(126) [~~(124)~~] Qualified groundwater scientist--A scientist or engineer who has received a baccalaureate or post-graduate degree in the natural sciences or engineering, and has sufficient training and experience in groundwater hydrology and related fields as may be demonstrated by state registration, professional certifications, or completion of accredited university courses that enable that individual to make sound professional judgments regarding groundwater monitoring and contaminant fate and transport.

(127) [~~(125)~~] Receiving country--A foreign country to which a hazardous waste is sent for the purpose of treatment, storage, or disposal (except short-term storage incidental to transportation).

(128) [~~(126)~~] Regional administrator--The regional administrator for the United States Environmental Protection Agency region in which the facility is located, or his designee.

(129) [~~(127)~~] Remediation--The act of eliminating or reducing the concentration of contaminants in contaminated media.

(130) [~~(128)~~] Remediation waste--All solid and hazardous wastes, and all media (including groundwater, surface water, soils, and sediments) and debris, which contain listed hazardous wastes or which themselves exhibit a hazardous waste characteristic, that are managed for the purpose of implementing corrective action requirements under §335.167 of this title (relating to Corrective Action for Solid Waste Management Units) and Texas Water Code, §7.031 (Corrective Action Relating to Hazardous Waste). For a given facility, remediation wastes may originate only from within the facility boundary, but may include waste managed in implementing corrective action for releases beyond the facility boundary under §335.166(5) of this title (relating to Corrective Action Program) or §335.167(c) of this title.

(131) [~~(129)~~] Remove--To take waste, contaminated design or operating system components, or contaminated media away from a waste management unit, facility, or area to another location for treatment, storage, or disposal.

(132) [~~(130)~~] Replacement unit--A landfill, surface impoundment, or waste pile unit:

(A) from which all or substantially all the waste is removed; and

(B) that is subsequently reused to treat, store, or dispose of hazardous waste. "Replacement unit" does not apply to a unit from which waste is removed during closure, if the subsequent reuse solely involves the disposal of waste from that unit and other closing units or corrective action areas at the facility, in accordance with an approved closure plan or United States Environmental Protection Agency or state approved corrective action.

(133) [~~(131)~~] Representative sample--A sample of a universe or whole (e.g., waste pile, lagoon, groundwater) which can be expected to exhibit the average properties of the universe or whole.

(134) [~~(132)~~] Run-off--Any rainwater, leachate, or other liquid that drains over land from any part of a facility.

(135) [~~(133)~~] Run-on--Any rainwater, leachate, or other liquid that drains over land onto any part of a facility.

(136) [~~(134)~~] Saturated zone or zone of saturation--That part of the earth's crust in which all voids are filled with water.

(137) [~~(135)~~] Shipment--Any action involving the conveyance of municipal hazardous waste or industrial solid waste by any means off-site.

(138) [~~(136)~~] Sludge dryer--Any enclosed thermal treatment device that is used to dehydrate sludge and that has a maximum total thermal input, excluding the heating valve of the sludge itself, of 2,500 British thermal units per pound of sludge treated on a wet-weight basis.

(139) [~~(137)~~] Small quantity generator--A generator who generates less than 1,000 kilograms of hazardous waste in a calendar month.

(140) [~~(138)~~] Solid waste--

(A) Any garbage, refuse, sludge from a waste treatment plant, water supply treatment plant or air pollution control facility, and other discarded material, including solid, liquid, semisolid, or contained gaseous material resulting from industrial, municipal, commercial, mining, and agricultural operations, and from community and institutional activities, but does not include:

(i) solid or dissolved material in domestic sewage, or solid or dissolved material in irrigation return flows, or industrial discharges subject to regulation by permit issued in accordance with Texas Water Code, Chapter 26 (an exclusion applicable only to the actual point source discharge that does not exclude industrial wastewaters while they are being collected, stored, or processed before discharge, nor does it exclude sludges that are generated by industrial wastewater treatment);

(ii) uncontaminated soil, dirt, rock, sand, and other natural or man-made inert solid materials used to fill land if the object of the fill is to make the land suitable for the construction of surface improvements. The material serving as fill may also serve as a surface improvement such as a structure foundation, a road, soil erosion control, and flood protection. Man-made materials exempted under this provision shall only be deposited at sites where the construction is in progress or imminent such that rights to the land are secured and engineering, architectural, or other necessary planning have been initiated. Waste disposal shall be considered to have occurred on any land which has been filled with man-made inert materials under this provision if the land is sold, leased, or otherwise conveyed prior to the completion of construction of the surface improvement. Under such conditions, deed recordation shall be required. The deed recordation shall include the information required under §335.5(a) of this title (relating to Deed Recordation of Waste Disposal), prior to sale or other conveyance of the property;

(iii) waste materials which result from activities associated with the exploration, development, or production of oil or gas or geothermal resources, as those activities are defined in this section, and any other substance or material regulated by the Railroad Commission of Texas in accordance with the Natural Resources Code, §91.101, unless such waste, substance, or material results from activities associated with gasoline plants, natural gas, or natural gas liquids processing plants, pressure maintenance plants, or repressurizing plants and is a hazardous waste as defined by the administrator of the United States Environmental Protection Agency in accordance with the federal Solid Waste Disposal Act, 42 United States Code, §§6901 *et seq.,* as amended; or

(iv) a material excluded by 40 Code of Federal Regulations (CFR) §§261.4(a)(1) - (22), 261.39, and 261.40, as amended through March 18, 2010 (75 FR 12989), subject to the changes in this clause, or by variance granted under §335.18 of this title (relating to Variances from Classification as a Solid Waste) and §335.19 of this title (relating to Standards and Criteria for Variances from Classification as a Solid Waste). For the purposes of the exclusions under 40 CFR §261.39 and §261.40, 40 CFR §261.41 is adopted by reference as amended through July 28, 2006 (71 FR 42928). For the purposes of the exclusion under 40 CFR §261.4(a)(16), 40 CFR §261.38 is adopted by reference as amended through July 10, 2000 (65 FR 42292), and is revised as follows, with "subparagraph (A)(iv) under the definition of 'solid Waste' in 30 TAC §335.1" meaning "subparagraph (A)(iv) under the definition of 'solid Waste' in §335.1 of this title (relating to Definitions)":

(I) in the certification statement under 40 CFR §261.38(c)(1)(i)(C)(4), the reference to "40 CFR §261.38" is changed to "40 CFR §261.38, as revised under subparagraph (A)(iv) under the definition of 'solid Waste' in 30 TAC §335.1," and the reference to "40 CFR §261.28(c)(10)" is changed to "40 CFR §261.38(c)(10)";

(II) in 40 CFR §261.38(c)(2), the references to "§260.10 of this chapter" are changed to "§335.1 of this title (relating to Definitions)," and the reference to "parts 264 or 265 of this chapter" is changed to "Chapter 335, Subchapter E of this title (relating to Interim Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities) or Chapter 335, Subchapter F of this title (relating to Permitting Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities)";

(III) in 40 CFR §261.38(c)(3) - (5), the references to "parts 264 and 265, or §262.34 of this chapter" are changed to "Chapter 335, Subchapter E of this title (relating to Interim Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities) and Chapter 335, Subchapter F of this title (relating to Permitting Standards for Owners and Operators of Hazardous Waste Treatment, Storage, or Disposal Facilities), or §335.69 of this title (relating to Accumulation Time)";

(IV) in 40 CFR §261.38(c)(5), the reference to "§261.6(c) of this chapter" is changed to "§335.24(e) and (f) of this title (relating to Requirements for Recyclable Materials and Nonhazardous Recyclable Materials)";

(V) in 40 CFR §261.38(c)(7), the references to "appropriate regulatory authority" and "regulatory authority" are changed to "executive director";

(VI) in 40 CFR §261.38(c)(8), the reference to "§262.11 of this chapter" is changed to "§335.62 of this title (relating to Hazardous Waste Determination and Waste Classification)";

(VII) in 40 CFR §261.38(c)(9), the reference to "§261.2(c)(4) of this chapter" is changed to §335.1(140)(D)(iv) [~~§335.1(138)(D)(iv)~~]" of this title (relating to Definitions)"; and

(VIII) in 40 CFR §261.38(c)(10), the reference to "implementing authority" is changed to "executive director."

(B) A discarded material is any material which is:

(i) abandoned, as explained in subparagraph (C) of this paragraph;

(ii) recycled, as explained in subparagraph (D) of this paragraph;

(iii) considered inherently waste-like, as explained in subparagraph (E) of this paragraph; or

(iv) a military munition identified as a solid waste in 40 CFR §266.202.

(C) Materials are solid wastes if they are abandoned by being:

(i) disposed of;

(ii) burned or incinerated; or

(iii) accumulated, stored, or processed (but not recycled) before or in lieu of being abandoned by being disposed of, burned, or incinerated.

(D) Except for materials described in subparagraph (H) of this paragraph, materials are solid wastes if they are "recycled" or accumulated, stored, or processed before recycling as specified in this subparagraph. The chart referred to as Table 1 indicates only which materials are considered to be solid wastes when they are recycled and is not intended to supersede the definition of solid waste provided in subparagraph (A) of this paragraph.

(i) Used in a manner constituting disposal. Materials noted with an asterisk in Column 1 of Table 1 are solid wastes when they are:

(I) applied to or placed on the land in a manner that constitutes disposal; or

(II) used to produce products that are applied to or placed on the land or are otherwise contained in products that are applied to or placed on the land (in which cases the product itself remains a solid waste). However, commercial chemical products listed in 40 CFR §261.33 are not solid wastes if they are applied to the land and that is their ordinary manner of use.

(ii) Burning for energy recovery. Materials noted with an asterisk in Column 2 of Table 1 are solid wastes when they are:

(I) burned to recover energy; or

(II) used to produce a fuel or are otherwise contained in fuels (in which cases the fuel itself remains a solid waste). However, commercial chemical products, which are listed in 40 CFR §261.33, not listed in §261.33, but that exhibit one or more of the hazardous waste characteristics, or will be considered nonhazardous waste if disposed, are not solid wastes if they are fuels themselves and burned for energy recovery.

(iii) Reclaimed. Materials noted with an asterisk in Column 3 of Table 1 are solid wastes when reclaimed (except as provided under 40 CFR §261.4(a)(17)). Materials without an asterisk in Column 3 of Table 1 are not solid wastes when reclaimed.

(iv) Accumulated speculatively. Materials noted with an asterisk in Column 4 of Table 1 are solid wastes when accumulated speculatively.

Figure: 30 TAC §335.1(140)(D)(iv)

[~~Figure:~~ ~~30 TAC~~ ~~§335.1(138)(D)(iv)~~]

(E) Materials that are identified by the administrator of the EPA as inherently waste-like materials under 40 CFR §261.2(d) are solid wastes when they are recycled in any manner.

(F) Materials are not solid wastes when they can be shown to be recycled by being:

(i) used or reused as ingredients in an industrial process to make a product, provided the materials are not being reclaimed;

(ii) used or reused as effective substitutes for commercial products;

(iii) returned to the original process from which they were generated, without first being reclaimed or land disposed. The material must be returned as a substitute for feedstock materials. In cases where the original process to which the material is returned is a secondary process, the materials must be managed such that there is no placement on the land. In cases where the materials are generated and reclaimed within the primary mineral processing industry, the conditions of the exclusion found at 40 CFR §261.4(a)(17) apply rather than this provision; or

(iv) secondary materials that are reclaimed and returned to the original process or processes in which they were generated where they are reused in the production process provided:

(I) only tank storage is involved, and the entire process through completion of reclamation is closed by being entirely connected with pipes or other comparable enclosed means of conveyance;

(II) reclamation does not involve controlled flame combustion (such as occurs in boilers, industrial furnaces, or incinerators);

(III) the secondary materials are never accumulated in such tanks for over 12 months without being reclaimed; and

(IV) the reclaimed material is not used to produce a fuel, or used to produce products that are used in a manner constituting disposal.

(G) Except for materials described in subparagraph (H) of this paragraph, the following materials are solid wastes, even if the recycling involves use, reuse, or return to the original process, as described in subparagraph (F) of this paragraph:

(i) materials used in a manner constituting disposal, or used to produce products that are applied to the land;

(ii) materials burned for energy recovery, used to produce a fuel, or contained in fuels;

(iii) materials accumulated speculatively; or

(iv) materials deemed to be inherently waste-like by the administrator of the EPA, as described in 40 CFR §261.2(d)(1) and (2).

(H) With the exception of contaminated soils which are being relocated for use under §350.36 of this title (relating to Relocation of Soils Containing Chemicals of Concern for Reuse Purposes) and other contaminated media, materials that will otherwise be identified as nonhazardous solid wastes if disposed of are not considered solid wastes when recycled by being applied to the land or used as ingredients in products that are applied to the land, provided these materials can be shown to meet all of the following criteria:

(i) a legitimate market exists for the recycling material as well as its products;

(ii) the recycling material is managed and protected from loss as will be raw materials or ingredients or products;

(iii) the quality of the product is not degraded by substitution of raw material/product with the recycling material;

(iv) the use of the recycling material is an ordinary use and it meets or exceeds the specifications of the product it is replacing without treatment or reclamation, or if the recycling material is not replacing a product, the recycling material is a legitimate ingredient in a production process and meets or exceeds raw material specifications without treatment or reclamation;

(v) the recycling material is not burned for energy recovery, used to produce a fuel, or contained in a fuel;

(vi) the recycling material can be used as a product itself or to produce products as it is generated without treatment or reclamation;

(vii) the recycling material must not present an increased risk to human health, the environment, or waters in the state when applied to the land or used in products which are applied to the land and the material, as generated:

(I) is a Class 3 waste under Subchapter R of this chapter (relating to Waste Classification), except for arsenic, cadmium, chromium, lead, mercury, nickel, selenium, and total dissolved solids; and

(II) for the metals listed in subclause (I) of this clause:

(-a-) is a Class 2 or Class 3 waste under Subchapter R of this chapter; and

(-b-) does not exceed a concentration limit under §312.43(b)(3), Table 3 of this title (relating to Metal Limits); and

(viii) with the exception of the requirements under §335.17(a)(8) of this title (relating to Special Definitions for Recyclable Materials and Nonhazardous Recyclable Materials):

(I) at least 75% (by weight or volume) of the annual production of the recycling material must be recycled or transferred to a different site and recycled on an annual basis; and

(II) if the recycling material is placed in protective storage, such as a silo or other protective enclosure, at least 75% (by weight or volume) of the annual production of the recycling material must be recycled or transferred to a different site and recycled on a biennial basis.

(I) Respondents in actions to enforce the industrial solid waste regulations who raise a claim that a certain material is not a solid waste, or is conditionally exempt from regulation, must demonstrate that there is a known market or disposition for the material, and that they meet the terms of the exclusion or exemption. In doing so, they must provide appropriate documentation (such as contracts showing that a second person uses the material as an ingredient in a production process) to demonstrate that the material is not a waste, or is exempt from regulation. In addition, owners or operators of facilities claiming that they actually are recycling materials must show that they have the necessary equipment to do so and that the recycling activity is legitimate and beneficial.

(J) Materials that are reclaimed from solid wastes and that are used beneficially are not solid wastes and hence are not hazardous wastes under 40 CFR §261.3(c) unless the reclaimed material is burned for energy recovery or used in a manner constituting disposal.

(K) Other portions of this chapter that relate to solid wastes that are recycled include §335.6 of this title (relating to Notification Requirements), §§335.17 - 335.19 of this title, §335.24 of this title (relating to Requirements for Recyclable Materials and Nonhazardous Recyclable Materials), and Subchapter H of this chapter (relating to Standards for the Management of Specific Wastes and Specific Types of Facilities).

(141) Solvent-contaminated wipe--A wipe that, after use or after cleaning up a spill, either:

(A) contains one or more of the F001 through F005 solvents listed in 40 Code of Federal Regulations (CFR) §261.31 or the corresponding P- or U-listed solvents found in 40 CFR §261.33;

(B) exhibits a hazardous characteristic found in 40 CFR Part 261, Subpart C, when that characteristic results from a solvent listed in 40 CFR Part 261; and/or

(C) exhibits only the hazardous waste characteristic of ignitability found in 40 CFR §261.21 due to the presence of one or more solvents that are not listed in 40 CFR Part 261. Solvent-contaminated wipes that contain listed hazardous waste other than solvents, or exhibit the characteristic of toxicity, corrosivity, or reactivity due to contaminants other than solvents, are not eligible for the exclusions at 40 CFR §261.4(a)(26) and (b)(18).

(142) [~~(139)~~] Sorbent--A material that is used to soak up free liquids by either adsorption or absorption, or both. Sorb means to either adsorb or absorb, or both.

(143) [~~(140)~~] Spill--The accidental spilling, leaking, pumping, emitting, emptying, or dumping of solid waste or hazardous wastes or materials which, when spilled, become solid waste or hazardous wastes into or on any land or water.

(144) [~~(141)~~] Staging pile--An accumulation of solid, nonflowing remediation waste, as defined in this section, that is not a containment building and that is used only during remedial operations for temporary storage at a facility. Staging piles must be designated by the executive director according to the requirements of 40 Code of Federal Regulations §264.554, as adopted by reference under §335.152(a) of this title (relating to Standards).

(145) [~~(142)~~] Standard permit--A Resource Conservation and Recovery Act (RCRA) permit authorizing management of hazardous waste issued under Chapter 305, Subchapter R of this title (relating to Resource Conservation and Recovery Act Standard Permits for Storage and Treatment Units) and Subchapter U of this chapter (relating to Standards for Owners and Operators of Hazardous Waste Facilities Operating Under a Standard Permit). The standard permit may have two parts, a uniform portion issued in all cases and a supplemental portion issued at the executive director's discretion.

(146) [~~(143)~~] Storage--The holding of solid waste for a temporary period, at the end of which the waste is processed, disposed of, recycled, or stored elsewhere.

(147) [~~(144)~~] Sump--Any pit or reservoir that meets the definition of tank in this section and those troughs/trenches connected to it that serve to collect solid waste or hazardous waste for transport to solid waste or hazardous waste treatment, storage, or disposal facilities; except that as used in the landfill, surface impoundment, and waste pile rules, "sump" means any lined pit or reservoir that serves to collect liquids drained from a leachate collection and removal system or leak detection system for subsequent removal from the system.

(148) [~~(145)~~] Surface impoundment or impoundment--A facility or part of a facility which is a natural topographic depression, man-made excavation, or diked area formed primarily of earthen materials (although it may be lined with man-made materials), which is designed to hold an accumulation of liquid wastes or wastes containing free liquids, and which is not an injection well or a corrective action management unit. Examples of surface impoundments are holding, storage, settling, and aeration pits, ponds, and lagoons.

(149) [~~(146)~~] Tank--A stationary device, designed to contain an accumulation of solid waste which is constructed primarily of non-earthen materials (e.g., wood, concrete, steel, plastic) which provide structural support.

(150) [~~(147)~~] Tank system--A solid waste or hazardous waste storage or processing tank and its associated ancillary equipment and containment system.

(151) [~~(148)~~] TEQ--Toxicity equivalence, the international method of relating the toxicity of various dioxin/furan congeners to the toxicity of 2,3,7,8-tetrachlorodibenzo-p-dioxin.

(152) [~~(149)~~] Thermal processing--The processing of solid waste or hazardous waste in a device which uses elevated temperatures as the primary means to change the chemical, physical, or biological character or composition of the solid waste or hazardous waste. Examples of thermal processing are incineration, molten salt, pyrolysis, calcination, wet air oxidation, and microwave discharge. *(See* also "incinerator" and "open burning.")

(153) [~~(150)~~] Thermostat--Has the definition adopted under §335.261 of this title (relating to Universal Waste Rule).

(154) [~~(151)~~] Totally enclosed treatment facility--A facility for the processing of hazardous waste which is directly connected to an industrial production process and which is constructed and operated in a manner which prevents the release of any hazardous waste or any constituent thereof into the environment during processing. An example is a pipe in which acid waste is neutralized.

(155) [~~(152)~~] Transfer facility--Any transportation-related facility including loading docks, parking areas, storage areas, and other similar areas where shipments of hazardous or industrial solid waste are held during the normal course of transportation.

(156) [~~(153)~~] Transit country--Any foreign country, other than a receiving country, through which a hazardous waste is transported.

(157) [~~(154)~~] Transport vehicle--A motor vehicle or rail car used for the transportation of cargo by any mode. Each cargo-carrying body (trailer, railroad freight car, etc.) is a separate transport vehicle. Vessel includes every description of watercraft, used or capable of being used as a means of transportation on the water.

(158) [~~(155)~~] Transporter--Any person who conveys or transports municipal hazardous waste or industrial solid waste by truck, ship, pipeline, or other means.

(159) [~~(156)~~] Treatability study--A study in which a hazardous or industrial solid waste is subjected to a treatment process to determine:

(A) whether the waste is amenable to the treatment process;

(B) what pretreatment (if any) is required;

(C) the optimal process conditions needed to achieve the desired treatment;

(D) the efficiency of a treatment process for a specific waste or wastes; or

(E) the characteristics and volumes of residuals from a particular treatment process. Also included in this definition for the purpose of 40 Code of Federal Regulations §261.4(e) and (f) (§§335.2, 335.69, and 335.78 of this title (relating to Permit Required; Accumulation Time; and Special Requirements for Hazardous Waste Generated by Conditionally Exempt Small Quantity Generators)) exemptions are liner compatibility, corrosion, and other material compatibility studies and toxicological and health effects studies. A treatability study is not a means to commercially treat or dispose of hazardous or industrial solid waste.

(160) [~~(157)~~] Treatment--To apply a physical, biological, or chemical process(es) to wastes and contaminated media which significantly reduces the toxicity, volume, or mobility of contaminants and which, depending on the process(es) used, achieves varying degrees of long-term effectiveness.

(161) [~~(158)~~] Treatment zone--A soil area of the unsaturated zone of a land treatment unit within which hazardous constituents are degraded, transferred, or immobilized.

(162) [~~(159)~~] Underground injection--The subsurface emplacement of fluids through a bored, drilled, or driven well; or through a dug well, where the depth of the dug well is greater than the largest surface dimension. *(See* also "injection well.")

(163) [~~(160)~~] Underground tank--A device meeting the definition of tank in this section whose entire surface area is totally below the surface of and covered by the ground.

(164) [~~(161)~~] Unfit-for-use tank system--A tank system that has been determined through an integrity assessment or other inspection to be no longer capable of storing or processing solid waste or hazardous waste without posing a threat of release of solid waste or hazardous waste to the environment.

(165) [~~(162)~~] Universal waste--Any of the hazardous wastes defined as universal waste under §335.261(b)(13)(F) of this title (relating to Universal Waste Rule) that are managed under the universal waste requirements of Subchapter H, Division 5 of this chapter (relating to Universal Waste Rule).

(166) [~~(163)~~] Universal waste handler--Has the definition adopted under §335.261 of this title (relating to Universal Waste Rule).

(167) [~~(164)~~] Universal waste transporter--Has the definition adopted under §335.261 of this title (relating to Universal Waste Rule).

(168) [~~(165)~~] Unsaturated zone or zone of aeration--The zone between the land surface and the water table.

(169) [~~(166)~~] Uppermost aquifer--The geologic formation nearest the natural ground surface that is an aquifer, as well as lower aquifers that are hydraulically interconnected within the facility's property boundary.

(170) [~~(167)~~] Used oil--Any oil that has been refined from crude oil, or any synthetic oil, that has been used, and, as a result of such use, is contaminated by physical or chemical impurities. Used oil fuel includes any fuel produced from used oil by processing, blending, or other treatment. Rules applicable to nonhazardous used oil, oil characteristically hazardous from use versus mixing, conditionally exempt small quantity generator hazardous used oil, and household used oil after collection that will be recycled are found in Chapter 324 of this title (relating to Used Oil Standards) and 40 Code of Federal Regulations Part 279 (Standards for Management of Used Oil).

(171) [~~(168)~~] Wastewater treatment unit--A device which:

(A) is part of a wastewater treatment facility subject to regulation under either the Federal Water Pollution Control Act (Clean Water Act), 33 United States Code, §§466 *et seq.,* §402 or §307(b), as amended;

(B) receives and processes or stores an influent wastewater which is a hazardous or industrial solid waste, or generates and accumulates a wastewater treatment sludge which is a hazardous or industrial solid waste, or processes or stores a wastewater treatment sludge which is a hazardous or industrial solid waste; and

(C) meets the definition of tank or tank system as defined in this section.

(172) [~~(169)~~] Water (bulk shipment)--The bulk transportation of municipal hazardous waste or Class 1 industrial solid waste

which is loaded or carried on board a vessel without containers or labels.

(173) [~~(170)~~] Well--Any shaft or pit dug or bored into the earth, generally of a cylindrical form, and often walled with bricks or tubing to prevent the earth from caving in.

(174) Wipe--A woven or non-woven shop towel, rag, pad, or swab made of wood pulp, fabric, cotton, polyester blends, or other material.

(175) [~~(171)~~] Zone of engineering control--An area under the control of the owner/operator that, upon detection of a solid waste or hazardous waste release, can be readily cleaned up prior to the release of solid waste or hazardous waste or hazardous constituents to groundwater or surface water.

§335.29. Adoption of Appendices by Reference.

The following appendices contained in 40 Code of Federal Regulations Part 261 are adopted by reference as amended and adopted through April 1, 1987, and as further amended as indicated in each paragraph:

(1) Appendix I--Representative Sampling Methods (as amended through August 1, 2005 (70 Federal Register (FR) 44150));

(2) Appendix VII--Basis for Listing Hazardous Waste (as amended through February 24, 2005 (70 FR 9138));

(3) Appendix VIII--Hazardous Constituents (as amended through December 17, 2010 (75 FR 78918)) [~~July 14, 2006 (71 FR 40254))~~]; and

(4) Appendix IX--Wastes Excluded Under §260.20 and §260.22 (as amended through July 14, 2006 (71 FR 40254)).

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

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Robert Martinez
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Texas Commission on Environmental Quality
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For further information, please call: (512) 239-2141

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SUBCHAPTER F. PERMITTING STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE TREATMENT, STORAGE, OR DISPOSAL FACILITIES

30 TAC §335.155

Statutory Authority

The amendment is proposed under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The proposed amendment implements THSC, Chapter 361.

§335.155. Additional Reports.

In addition to submitting the waste reports described in §335.15 of this title (relating to Recordkeeping and Reporting Requirements Applicable to Owners or Operators of Treatment, Storage, or Disposal Facilities), the owner or operator must also report to the executive director:

(1) releases, fires, and explosions as specified in 40 Code of Federal Regulations (CFR) §264.56(i) [~~§264.56(j)~~];

(2) facility closure as specified in 40 CFR §264.115;

(3) as otherwise required by 40 CFR Part 264, Subparts F, K - N, X, AA, BB, and CC.

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

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SUBCHAPTER H. STANDARDS FOR THE MANAGEMENT OF SPECIFIC WASTES AND SPECIFIC TYPES OF FACILITIES
DIVISION 1. RECYCLABLE MATERIALS USED IN A MANNER CONSTITUTING DISPOSAL

30 TAC §335.211

Statutory Authority

The amendment is proposed under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The proposed amendment implements THSC, Chapter 361.

§335.211. Applicability.

(a) The regulations of this section and §§335.212 - 335.214 of this title (relating to Standards Applicable to Generators and Transporters of Materials Used in a Manner that Constitutes Disposal; Standards Applicable to Storers of Materials That Are To Be Used In a

Manner that Constitutes Disposal Who Are Not the Ultimate Users; and Standards to Users of Materials That Are Used in a Manner that Constitutes Disposal) [§§335.211 - 335.214 of this title (relating to Recyclable Materials Used in a Manner Constituting Disposal)] apply to recyclable materials that are applied to or placed on the land:

(1) without mixing with any other substance(s);

(2) after mixing or combination with any other substance(s). These materials will be referred to throughout this subpart as materials used in a manner that constitutes disposal.

(b) Products produced for the general public's use that are used in a manner that constitutes disposal and that contain recyclable materials are not presently subject to regulation if the recyclable materials have undergone a chemical reaction in the course of producing the product so as to become inseparable by physical means and if such products meet the applicable treatment standards in 40 Code of Federal Regulations (CFR), Part 268, Subpart D[, of Part 268] (or applicable prohibition levels in 40 CFR §268.32 or Resource Conservation Recovery Act [RCRA], §3004(d), where no treatment standards have been established) for each recyclable material (i.e., hazardous waste) that they contain, and the recycler complies with 40 CFR §268.7(b)(6). Commercial fertilizers that are produced for the general public's use that contain recyclable materials also are not presently subject to regulation provided they meet these same treatment standards or prohibition levels for each recyclable material that they contain. However, zinc-containing fertilizers using hazardous waste K061 that are produced for the general public's use are not presently subject to regulation.

(c) Anti-skid/deicing uses of slags, which are generated from high temperature metals recovery (HTMR) processing of hazardous waste K061, K062, and F006, in a manner constituting disposal are not covered by the exemption in subsection (b) of this section and remain subject to regulation.

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

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DIVISION 5. UNIVERSAL WASTE RULE

30 TAC §335.261

Statutory Authority

The amendment is proposed under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The proposed amendment implements THSC, Chapter 361.

§335.261. Universal Waste Rule.

(a) This section establishes requirements for managing universal wastes as defined in this section, and provides an alternative set of management standards in lieu of regulation, except as provided in this section, under all otherwise applicable chapters under 30 Texas Administrative Code. Except as provided in subsection (b) of this section, 40 Code of Federal Regulations (CFR) Part 273 is adopted by reference as amended and adopted in the Federal Register through July 14, 2006 (71 FR 40254).

(b) 40 CFR Part 273, except 40 CFR §273.1, is adopted subject to the following changes.

(1) The term "regional administrator" is changed to "executive director" or "commission" consistent with the organization of the commission as set out in the Texas Water Code, Chapter 5.

(2) The terms "U.S. Environmental Protection Agency" and "EPA" are changed to "the Texas Commission on Environmental Quality," "the agency," or "the commission" consistent with the organization of the commission as set out in Texas Water Code, Chapter 5. This paragraph does not apply to 40 CFR §273.32(a)(3) or §273.52 or to references to the following: "EPA Acknowledgment of Consent" or "EPA Identification Number."

(3) The term "treatment" is changed to "processing."

(4) The term "universal waste" is changed to "universal waste as defined under §335.261(b)(16)(F) of this title (relating to Universal Waste Rule)."

(5) The term "this part" is changed to "Chapter 335, Subchapter H, Division 5 of this title (relating to Universal Waste Rule)."

(6) In 40 CFR §273.2(a) and (b), references to "40 CFR Part [part] 266, Subpart [subpart] G," are changed to "§335.251 of this title (relating to Applicability and Requirements)."

(7) In 40 CFR §273.2(b)(2), the reference to "part 261 of this chapter" is changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(8) In 40 CFR §273.3(b)(1), the reference to "40 CFR §262.70" is changed to "§335.77 of this title (relating to Farmers)." Also, the phrase "(40 CFR §262.70 addresses pesticides disposed of on the farmer's own farm in a manner consistent with the disposal instructions on the pesticide label, providing the container is triple rinsed in accordance with 40 CFR §261.7(b)(3))" is deleted.

(9) In 40 CFR §273.3(b)(2), the reference to "40 CFR parts 260 through 272" is changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(10) In 40 CFR §273.3(b)(3), the reference to "part 261 of this chapter" is changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(11) In 40 CFR §273.3(d)(1)(i) and (ii), references to "40 CFR §261.2" are changed to "§335.1 of this title (relating to Definitions)."

(12) In 40 CFR §273.4(a), the reference to "§273.9" as it relates to the definition of "mercury-containing equipment" is amended to include the commission definition of "thermostats" as contained in §335.261(b)(16)(E) of this title (relating to Universal Waste Rule) and in 40 CFR §273.4(b)(1), the reference to "part 261 of this chapter" is

changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(13) In 40 CFR §273.5(b)(1), the reference to "part 261 of this chapter" is changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(14) In 40 CFR §273.8(a)(1), the reference to "40 CFR §261.4(b)(1)" is changed to "§335.1 of this title (relating to Definitions)" and the reference to "§273.9" is changed to "§335.261(b)(16)(F) of this title (relating to Universal Waste Rule)."

(15) In 40 CFR §273.8(a)(2) [~~40 CFR §273.8(a)(1)~~], the reference to "40 CFR §261.5" [~~"40 CFR §261.4(b)(1)"~~] is changed to "§335.78 of this title (relating to Special Requirements for Hazardous Waste Generated by Conditionally Exempt Small Quantity Generators)" and to "§335.402(5) of this title (relating to Definitions)" and the reference to "§273.9" is changed to "§335.261(b)(16)(F) of this title (relating to Universal Waste Rule)."

(16) In 40 CFR §273.9, the following definitions are changed to the meanings described in this paragraph.

(A) Destination facility--A facility that treats, disposes, or recycles a particular category of universal waste, except those management activities described in 40 CFR §273.13(a) and (c) and 40 CFR §273.33(a) and (c), as adopted by reference in this section. A facility at which a particular category of universal waste is only accumulated is not a destination facility for purposes of managing that category of universal waste.

(B) Generator--Any person, by site, whose act or process produces hazardous waste identified or listed in 40 CFR Part 261 or whose act first causes a hazardous waste to become subject to regulation.

(C) Large quantity handler of universal waste--A universal waste handler (as defined in this section) who accumulates at any time 5,000 kilograms or more total of universal waste (as defined in this section), calculated collectively. This designation as a large quantity handler of universal waste is retained through the end of the calendar year in which 5,000 kilograms or more total universal waste is accumulated.

(D) Small quantity handler of universal waste--A universal waste handler (as defined in this section) who does not accumulate at any time 5,000 kilograms or more total of universal waste (as defined in this section), calculated collectively.

(E) Thermostat--A temperature control device that contains metallic mercury in an ampule attached to a bimetal sensing element, and mercury-containing ampules that have been removed from these temperature control devices in compliance with the requirements of 40 CFR §273.13(c)(2) or §273.33(c)(2) as adopted by reference in this section.

(F) Universal waste--Any of the following hazardous wastes that are subject to the universal waste requirements of this section:

(i) batteries, as described in 40 CFR §273.2;

(ii) pesticides, as described in 40 CFR §273.3;

(iii) mercury-containing equipment, including thermostats, as described in 40 CFR §273.4;

(iv) paint and paint-related waste, as described in §335.262(b) of this title (relating to Standards for Management of Paint and Paint-Related Waste); and

(v) lamps, as described in 40 CFR §273.5.

(17) In 40 CFR §273.10, the reference to "40 CFR §273.9" is changed to "§335.261(b)(16)(D) of this title (relating to Universal Waste Rule)."

(18) 40 CFR §273.11(b) is changed to read as follows: "Prohibited from diluting or treating universal waste, except when responding to releases as provided in 40 CFR §273.17; managing specific wastes as provided in 40 CFR §273.13; or crushing lamps under the control conditions of §335.261(e) of this title (relating to Universal Waste Rule)."

(19) In 40 CFR §273.13(a)(3)(i), the reference to "40 CFR parts 260 through 272" and the reference to "40 CFR part 262" are changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(20) In 40 CFR §273.13(c)(2)(iii) and (iv), references to "40 CFR §262.34" are changed to "§335.69 of this title (relating to Accumulation Time)."

(21) In 40 CFR §273.13(d)(1), the phrase "adequate to prevent breakage" is changed to "adequate to prevent breakage, except as specified in §335.261(e) of this title (relating to Universal Waste Rule)."

(22) In 40 CFR §273.17(b), the reference to "40 CFR parts 260 through 272" and the reference to "40 CFR part 262" are changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(23) In 40 CFR §273.20(a), the reference to "40 CFR §§262.53, 262.56(a)(1) through (4), (6), and (b) and 262.57" is changed to "§335.13 of this title (relating to Recordkeeping and Reporting Procedures Applicable to Generators Shipping Hazardous Waste or Class 1 Waste and Primary Exporters of Hazardous Waste) and §335.76 of this title (relating to Additional Requirements Applicable to International Shipments)."

(24) In 40 CFR §273.20(b), the reference to "subpart E of part 262 of this chapter" is changed to "§335.13 of this title and §335.76 of this title."

(25) In 40 CFR §273.30, the reference to "§273.9" is changed to "§335.261(b)(16)(C) of this title (relating to Universal Waste Rule)."

(26) 40 CFR §273.31(b) is changed to read as follows: "Prohibited from diluting or treating universal waste, except when responding to releases as provided in 40 CFR §273.37; managing specific wastes as provided in 40 CFR §273.33; or crushing lamps under the control conditions of §335.261(e) of this title (relating to Universal Waste Rule)."

(27) In 40 CFR §273.33(a)(3)(i), the reference to "40 CFR parts 260 through 272" and the reference to "40 CFR part 262" are changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(28) In 40 CFR §273.33(c)(2)(iii) and (iv), the references to "40 CFR §262.34" are changed to "§335.69 of this title (relating to Accumulation Time)."

(29) In 40 CFR §273.33(c)(4)(i), the reference, "40 CFR part 261, subpart C," is changed to "Chapter 335, Subchapter R of this title (relating to Waste Classification)."

(30) In 40 CFR §273.33(c)(3)(ii), the reference, "40 CFR parts 260 through 272," is changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(31) In 40 CFR §273.33(d)(1), the phrase "adequate to prevent breakage" is changed to "adequate to prevent breakage, except as specified in §335.261(e) of this title (relating to Universal Waste Rule)."

(32) In 40 CFR §273.37(b), the reference to "40 CFR parts 260 through 272" and the reference to "40 CFR part 262" are changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(33) In 40 CFR §273.40(a), the reference to "40 CFR §§262.53, 262.56(a)(1) through (4), (6), and (b) and 262.57" is changed to "§335.13 of this title (relating to Recordkeeping and Reporting Procedures Applicable to Generators Shipping Hazardous Waste or Class 1 Waste and Primary Exporters of Hazardous Waste) and §335.76 of this title (relating to Additional Requirements Applicable to International Shipments)."

(34) In 40 CFR §273.40(b), the reference to "subpart E of part 262 of this chapter" is changed to "§335.13 of this title and §335.76 of this title."

(35) In 40 CFR §273.52(a), the reference to "40 CFR part 262" is changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(36) In 40 CFR §273.52(b), the reference to "40 CFR part 262" is changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(37) In 40 CFR §273.54(b), the reference to "40 CFR parts 260 through 272" and the reference to "40 CFR part 262" are changed to "Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste)."

(38) In 40 CFR §273.60(a), the reference to "§273.9" is changed to "§335.261(b)(16)(A) of this title (relating to Universal Waste Rule)" and the reference to "parts 264, 265, 266, 268, 270, and 124 of this chapter" is changed to " 30 Texas Administrative Code (relating to Environmental Quality)."

(39) In 40 CFR §273.60(b), the reference to "40 CFR §261.6(c)(2)" is changed to "§335.24 of this title (relating to Requirements for Recyclable Materials and Nonhazardous Recyclable Materials)."

(40) In 40 CFR §273.80(a), the reference to "40 CFR §260.20 and §260.23" is changed to "§20.15 of this title (relating to Petition for Adoption of Rules) and §335.261(c) of this title (relating to Universal Waste Rule)."

(41) In 40 CFR §273.80(b), the reference to "40 CFR §260.20(b)" is changed to "§20.15 of this title (relating to Petition for Adoption of Rules)."

(42) In 40 CFR §273.81(a), the reference to "40 CFR §260.10" is changed to "§335.1 of this title (relating to Definitions) and the reference to "§273.9" is changed to "§335.261(b)(16)(F) of this title (relating to Universal Waste Rule)."

(c) Any person seeking to add a hazardous waste or a category of hazardous waste to the universal waste rule may file a petition for rulemaking under this section, §20.15 of this title, and 40 CFR Part 273, Subpart G as adopted by reference in this section.

(1) To be successful, the petitioner must demonstrate to the satisfaction of the commission that regulation under the universal waste rule: is appropriate for the waste or category of waste; will improve management practices for the waste or category of waste; and will improve implementation of the hazardous waste program. The petition must include the information required by §20.15 of this title. The petition should also address as many of the factors listed in 40 CFR §273.81 as are appropriate for the waste or category of waste addressed in the petition.

(2) The commission will grant or deny a petition using the factors listed in 40 CFR §273.81. The decision will be based on the commission's determinations that regulation under the universal waste rule is appropriate for the waste or category of waste, will improve management practices for the waste or category of waste, and will improve implementation of the hazardous waste program.

(3) The commission may request additional information needed to evaluate the merits of the petition.

(d) Any waste not qualifying for management under this section must be managed in accordance with applicable state regulations.

(e) Crushing lamps is permissible only in a crushing system for which the following control conditions are met:

(1) an exposure limit of no more than 0.05 milligrams of mercury per cubic meter is demonstrated through sampling and analysis using Occupational Safety and Health Administration (OSHA) Method ID-140 or National Institute for Occupational Safety and Health Method Number 6009, based on an eight-hour time-weighted average of samples taken at the breathing zone height near the crushing system operating at the maximum expected level of activity;

(2) compliance with the notification requirements of §106.262 of this title (relating to Facilities (Emission and Distance Limitations) (Previously SE 118)) is demonstrated;

(3) documentation of the demonstrations under paragraphs (1) and (2) of this subsection is provided in a written report to the executive director; and

(4) the executive director approves the crushing system in writing.

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

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Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
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For further information, please call: (512) 239-2141

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SUBCHAPTER O. LAND DISPOSAL RESTRICTIONS

30 TAC §335.431

Statutory Authority

The amendment is proposed under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and

Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The proposed amendment implements THSC, Chapter 361.

§335.431. Purpose, Scope, and Applicability.

(a) Purpose. The purpose of this subchapter is to identify hazardous wastes that are restricted from land disposal and define those limited circumstances under which an otherwise prohibited waste may continue to be land disposed.

(b) Scope and Applicability.

(1) Except as provided in paragraph (2) of this subsection, the requirements of this subchapter apply to persons who generate or transport hazardous waste and owners and operators of hazardous waste treatment, storage, and disposal facilities.

(2) The requirements of this subchapter do not apply to any entity that is either specifically excluded from coverage by this subchapter or would be excluded from the coverage of 40 Code of Federal Regulations (CFR) Part 268 by 40 CFR Part 261, if those parts applied.

(3) Universal waste handlers and universal waste transporters, as defined in and subject to regulation under Subchapter H, Division 5 of this chapter (relating to Universal Waste Rule) are exempt from 40 CFR §268.7 and §268.50.

(c) Adoption by Reference.

(1) except as provided in paragraph (2) of this subsection, and subject to the changes indicated in subsection (d) of this section, the regulations contained in 40 CFR Part 268, as amended through June 13, 2011 (76 FR 34147) [~~March 18, 2010 (75 FR 12989)~~] are adopted by reference.

(2) The following sections of 40 CFR Part 268 are excluded from the sections adopted in paragraph (1) of this subsection: §§268.1(f), 268.5, 268.6, 268.7(a)(10), 268.13, 268.42(b), and 268.44.

(3) Appendices IV, VI - IX, and XI of 40 CFR Part 268 are adopted by reference as amended through July 14, 2006 (71 FR 40254).

(d) Changes to Adopted Parts. The parts of the CFR that are adopted by reference in subsection (c) of this section are changed as follows:

(1) The words "Administrator" or "Regional Administrator" are changed to "Executive Director;"

(2) The word "treatment" is changed to "processing;"

(3) The words *"Federal Register,"* when they appear in the text of the regulation, are changed to *"Texas Register;"*

(4) In 40 CFR §268.7(a)(6) and (a)(7), the applicable definition of hazardous waste and solid waste is the one that is set out in this chapter rather than the definition of hazardous waste and solid waste that is set out in 40 CFR Part 261.

(5) In 40 CFR §268.50(a)(1), the citation to "§262.34" is changed to "§335.69."

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

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TRD-201403604

Robert Martinez

Director, Environmental Law Division

Texas Commission on Environmental Quality

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For further information, please call: (512) 239-2141

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SUBCHAPTER R. WASTE CLASSIFICATION

30 TAC §335.503, §335.504

Statutory Authority

The amendments are proposed under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The proposed amendments implement THSC, Chapter 361.

§335.503. Waste Classification and Waste Coding Required.

(a) All industrial solid and municipal hazardous waste generated, stored, processed, transported, or disposed of in the state shall be classified according to the provisions of this subchapter.

(1) All solid waste shall be classified at the point of generation of the waste. A generator may not dilute a waste to avoid a Class 1 classification; however, combining waste streams for subsequent legitimate processing, storage, or disposal does not constitute dilution and is acceptable. Wastes shall be classified prior to, and following any type of processing or mixing of the waste.

(2) All industrial solid and municipal hazardous waste shall be classified as either:

(A) hazardous;

(B) Class 1;

(C) Class 2; or

(D) Class 3.

(3) A person who generates a solid waste shall first determine if that waste is hazardous pursuant to §335.504 of this title (relating to Hazardous Waste Determination).

(4) After making the hazardous waste determination as required in paragraph (3) of this subsection, if the waste is determined to be nonhazardous, the generator shall then classify the waste as Class 1, Class 2, or Class 3, pursuant to §§335.505 - 335.507 of this title (relating to Class 1 Waste Determination, Class 2 Waste Determination, and Class 3 Waste Determination) using one or more of the following methods:

(A) use the criteria for waste classification as provided in §§335.505 - 335.507 of this title;

(B) use process knowledge as provided in §335.511 of this title (relating to Use of Process Knowledge);

(C) classify the waste as directed under §335.508 of this title (relating to Classification of Specific Industrial Wastes); or

(D) choose to classify a nonhazardous waste as Class 1 without any analysis to support that classification. However, documentation (analytical data and/or process knowledge) is necessary to classify a waste as Class 2 or Class 3, pursuant to §335.513 of this title (relating to Documentation Required).

(b) All industrial solid waste and municipal hazardous waste generated, stored, processed, transported or disposed of in the state shall be coded with an eight-digit waste code number which shall include a four-digit waste sequence number, a three-digit form code, and a one-character classification (either H, 1, 2, or 3). Form codes are provided in §335.521(c) of this title (relating to Appendix 3). Procedures for assigning waste code numbers and sequence numbers are outlined as follows and available from the agency at the address listed in §335.521(b) of this title (relating to Appendix 2).

(1) A waste code is represented by the following 8-digit character string: sequence number + form code + classification code (H, 1, 2, or 3).

(2) In-state generators will assign a unique four-digit sequence number to each individual waste. These sequence numbers will range from 0001 to 9999. They need not be assigned in sequential order. An in-state registered generator may choose to request the executive director assign a sequence number to a specific waste which is not regularly generated by a facility and is being shipped as a one-time shipment or choose to add that waste to the regular sequence numbers on a notice of registration. Sequence numbers provided by the executive director may be a combination of alpha and numeric characters.

(3) The executive director will provide in-state unregistered generators a four-digit sequence number for each regulated waste it generates, which may be a combination of alpha and numeric characters.

(4) Generators of wastes resulting from a spill may obtain a sequence number for the spill related wastes from the agency's Emergency Response Section.

(5) Out-of-state generators will use the sequence code "OUTS" in the first four digits of the waste code.

(6) CESQGs or industrial Class 1 non-hazardous waste generators that are exempt from manifesting as specified in §335.10 of this title (relating to Shipping and Reporting Procedures Applicable to Generators of Hazardous Waste or Class 1 Waste and Primary Exporters of Hazardous Waste) who voluntarily manifest their hazardous and or Class 1 nonhazardous waste may use "CESQ" as the first four digits of the waste code.

(7) A facility which receives and consolidates like waste from Municipal Conditionally Exempt Small Quantity Generators should use "CESQ" in the first four positions of the waste code for any manifesting and/or reporting associated with that waste.

(8) A facility which receives a waste and consolidates that waste with other like waste, other than its own, (thus not changing the form code of the waste stream or its composition, hazardous, or Texas waste class), or stores a waste without treating, processing (as defined in §335.1 of this title (relating to Definitions)), or changing the form or composition of that waste may ship that waste to a storage, treatment, or disposal facility using the sequence code "TSDF" in the first four positions of the waste code. This does not pertain to wastes which are treated or altered or combined with unlike wastes. This "TSDF" designation is only to be used by facilities that store and/or accumulate a quantity of wastes from more than one site for subsequent shipment to a treatment or disposal facility. Manifest documents must note a final destination designated to receive a consolidated waste. The designated "final destination" receiving facility noted on the manifest must be a permitted facility in order to terminate the manifest, unless the waste is nonhazardous and does not require manifesting in accordance with §335.10(e) [~~§335.10(g)~~] of this title and is going to a facility described in §335.10(e) [~~§335.10(g)~~] of this title. A consolidated waste shipped to a non-permitted facility prior to being shipped to the final destination must proceed with the original manifests (noted with any appropriate changes) to the facility designated on the manifest for final handling.

§335.504. Hazardous Waste Determination.

A person who generates a solid waste must determine if that waste is hazardous using the following method:

(1) Determine if the material is excluded or exempted from being a solid waste or hazardous waste per §335.1 of this title (relating to Definitions) or identified in 40 Code of Federal Regulations (CFR) Part 261, Subpart A, as amended through January 3, 2014 (79 FR 350) [~~March 18, 2010 (75 FR 12989)~~], or identified in 40 CFR Part 261, Subpart E, as amended through July 28, 2006 (71 FR 42928).

(2) If the material is a solid waste, determine if the waste is listed as, or mixed with, or derived from a listed hazardous waste identified in 40 CFR Part 261, Subpart D, as amended through March 18, 2010 (75 FR 12989).

(3) If the material is a solid waste, determine whether the waste exhibits any characteristics of a hazardous waste as identified in 40 CFR Part 261, Subpart C, as amended through April 13, 2012 (77 FR 22229) [~~March 18, 2010 (75 FR 12989)~~].

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

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE JUSTICE DEPARTMENT

CHAPTER 380. RULES FOR STATE-OPERATED PROGRAMS AND FACILITIES

SUBCHAPTER F. SECURITY AND CONTROL

37 TAC §380.9707

The Texas Juvenile Justice Department (TJJD) proposes amendments to §380.9707, relating to Custody and Supervision Rating.

SUMMARY OF CHANGES

Subsection (b) will clarify that the rule does not apply to youth who are released from a facility on a conditional placement, as described in §380.8545 of this title.

Subsection (g) will be amended to allow the facility administrator, rather than the division director, to grant a one-level waiver of a youth's custody and supervision rating under certain circumstances. Additionally, the list of incidents that preclude a youth from receiving a one-level waiver from the facility administrator will now include a major rule violation within the past 90 days and escape from a high restriction facility. Release from the Security Program within the past 90 days will no longer preclude a youth from receiving a one-level waiver.

Subsection (g) will also include a new provision that allows the division director to grant a two-level waiver of any youth's custody and supervision rating.

FISCAL NOTE

Mike Meyer, Chief Financial Officer, has determined that for each year of the first five years the amended section will be in effect, there is no significant fiscal impact to state or local governments as a result of enforcing or administering the section.

PUBLIC BENEFIT AND COSTS

Teresa Stroud, Senior Director of State Programs and Facilities, has determined that for each year of the first five years the amended section is in effect, the public benefit anticipated as a result of administering the section will be the promotion of youth rehabilitation through increased opportunities for supervised engagement with the community. An additional benefit will be increased efficiency of operations by empowering decision-making at the local level by facility administrators.

Mr. Meyer has also determined that there will be no effect on small businesses or micro-businesses. There is no anticipated economic cost to persons who are required to comply with the section as proposed. No private real property rights are affected by adoption of this section.

PUBLIC COMMENT

Comments on the proposal may be submitted within 30 days after publication of this notice to Steve Roman, Policy Coordinator, Texas Juvenile Justice Department, P.O. Box 12757, Austin, Texas 78711 or email to policy.proposals@tjjd.texas.gov.

STATUTORY AUTHORITY

The amendments are proposed under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for the government of the schools, facilities, and programs under TJJD's authority. The section is also proposed under Texas Human Resources Code §244.005, which authorizes TJJD to permit a child liberty under supervision on conditions TJJD believes to be conducive to acceptable behavior and to order the child's confinement under conditions TJJD believes best designed for the child's welfare and the interests of the public.

No other statute, code, or article is affected by this proposal.

§380.9707. Custody and Supervision Rating.

(a) Purpose. The purpose of this rule is to establish the minimum supervision requirements for youth assigned to high restriction facilities who are authorized to leave facility grounds.

(b) Applicability.

(1) This rule applies only to youth placed in TJJD-operated [~~TYC-operated~~] high restriction facilities.

(2) This rule does not apply to youth assignments to a conditional placement. See §380.8545 of this title.

(c) Definitions.

(1) Custody and Supervision Rating (CSR)--a rating which determines whether youth will be permitted to participate in off-campus activities and the level of required staff supervision for such activities.

(2) Staff supervision--refers to supervision provided by a sole-supervision certified TJJD [~~TYC~~] employee. See §380.9951 [~~§105.1~~] of this title for the definition of sole-supervision. The proportion of juvenile correctional officer [~~Juvenile Correctional Officer~~] staff included in the staff supervision team will be appropriate to the type of activity and number of youth participating.

(d) General Provisions.

(1) Each off-campus activity must be approved on a case-by-case basis for each youth.

(2) Youth may be subject to criteria in addition to the CSR in order to qualify for participation in off-campus activities.

(e) Calculation of the Custody and Supervision Rating. A CSR of high, medium, or low is calculated for each youth using several factors, such as [~~including but not limited to~~]:

(1) the severity of the committing offense;

(2) the youth's delinquent history prior to commitment to TJJD [~~TYC~~];

(3) the youth's runaway/escape history;

(4) the youth's recent performance and behaviors; and

(5) the length of time the youth has been in a secure residential placement.

(f) Supervision Ratios.

(1) A youth with a high CSR is not permitted to [~~shall not~~] leave the grounds except for necessary healthcare services or emergencies. Constant supervision is [~~shall be~~] provided at a ratio of at least two staff members for one youth, or at least one staff member for one youth if the youth is in mechanical restraints.

(2) A youth with a medium CSR may leave the grounds for approved activities. Constant supervision is [~~shall be~~] provided at a ratio of at least one staff member for one youth.

(3) A youth with a low CSR may leave the grounds for approved activities with or without direct staff supervision. For group activities, supervision is [~~Supervision shall be~~] provided [~~for group activities~~] at a ratio of at least one staff member for every four youth.

(4) At least two staff members are required for any staff-supervised off-campus activity, even if the supervision ratio would allow for one staff member.

(g) Waivers.

[~~(1) Except as described in paragraph (3) of this subsection, the division director over youth services or his/her designee may grant a waiver of a youth's CSR. The waiver may reduce a youth's CSR by one level only.~~]

(1) [~~(2)~~] A waiver of a youth's CSR must be based on a recommendation by the youth's multi-disciplinary [~~treatment~~] team that participation in the off-campus activity would promote progress in the youth's rehabilitation and/or community reintegration.

(2) [~~(3)~~] The facility administrator may grant a waiver to reduce a youth's CSR by one level. However, the facility administrator may not grant a waiver if the youth: [~~The following youth will not be eligible to receive a waiver to a lower CSR level:~~]

(A) is [~~a youth~~] placed under detainer by another jurisdiction;

(B) is [~~a youth currently~~] serving an extension length of stay;

(C) [~~a youth who~~] has been released from the Redirect program within the last 90 days;

(D) has had a Level II hearing (see §380.9555 of this title) proven true for a major rule violation that occurred [~~a youth who has been released from the Security program~~] within the last 90 days; [~~or~~]

(E) [~~a youth who~~] has had his/her parole revoked; or[~~.~~]

(F) has ever escaped from a high restriction TJJD facility.

(3) The division director over residential services or his/her designee may grant a waiver of any youth's CSR by up to two levels.

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

Filed with the Office of the Secretary of State on August 4, 2014.

TRD-201403530
Chelsea Buchholtz
General Counsel
Texas Juvenile Justice Department
Earliest possible date of adoption: September 21, 2014
For further information, please call: (512) 490-7014

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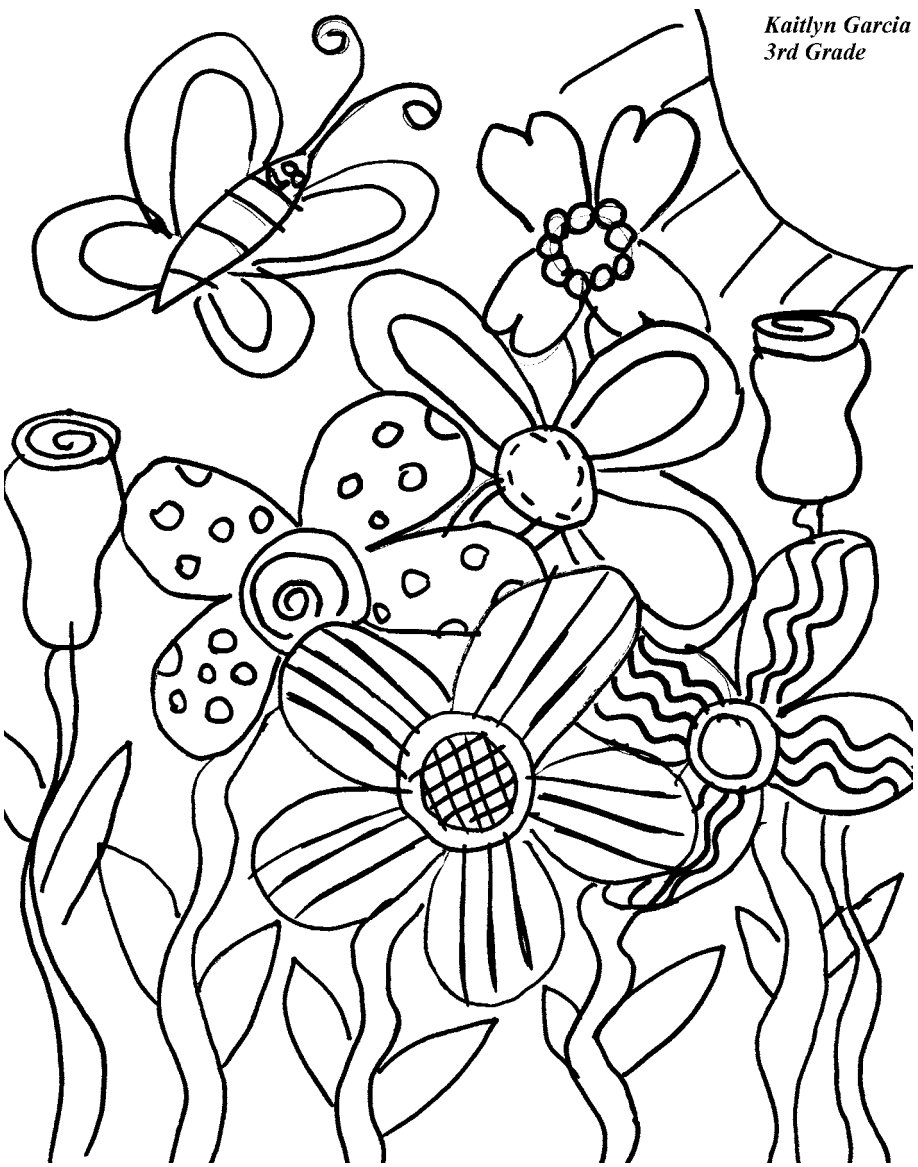

Kaitlyn Garcia
3rd Grade

WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 22. EXAMINING BOARDS

PART 32. STATE BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

CHAPTER 741. SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS
SUBCHAPTER P. JOINT RULES FOR FITTING AND DISPENSING OF HEARING INSTRUMENTS BY TELEPRACTICE

22 TAC §§741.231 - 741.233

The State Board of Examiners for Speech-Language Pathology and Audiology withdraws proposed new §§741.231 - 741.233 which appeared in the June 6, 2014, issue of the *Texas Register* (39 TexReg 4397).

Filed with the Office of the Secretary of State on August 8, 2014.

TRD-201403635
Vickie Dionne, AuD.
Presiding Officer
State Board of Examiners for Speech-Language Pathology and Audiology
Effective date: August 8, 2014
For further information, please call: (512) 776-6972

♦ ♦ ♦

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 354. MEDICAID HEALTH SERVICES

SUBCHAPTER A. PURCHASED HEALTH SERVICES

DIVISION 35. REIMBURSEMENT ADJUSTMENTS FOR POTENTIALLY PREVENTABLE EVENTS

1 TAC §354.1445, §354.1446

The Texas Health and Human Services Commission (HHSC) adopts amendments to §354.1445, concerning Potentially Preventable Readmissions, and §354.1446, concerning Potentially Preventable Complications, without changes to the proposed text as published in the July 4, 2014, issue of the *Texas Register* (39 TexReg 5009) and will not be republished.

Background and Justification

Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, and S.B. 7, 83rd Legislature, Regular Session, 2013, codified at Texas Government Code §536.151 and §536.152, require HHSC to implement a reporting process and reimbursement reductions to hospitals based on performance with respect to potentially preventable readmissions (PPRs) and potentially preventable complications (PPCs) (collectively, "potentially preventable events"). Specifically, Texas Government Code §536.151 requires HHSC to collect data from each hospital on present-on-admission indicators and to provide to each hospital that participates in Medicaid or the children's health plan with a confidential report discussing the hospital's performance with respect to potentially preventable events (PPRs and PPCs). Then, in accordance with Texas Government Code §536.152, HHSC, "to the extent feasible," must use the data discussed in the report to adjust the hospital's reimbursement rate under the children's health plan or Medicaid. Texas Government Code §536.152(b) requires HHSC to provide "the report" to a hospital at least one year before adjusting reimbursements.

As directed by the statutes, HHSC has developed a program for fee-for-service (FFS) Medicaid under which HHSC may penalize a hospital based upon the hospital's rate of PPRs and PPCs.

Title 1, Texas Administrative Code, §354.1445 and §354.1446 set out the methodology HHSC uses to determine a hospital's reimbursement adjustment. In short, HHSC compares a hospital's actual rate of potentially preventable events to the hospital's expected rate, adjusts the hospital's reimbursement based on that comparison, and applies the adjustment to all claims paid by HHSC. A hospital may be penalized up to two percent based on PPR performance and up to two and a half percent based on PPC performance for a total possible rate reduction of four and a half percent.

Currently, HHSC adjusts reimbursements one year after the reports are provided, based on Texas Government Code §536.152(b). HHSC believes Texas Government Code §536.151 and §536.152 to be ambiguous with respect to the required delay, however. Both sections speak of the report in the singular--"a confidential report"; "the report"--but the Legislature clearly intended the data-gathering, reports, and reimbursement adjustments to occur on a regular basis. Indeed, the program would make little sense if the data-gathering, reports, and adjustments were not ongoing, and hospitals would be unable to escape negative adjustments if the process were simply a one-time occurrence. Assuming that the Legislature indeed intended more reports than one, the timing of adjustments following subsequent reports is not clearly set out in statute. HHSC interprets the statute to allow the use of more current report periods to implement reimbursement adjustments following the initial report-and-adjustment cycle. HHSC believes this construction is reasonable. A court will defer to a state agency's construction of a statute that it is charged with enforcing if the interpretation is reasonable and does not contradict the statute's plain language. *See Tarrant Appraisal Dist. v. Moore,* 845 S.W.2d 820, 823 (Tex. 1993).

Accordingly, the rule amendments adopted here allow HHSC to shorten the lag time between the provision of the confidential reports and the consequent reimbursement adjustment. This will permit HHSC to align rates with more current reporting data and will allow a hospital that improves its performance to more quickly reap the rewards.

In addition, the proposed amendments include financial disincentives for any hospital that does not properly code "present on admission" conditions. Such misreporting could unfairly advantage some hospitals.

Finally, the rule refines methodology previously used in PPR and PPC reports to more closely align with software specifications.

Comments

The 30-day comment period ended August 3, 2014. During this period, HHSC received written comments from Parkland Health & Hospital System, Texas Hospital Association, Children's Hospital Association of Texas, and Teaching Hospitals of Texas. None of the commenters were solely in favor of nor opposed to the proposed amendments. A summary of comments relating to the rules and HHSC's responses follows.

General comments

Many comments related to the rules generally.

Comment: Commenters suggested that HHSC should modify the existing PPR and PPC programs by utilizing other, non-claims-based socioeconomic factors in addition to risk adjustment. For example, the commenters suggested, HHSC could reduce reimbursement adjustments for providers that commit resources to addressing socioeconomic factors that can contribute to PPRs and PPCs.

Response: HHSC declines to amend the rule in response to this comment. However, HHSC has met with the hospital associations to discuss and consider this issue, and HHSC will continue to meet with the associations and complete analysis on this issue. If warranted, HHSC may amend the rule in the future to account for socioeconomic factors.

Comment: Commenters recommend that HHSC develop a reward system that provides reimbursement incentives for hospitals that exceed outcome standards established by HHSC or that recognizes and rewards quality improvement process measures hospitals have in place. Similarly, a commenter suggests that the proposed rules be amended to adjust reimbursement upwards for a hospital that exceeds outcome standards established by HHSC.

Response: HHSC declines to amend the rule in response to this comment but is continuing to study the issue. HHSC may amend the rule in the future to provide a rewards system.

Comment: Commenters suggested amending the rules to provide a hospital with an opportunity to review the hospital's hospital-specific data on which the adjustments are based. A commenter requests that HHSC establish a process that will allow each hospital an opportunity to review the hospital's hospital-specific data that HHSC uses to make its PPR, PPC, and POA determinations. Similarly, a commenter suggests the proposed rules be amended to provide a hospital subject to a reimbursement reduction the opportunity to validate the hospital specific data used in the calculation of PPR, PPC, or POA rates.

Response: HHSC declines to amend the rule in response to these comments. A hospital may request underlying data for their hospital.

Comment: Commenters suggested amending the rules to provide a hospital with an opportunity to appeal HHSC's adjustment decisions. Commenters suggested that HHSC amend the rules to provide a process by which a hospital could appeal HHSC's data before HHSC reduces payments to the hospital based on the hospital's review. Another commenter suggested that HHSC create and implement an appeals process inclusive of appeals related to socioeconomic factors.

Response: HHSC declines to amend the rule in response to these comments. Historically, HHSC has not allowed hospitals to appeal these adjustment decisions unless there is an error between the data used for the calculations and the hospitals that received any reimbursement reductions. The entire analytical dataset is used to create a state norm, which is then used to determine each hospital's actual to expected ratios.

Comment: A commenter recommends that HHSC develop additional reports that will help hospitals understand their performance relative to other hospitals in the state.

Response: HHSC declines to amend the rule in response to this comment. HHSC feels that the reporting structure currently in place provides a hospital with the information necessary to identify targeted improvement strategies.

Comment: Commenters recommend that HHSC provide hospital associations a database of the hospital information used in the calculations of POAs, PPRs, and PPCs.

Response: HHSC declines to amend the rule in response to this comment. HHSC may consider providing hospital-specific data to a hospital association, but all member hospitals must confirm and approve the data release because the data would include patient-specific detail.

Comment: A commenter recommends that HHSC delay for one year implementing the POA payment reductions so that HHSC has the opportunity to develop fully its POA reporting infrastructure.

Response: HHSC declines to delay implementation of this provision, as accurate POA data is critical to calculation of PPCs.

Comment: A commenter supports rule changes that shorten the lag between reporting and adjustment periods, but asks that HHSC consider a mechanism for providers to request an interim report with the potential for probationary relief from reimbursement adjustment if performance exceeds existing cutoffs.

Response: HHSC declines to amend the rule in response to this comment. Unfortunately, HHSC cannot provide interim reports due to resource limitations, but HHSC's contractor makes the software available to hospitals for a fee. Once purchased, the software will allow the hospital to generate customized reports and target specific groups.

Comment: A commenter believes that the statutory language requiring HHSC to provide the PPC performance report to a hospital at least one year before adjusting reimbursements might reasonably be interpreted as requiring HHSC to ensure that the PPC performance standards and expectations used in the HHSC-designated software and methodology are made available to a hospital well before the measurement of performance of a given time period.

Response: HHSC declines to amend the rule in response to this comment. Without opining as to whether the interpretation the commenter sets out is reasonable, HHSC believes its interpretation is reasonable. After the initiation of this program, the determination of the reporting schedule for reports relative to reimbursement adjustments is within HHSC's purview.

Comment: A commenter recommends modifying the proposed rules so that HHSC can make exclusions in the calculation of PPC rates to avoid the inappropriate retrospective application of components of the software and methodology.

Response: HHSC declines to amend the rules in response to this comment. HHSC does not believe such exclusions will be necessary.

Comment: A commenter suggests HHSC provide a two year period before implementing penalties related to methodology or data changes.

Response: HHSC declines to delay implementation of this provision. HHSC does not believe Texas Government Code §536.151, §536.152 requires a two year delay.

Comment: A commenter recommends that POA methodology be provided to hospitals and associations.

Response: HHSC declines to amend the rule in response to this comment. However, HHSC is dedicated to provide as much information to hospitals and associations via communication outreach, webinars, and the HHSC Medicaid Quality and Efficiency Improvement webpage.

Comments related to specific rules

Other comments related to specific rules.

Comment: A commenter recommends amending §354.1445(b)(1), defining the term "actual-to-expected ratio," and §354.1445(c) to delete the use of cost of PPR as a factor in weighting PPRs. The commenter states that some hospitals, such as children's hospitals and state-owned hospitals, are paid close to Medicaid allowable cost while other hospitals are paid well below cost. Hospitals with better Medicaid rates could be unfairly disadvantaged because of these legislatively determined differences in hospital payment rates.

Response: HHSC declines to amend the rules in response to this comment. In order to account for different types of readmissions and their relative resource use in the calculation of PPR, HHSC plans to use a "standardized reimbursement rate" for this rather than actual reimbursement rates.

Comment: A commenter recommends amending §354.1445(b)(2) and §354.1446(b)(2), defining the term "adjustment time period," to provide HHSC with discretion to make an adjustment sooner than annually if a hospital improves its performance through short term quality improvement efforts. A commenter makes an identical comment about §354.1446(g)(3).

Response: HHSC declines to amend the rules in response to this comment. HHSC plans to keep to the fiscal year schedule.

Comment: With respect to §354.1445(b)(6) and §54.1446(b)(6), which define the term "claims during the reporting time period," a commenter supports the ability of HHSC to make other PPR exclusions. The commenter suggests, however, that HHSC should make the list of exclusions available to hospitals and published online. The commenter also suggests that HHSC should seek input from Texas clinical experts and the appropriate HHSC advisory committees to help identify appropriate exclusions.

Response: HHSC declines to amend the rules in response to this comment, but HHSC will make available to the public any information regarding exclusions.

Comment: A commenter suggests that the definition of "potentially preventable event" in §354.1445(b)(13) and §354.1446(b)(12) encompasses more than PPRs and PPCs, and it is not clear that it is necessary to the rulemaking on these two subjects.

Response: HHSC declines to amend the rule in response to the comment. This definition is provided to give the reader the context of potentially preventable events.

Comment: A commenter recommends adding language to §354.1445(f) and §354.1446(f), (g), which set adjustment amounts, that would cap the amount of the total annual PPR/PPC/POA penalty at $250,000. In the commenter's view, the goal of the PPR and PPC program is to improve the quality of care. A hospital with Medicaid volume (a safety net provider) could be subject to excessive penalties under the proposed system, reducing the resources available to the hospital for important functions like quality monitoring, control, and improvement, as well as patient care. Further, the commenter readers, because managed care organizations (MCOs) are subject to rewards and penalties for PPR performance, MCOs may choose to direct patients away from certain hospitals, impose their own reimbursement adjustments, or not contract with a hospital. And finally, the commenter states, $250,000 is a substantial penalty that will be more than sufficient to achieve the intended effect in light of the other consequences of having a high PPR rate.

Response: HHSC declines to amend the rule in response to the comment. HHSC feels that the penalty structure is sound. In addition, HHSC believes that having the penalty relative to a hospitals reimbursement volume is appropriate.

Comment: A commenter suggests HHSC make information about the relative weights used in calculating the actual to expected ratio under §354.1446(b)(1) available to appropriate HHSC advisory committees for review.

Response: HHSC agrees with the comment but does not believe that a rule change is necessary to effectuate the suggestion.

Comment: With respect to the deletion of current §354.1446(b)(6)(E), which excludes from the calculation of the actual to expected ratio claims for newborn or pediatric patients up to 18 years of age, a commenter suggests that including pediatric populations in the calculation of PPCs is a major change to the methodology and has substantial implications for children's hospitals and other hospitals serving significant volumes of pediatric patients and newborns. The commenter argues that HHSC should not apply any reimbursement penalty to hospitals for PPC performance for this group in a time period prior to the adoption of this rule. The commenter recommends rule modifications to exclude from the penalty calculation claims for newborn or pediatric clients under 18 years of age for services provided before September 1, 2014. The commenter further supports providing the PPC rates to hospitals for performance related to this population to allow hospitals to undertake any needed quality improvement efforts.

Response: HHSC declines to amend the rule in response to the comment. Texas Government Code §536.151 and §536.152 do not require HHSC to exclude pediatric claims from the calculations. However, HHSC did make the internal decision to use the most recent PPC data (FY13) as a *reporting-only* period for the designated children's hospitals.

Comment: With respect to §354.1446(C), a commenter notes that the. proposed amendments include financial disincentives for any hospital that does not properly code "present on admission" conditions because such misreporting could unfairly advantage that hospital. While the commenter indicates that it understands that HHSC may exclude hospitals from the PPC calculations based on the quality of POA data, the commenter suggests that excluding those hospitals may affect the PPC norms, especially if a large number of hospitals are excluded and those hospitals are "different" than the hospitals included in the calculation. The commenter therefore recommends that HHSC consider some adjustment for this selection bias.

Response: HHSC declines to amend the rule in response to the comment. At this point, HHSC feels that this is necessary to create a more stable statewide norm.

Comment: A commenter suggests reducing the penalties for PPR set out in §354.1446(f) from 1%-2% to 0.5%-1%.

Response: HHSC declines to amend the rule in response to the comment. HHSC feels that these penalties are appropriate to the

scale of the issue and are of a size that is necessary to compel improvements.

Statutory Authority

The amendments are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code Chapter §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 §536.151(a), which requires the Executive Commissioner to adopt rules for identifying potentially preventable events.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403638
Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Effective date: September 1, 2014
Proposal publication date: July 4, 2014
For further information, please call: (512) 424-6900

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CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER A. COST DETERMINATION PROCESS

1 TAC §355.101

The Texas Health and Human Services Commission (HHSC) adopts amendments to §355.101, Introduction, concerning Cost Determination Process, without changes to the proposed text as published in the May 30, 2014, issue of the *Texas Register* (39 TexReg 4073) and will not be republished.

Background and Justification

This rule introduces the cost-determination process for purposes of determining reimbursement rates. HHSC, under its authority and responsibility to administer and implement rates, is amending this rule to add language describing cost-reporting requirements pertaining to providers contracted with Managed Care Organizations (MCOs) for the provision of Long-Term Services and Supports (LTSS) to State of Texas Medicaid clients and update references to health and human services (HHS) agencies.

Chapter 355, Subchapter A of the Texas Administrative Code, relating to Cost Determination Process, describes the process HHSC uses to gather provider cost information and calculate proposed Medicaid and non-Medicaid payment rates. In particular, §355.105 requires a Medicaid provider to periodically submit to HHSC financial and statistical information on HHSC-designated cost-report forms. Currently, Subchapter A applies only to providers contracting directly with a HHSC agency. However, HHSC has been expanding its Medicaid managed care program for a number of years. With the statewide expansion of STAR+PLUS, much of Texas' Medicaid LTSS will be provided under the managed care model. Subchapter A currently does not contemplate collecting cost-report information from providers that provide Medicaid services under contract with MCOs.

As more providers move to contracting solely with one or more MCOs, and not directly with HHSC, the robustness of the databases HHSC builds and analyzes for cost determination and rate development purposes will decline. Nevertheless, HHSC still must analyze costs and develop rates for use in its remaining fee-for-service (FFS) programs, for use by its actuaries in determining actuarially sound MCO per patient per month (PMPM) premiums, and for use by MCOs and providers in their own contract negotiations. This rule amendment, by requiring providers contracted with MCOs to provide LTSS to Texas Medicaid clients to complete cost reports, will preserve the robustness of HHSC's various cost report databases so that HHSC and stakeholders can continue to rely upon them for the purposes described above.

HHSC is also updating references to HHS agencies to add all agencies referred to in Subchapter A, Cost Determination Process; to delete definitions for agencies that no longer exist; to change some language to be internally consistent; and to present references in alphabetical order.

Comments

The 30-day comment period ended June 30, 2014. During this period, HHSC received no comments regarding the proposed amendments to this rule.

Statutory Authority

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resource 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)(2), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 6, 2014.

TRD-201403575
Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Effective date: September 1, 2014
Proposal publication date: May 30, 2014
For further information, please call: (512) 424-6900

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SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8052

The Texas Health and Human Services Commission (HHSC) adopts amendments to §355.8052, concerning Inpatient Hospital Reimbursement. The amendments are adopted without changes to the proposed text as published in the April 25, 2014,

issue of the *Texas Register* (39 TexReg 3320). The text of the rule will not be republished.

Background and Justification

The current version of §355.8052 was published in the *Texas Register* on August 23, 2013, and was effective on September 1, 2013. Following publication of the adopted rule, HHSC discovered a drafting error in the language of the rule describing the methodology HHSC uses to calculate final full-cost standard dollar amounts (SDAs) for children's hospitals for state fiscal year (SFY) 2014 only and for rural hospitals. The drafting error, if implemented, would produce unintended erroneous payments for children's and rural hospitals. Specifically, the published rule states that, in calculating the final SDA for children's hospitals for SFY 2014 and for rural hospitals, HHSC first divides a hospital's base year cost "by the number of claims in the base year." In fact, HHSC divides a hospital's base year cost by the sum of the relative weights of the claims in the base year.

Information regarding the final children's and rural hospital SDA calculation that was shared with the hospital industry during the rulemaking process illustrated the correct methodology. Additionally, the rates that were the subject of the inpatient reimbursement rate hearing conducted by HHSC and that were implemented on September 1, 2013, were based on the correct methodology. The erroneous language of the adopted rule was not intended to effect a change in the methodology, and implementation of the erroneous language would result in unintended overpayments for some hospitals and underpayments for others. To avoid this result, HHSC is correcting the drafting error in this rule amendment.

Additionally, there was a clerical mistake in transmitting the final adopted version of this rule to the *Texas Register.* The phrase "hospital's-specific full cost SDA" which was in the rule as adopted by HHSC, was changed to "specific-specific full cost SDA" during final transmission process. HHSC is also correcting this error.

Finally, HHSC is changing the methodology used to calculate the inpatient rate that is assigned to new rural hospitals for which HHSC has no base year claims data. According to the current rule, such hospitals are assigned an SDA equal to the mean SDA of all rural hospitals for which HHSC has base year claims data. This amendment revises the methodology to assign an SDA calculated by dividing the sum of the base year costs per claim for the rural hospital group by the sum of the relative weights for the rural hospital group of claims. This change will make the methodology for calculating new rural hospital SDAs consistent with the methodology for calculating the SDAs for new urban and children's hospitals. This amendment will change the SDA for two hospitals. There is no fiscal impact associated with this change since the impacted hospitals did not have claim payments in the base year data used to calculate the rates. Neither of the two impacted hospitals has filed any claims or managed-care encounters since the rates were made effective September 1, 2013.

Comments

The 30-day comment period ended May 25, 2014. During this period, HHSC received no comments regarding the proposed amendments to this rule.

Statutory Authority

The amendments are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; 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 amendments affect Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32. No other statutes, articles, or codes are affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

TRD-201403587
Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Effective date: September 1, 2014
Proposal publication date: April 25, 2014
For further information, please call: (512) 424-6900

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SUBCHAPTER J. PURCHASED HEALTH SERVICES

The Texas Health and Human Services Commission (HHSC) adopts the amendments to §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology, §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care, §355.8202, concerning Waiver Payments to Physician Group Practices for Uncompensated Care, and §355.8441, concerning Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services. Section 355.8065 and §355.8201 are adopted with changes to the proposed text as published in the June 27, 2014, issue of the *Texas Register* (39 TexReg 4841). The text of the rules will be republished. Section 355.8202 and §355.8441 are adopted without changes. The text of the rules will not be republished.

Background and Justification

Section 355.8065 describes the eligibility requirements and reimbursement methodology for the disproportionate share hospital (DSH) program and §§355.8201, 355.8202 and 355.8441 describe the eligibility requirements and reimbursement methodology for the uncompensated care (UC) program under the 1115 Texas Healthcare Transformation and Quality Improvement Program (the waiver). HHSC is adopting amendments to these rules to revise the way that the state's DSH and UC allocations are distributed among eligible providers.

The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 86, Transitional Medicaid DSH and Related Payments), allows HHSC to expend up to $160 million in general revenue funds in fiscal year 2014 and $140 million in general revenue funds in fiscal year 2015 to stabilize and improve Medicaid hospital payments, including providing a portion of the non-federal share of Medicaid DSH payments. Expenditure of general revenue funds under Rider 86 is contingent upon HHSC achieving measurable progress towards a plan to stabi-

lize and improve the system for providing hospital payments for Medicaid services and uncompensated care (UC) in fiscal year 2014. No funds may be expended in fiscal year 2015 before such a plan is finalized.

Rider 86 makes the expenditure of the general revenue funds contingent upon measurable progress by HHSC towards a plan that addresses the following:

--The appropriate balance and a proportional allocation of supplemental hospital payments, including DSH and UC payments, among large public, small public, and non-public providers taking into consideration the provision of care to Medicaid and low income patients and the ongoing availability of DSH IGT provided by large public hospitals;

--The Medicaid shortfall that occurs due to state Medicaid rates paid to hospitals and the impact of such rates on hospitals that provide a disproportionate share of Medicaid and uncompensated care;

--Mechanisms through which Medicaid payments are made through managed care organizations;

--Recommended statutory changes and any other legislative direction needed to fully implement the plan;

--An assessment of the extent to which supplemental payments are needed to cover Medicaid and uninsured/uncompensated care costs;

--A plan to transition from supplemental payments to rates that recognize improvements in quality of patient care, the most appropriate use of care, and patient outcomes, and;

--Steps to ensure general revenue funds appropriated to HHSC will no longer be used as the non-federal share of DSH payments by the end of fiscal year 2015.

The Rider also requires that HHSC submit a request to expend the general revenue funds to the Legislative Budget Board (LBB) and the Governor. For fiscal year 2014, the request is required to demonstrate progress toward the plan described above; HHSC can only access the fiscal year 2014 general revenue funds for DSH upon approval of its request to the LBB and the Governor. The rider indicates that the request is considered approved unless the LBB or the Governor issues a written disapproval within 45 calendar days of the date on which the LBB receives the request.

In late 2013, stakeholders requested that HHSC establish and guide a workgroup of hospital chief executive officers to address the requirements of Rider 86. This DSH/UC workgroup met three times and while some areas of tentative agreement were developed among stakeholders during the meetings, no overarching agreement was reached. After the last workgroup meeting, small groups of stakeholders continued meeting independently to develop approaches to the outstanding items that would provide a way forward. While stakeholders worked in good faith with each other, they were unable to reach agreement on outstanding issues and in April 2014, HHSC determined that in order to facilitate a September 2014 DSH payment, it had to begin drafting Texas Administrative Code (TAC) rule amendments immediately.

In developing its proposed rule amendments, HHSC reviewed detailed notes from discussions during the three workgroup meetings as well as communications from various stakeholders and stakeholder groups regarding options under consideration since the last workgroup meeting. HHSC also engaged the services of an external consulting firm to model the impact of the various models under discussion at both the individual hospital and aggregate hospital-type level. Based on this information, HHSC developed several concept models for DSH in combination with changes to UC around which initial steps such as rule drafting could begin. These concept models were shared with stakeholders in early April 2014 for review and comment and two of the concept models formed the basis of the proposed rule item.

Proposed Changes to the DSH Allocation Methodology

Section 355.8065 describes the eligibility requirements and reimbursement methodology for the DSH program. HHSC proposed to amend the rule to revise the way that the state's DSH allocation is distributed among eligible hospitals. HHSC's proposal included the following features.

1. HHSC would determine the total amount of funds that may be distributed to eligible, qualifying DSH hospitals during the DSH program year, based on the federal DSH allotment for Texas and available non-federal funds.

2. State-owned teaching hospitals, state-owned institutions for mental diseases (IMDs) and state chest hospitals could be funded up to 100 percent of their interim hospital-specific limits (HSLs), except that aggregate payments to IMDs statewide could not exceed the federally mandated DSH reimbursement limits for IMD facilities.

3. Remaining available DSH funds, including available general revenue funds and their associated federal matching funds, if any, would be divided into three DSH funding pools as follows:

Pool One. Pool One would be comprised of all non-state-owned DSH hospitals and be funded by the remaining available state general revenue and associated federal matching funds.

Pool Two. Pool Two would be comprised of all non-state-owned DSH hospitals and be funded with the federal matching funds associated with the IGTs that make up the funds for Pool Three.

Pool Three. Pool Three would be comprised of all non-state-owned public DSH hospitals operated by or under a lease contract with a governmental entity that transfers funds for Pool Three. Responsibility for funding Pool Three would be allocated as follows: Urban public hospitals - Class one and Class two would be responsible for funding the non-federal share of their Pass One and Pass Two DSH Payments from Pool Two; Non-urban public DSH hospitals would be responsible for funding one-half of the non-federal share of their Pass One and Pass Two DSH payments from Pool Two; and Urban public hospitals - Class One would be responsible for funding the non-federal share of the Pass One and Pass Two DSH payments from Pool Two for private DSH hospitals.

4. A weight equal to one plus one-half of the non-federal percentage in effect for the program year would be assigned to non-urban public DSH hospitals. This weight is intended to ensure that there is not a significant reduction in net DSH payments in the aggregate for these hospitals as a result of their new IGT requirement.

5. All other weights in the current rule were proposed to be deleted.

6. Pool One and Pool Two Pass One funding distributions would be based on each member hospital's sum of weighted Medicaid inpatient days and weighted low-income days as a percentage of the total sum of weighted Medicaid inpatient days and weighted low-income days for all member hospitals.

7. Pool Three funding distributions were proposed to be determined in a two-step fashion. Under the first step, all public hospitals would be compensated for the burden they assume in funding the non-federal share of their own Pool Two payments while under the second step, Urban public hospitals - Class one would be compensated for the burden they assume in funding the non-federal share of Pool Two payments for private hospitals.

8. Pass Two, which ensures that Pass One payments do not result in any hospital receiving a DSH payment greater than its HSL, was proposed to be conducted separately, first for Pools One and Two combined and then for Pool Three. Otherwise, the method of calculating Pass Two payments remained essentially unchanged from the methodology described under the current rule.

9. Pass Three, which allows rural public and rural public-financed hospitals to self-fund additional DSH payments in the event DSH payments from Passes One and Two do not exhaust the total amount of funds that may be distributed to eligible, qualifying DSH hospitals during the DSH program year, remained essentially unchanged except that under the proposed language rural public and rural public-financed hospitals that do not meet their funding requirements for Pool Three are excluded from participation in Pass Three.

Proposed Changes to the UC Allocation Methodology

Sections 355.8201, 355.8202 and 355.8441 describe the eligibility requirements and reimbursement methodology for the UC program for hospitals, physician group practices and publicly owned dental providers, respectively. HHSC proposed to amend these rule sections to allocate the maximum aggregate amount of funds approved by CMS for UC payments for a waiver program year among different types of UC providers. Current rule language bases UC payments for a program year on the maximum aggregate amount of funds approved by CMS for that year, each provider's annual maximum uncompensated-care amount for the year and the amount of IGT available to each provider for the year. Providers that are able to make IGTs for themselves are at a distinct advantage in maximizing their UC funding as opposed to providers that rely upon unrelated entities to IGT for them. HHSC proposed to establish distinct UC pools for different types of providers. If payments for a UC pool are expected to exceed the aggregate amount of funds allocated to that pool, HHSC would reduce payments to providers in the pool such that total payments to providers in the pool did not exceed the amount of funds allocated to the pool with special protections for hospitals located in a county with 60,000 or fewer persons according to the most recent United States Census, Medicare-designated Rural Referral Centers, Sole Community Hospitals and Critical Access Hospitals (Rider 38 hospitals). HHSC proposed this change as part of its efforts to address the Rider 86 requirement that HHSC develop a plan to address the appropriate balance and a proportional allocation of supplemental hospital payments, including DSH and UC payments, among large public, small public, and non-public providers taking into consideration the provision of care to Medicaid and low income patients and the ongoing availability of DSH IGT provided by large public hospitals.

HHSC proposed to establish seven UC pools (a state-owned hospital pool; a large public hospital pool; a small public hospital pool; a private hospital pool; a physician group practice pool; a governmental ambulance provider pool; and a publicly owned dental provider pool).

1. The state-owned hospital pool would include state-owned teaching hospitals, state-owned IMDs and state chest hospitals. The allocation for this pool would be determined by HHSC at an amount less than or equal to the total annual maximum UC payment amount for these hospitals after accounting for DSH payments made to the same hospitals for the same program year.

2. Set-aside amounts would be determined for Rider 38 small public hospitals and Rider 38 private hospitals. These set-aside amounts would equal the sum of these hospitals' HSLs (prior to any adjustments to reflect increases or decreases in costs resulting from changes between the data year and the program year) after accounting for DSH payments made to the same hospitals for the same program year, reduced by the percentage decline in the maximum aggregate amount of funds approved by CMS from the 2013 demonstration year to the demonstration year in question.

The purpose of these set-asides was to spread the negative impact of guaranteeing a certain level of UC payments to Rider 38 hospitals evenly across all non-state-owned UC hospitals. Rider 38 hospitals were guaranteed a certain level of protection in UC in recognition of the financial vulnerability of these hospitals and the critical role they play in preserving the rural safety net.

3. Remaining available UC funds for the program year would be distributed across the other six UC pools based on the ratio of each pool's need for UC to the total of all the six UC pools' need for UC. UC need for the small public and private hospital pools would be determined exclusive of UC need for Rider 38 hospitals. After calculating all pool sizes, the small public and private pools would be increased by their associated Rider 38 set-aside amounts. HHSC proposed that the various pools' needs for UC be established as follows:

Large public hospitals. UC need was proposed to equal the sum of the interim HSLs (prior to any adjustments to reflect increases or decreases in costs resulting from changes between the data year and the program year) for all large public hospitals eligible to receive UC payments less payments to these hospitals made under the DSH program for the same program year plus an amount equal to the IGTs transferred to HHSC by large public hospitals to support DSH payments to private hospitals for the same demonstration year. The adjustment to UC need for these hospitals was proposed to offset the negative impact to large public hospital HSLs from their funding of the DSH program for private hospitals through IGTs.

Small public hospitals. UC need was proposed to equal the sum of the interim HSLs (prior to any adjustments to reflect increases or decreases in costs resulting from changes between the data year and the program year) for all non-Rider 38 small public hospitals eligible to receive UC payments less payments to these hospitals made under the DSH program for the same program year. Once the small public hospital pool size based on UC need was determined, the pool would be increased by the Rider 38 small public hospital set-aside amount.

Private hospitals. UC need was proposed to equal the sum of the interim HSLs (prior to any adjustments to reflect increases or decreases in costs resulting from changes between the data year and the program year) for all non-Rider 38 private hospitals eligible to receive UC payments less payments to these hospitals made under the DSH program for the same program year. Once the private hospital pool size based on UC was determined, the pool would be increased by the Rider 38 private hospital set-aside amount.

Physician group practices. UC need was proposed to equal the sum of unreimbursed uninsured costs and Medicaid shortfall as reported on the UC physician application for physicians and mid-level professionals (prior to any adjustments to reflect increases or decreases in costs resulting from changes between the data year and the program year). Physician group practices are not eligible for DSH payments and so no offset of these payments from UC need was required.

Governmental ambulance providers. UC need was proposed to equal the federal share of the sum of UC costs for all governmental ambulance providers eligible to receive UC payments. Because governmental ambulance provider costs are collected at a different time than hospital and physician group practice costs, the proposed rule allowed estimated amounts to be used for governmental ambulance providers if actual data is not available at the time the UC pools are established.

Publicly owned dental providers. UC need was proposed to equal total allowable costs (based on a cost-to-billed-charges ratio) less any payments for all publicly owned dental providers eligible to receive UC payments. Because publicly owned dental provider costs are collected at a different time than hospital and physician group practice costs, the proposed rule allowed estimated amounts to be used for publicly owned dental providers if actual data is not available at the time the UC pools are established.

Providers could only access UC funds from their assigned pool. Rider 38 hospitals were guaranteed payments at least equal to their set-aside amounts to the extent that these payments were supported by IGT. Any unused pool funds would be used to offset $466,091,028 in supplemental payments made to hospitals and physicians in November and December 2011 under the Medicaid State plan. As per the waiver standard terms and conditions, these payments are to be considered as if they were payments under the waiver and will be included in the budget neutrality test, and the amount available as payment from the UC pool. The standard terms and conditions allow the State to count these payments under the UC pool for any of the five years of the waiver.

Comments

HHSC conducted two public hearings to receive comment on the proposed amendments. HHSC also received written comments on the proposed amendments. Oral and written comments were received from the following entities (listed in alphabetical order):

Baylor Scott & White Health

Big Bend Regional Medical Center

Central Health

Childress Hospital

CHRISTUS Health

Harris Health System

HCA Central/West Texas Division

Lubbock County Hospital District

Memorial Hermann

Midland Memorial Hospital

Oakbend Medical Center

Parkland

State Senator Kirk Watson

Teaching Hospitals of Texas

Texas Coalition of Transferring Hospitals

Tenet Healthcare Corporation, Central Region

Texas Health Resources

Texas Organization of Rural and Community Hospitals

University Health System

University Medical Center - El Paso

Summaries of the comments and HHSC's responses to the comments, grouped by topic, follow:

General Support for DSH Rules

Comment: One commenter expressed support for the concept of the use of separate and distinct DSH funding pools for allocation to eligible hospitals. This commenter also indicated support for the use of hospital industry benchmarks as contemplated in the proposed DSH rules.

Response: HHSC appreciates the comment. No changes were made in response to this comment.

General Support for DSH and UC Rules

Comment: Several commenters expressed support for the proposed DSH and UC rule amendments and requested that they be adopted without change. These commenters indicated that it is reasonable to evaluate the financial interplay of the DSH and UC amendments by linking the modeling of those proposed amendments and that the HSL is the appropriate proxy for the cost of care for Medicaid and low-income patients. These commenters requested that, to the extent that the fairness of the proposed rules is evaluated in terms of the percentage of HSL covered by net supplemental payments, all public and private hospital categories should be included in the analysis and that any modification in allocation for purposes of correcting perceived imbalances should occur within the respective category of hospitals within which HHSC seeks to address any imbalance.

These commenters also asked that HHSC consider all aspects of the waiver, including the following: (1) over the full five years of the waiver, the public hospitals will receive the great majority of Delivery System Reform Incentive Payment (DSRIP) funds and also received, in the first two years of the waiver, proportionally more in UC payments than could be justified, based on the proportionate share of Medicaid and low-income care they provide when compared to private hospitals; (2) the financial support private hospitals provide to their public hospital partners through expense alleviation arrangements; and (3) the property tax revenues that support public hospital districts, for care they provided to the uninsured and underinsured. Finally, these commenters asked that HHSC consider the fact that further adjustments to the proposed rules, which are based on 2013 data, will almost certainly play out differently once 2014 data are known and that modifying the rule to remedy a perceived imbalance in payments relative to HSLs in 2013, may have a completely unintended consequence in 2014, once HSLs for that year are computed.

Response: HHSC appreciates the comment. While no changes were made in response to this comment, HHSC has changed the UC rule amendment at §355.8201(f)(2)(C)(i)(I)(-b-) to increase the allocation basis for the large public hospital pool by an amount equal to the IGTs transferred to HHSC by large public hospitals to support DSH payments to public and private

hospitals for the same demonstration year. The original proposal limited this increase to the IGTs transferred to HHSC to support DSH payments to private hospitals. HHSC has also changed the UC rule amendment at §355.8201(f)(2)(C)(i)(II) by adding a similar adjustment for small public hospitals. HHSC made these changes in response to comments detailed below and based upon its review of the impact of the proposed rules on the percentage of each hospital type's aggregate HSL that is covered by combined DSH and UC payments. Analyses conducted during the comment period indicated that, under the proposed rules, once the modeling of the proposed DSH and UC changes was linked, with HSLs after application of the DSH changes carried into UC for purposes of calculating the UC pool sizes and payments, proposed supplemental payments as percent of initial HSL equaled 67.7 percent for large public hospitals, 65.8 percent for non-Rider 38 small public hospitals and 72.0 percent for non-Rider 38 private hospitals. HHSC does not believe that these percentages represent an equitable outcome. The adopted rules, by way of contrast, result in proposed supplemental payments as a percent of initial HSL equal to 70.2 percent for large public hospitals, 70.1 percent for non-Rider 38 small public hospitals, and 70.8 percent for non-Rider 38 private hospitals.

HHSC does not agree that the various points raised in this comment counterbalance the logic of using percent of initial HSL covered by supplemental payments as a primary metric in determining whether the impact of the proposed rules is equitable. Regarding the commenters' concern that public hospitals will receive the great majority of DSRIP funds under the waiver, HHSC does not believe that DSRIP funds are appropriate for inclusion in an evaluation of the equity of the DSH and UC supplemental payment programs. DSH and UC are intended to reimburse providers for expenses accrued in providing care to Medicaid and low-income uninsured individuals, while DSRIP funds are incentive payments for implementing various projects intended to reform the health care delivery system in Texas. As such, DSRIP payments are tied to the achievement of multiple metrics related to both process and outcomes and involve additional costs to the provider conducting the DSRIP activity.

As well, HHSC does not believe that, in this situation, it is appropriate to create an inequitable system going forward to counterbalance perceived historical inequities. While some stakeholders could argue that their hospitals were inequitably reimbursed in the early years of the waiver, other stakeholders could just as easily argue that their hospitals were inequitably reimbursed under the former-UPL supplemental payment programs. Choosing a cut-off point to say we will correct for inequities back to a certain date but no further, does not in itself appear to be an equitable approach. As well, payments under both the former-UPL programs and the early years of the waiver were made under legally adopted TAC rules that went through a public process wherein all commenters were given the opportunity to comment and suggest modifications.

HHSC is unable to consider the financial support private hospitals provide to their public hospital partners through expense alleviation arrangements as part of its rule development and adoption process. Any such financial support is given under a voluntary arrangement between the private entity and the public entity and cannot be tied in any way to Medicaid payments or other supplemental payments. See 42 Code of Federal Regulations, Section 433, Subpart B for further information on permissible and impermissible provider-related donations.

HHSC did not consider property tax revenue in its equity calculations in the same way that it did not consider the percentage of each type of hospital's total services funded through private health insurance and Medicare in its calculations. HHSC is charged with reimbursing hospitals for care provided to Medicaid recipients and, through the DSH and UC programs for care provided to low-income uninsured individuals. Issues of property tax revenues and payor mixes, for the most part, fall outside of HHSC's purview.

Finally, while HHSC agrees that HSLs can vary over time and that modeling results based on a certain year's data may change when updated with more current data, it does not have any reason to believe that the data used in its modeling is in any way unrepresentative of the historical distribution of HSLs across various types of hospitals.

IGT Burdens

Comment: One commenter expressed concern that the proposed rules rely to a greater extent on IGTs from six urban public hospitals, while requiring very little from small public hospitals, and failing to require any IGTs from several public hospitals.

Response: All public hospitals are expected to IGT under the proposed DSH rules; large public hospitals are expected to IGT to support both their own and private hospitals' non-general revenue supported Pass 1 and Pass 2 DSH payments; University Medical Center - Lubbock and Ector County Hospital District are expected to IGT to support their own non-general revenue supported Pass 1 and Pass 2 payments; and all other public hospitals are expected to IGT to support 50 percent of their own non-general revenue supported Pass 1 and Pass 2 payments. In addition, if Pass 3 is accessed, all IGTs would be provided by small public hospitals. While large urban hospitals are expected to IGT more funds for FFY 2014 DSH ($377.6 million) than they provided for FFY 2013 ($313.9 million), they will be IGT'ing significantly less than they IGT'ed for FFY's 2010 ($553.0 million), 2011 ($448.2 million) or 2012 ($502 million). No changes were made in response to this comment.

Compliance with Rider 86 Requirements

Comment: Two commenters stated that the proposed rules fail to address even the minimum requirements of Rider 86 which required HHSC to: 1) allocate supplemental hospitals payments including DSH and UC among large public, small public and non-public providers while considering the provision of care to Medicaid and low-income patients and the ongoing availability of DSH funding support provided by large public hospitals; 2) develop methods to move some payments through Medicaid MCOs and transition DSH payments to a quality-based system; 3) transform DSH into a quality-based system; 4) identify an ongoing and stable funding source for DSH; 5) limit UC funds to true safety net hospitals; and 6) modify the allocation of DSH so that it no longer services as a Medicaid subsidy payment.

Response: While HHSC believed that its initial proposal met the requirements of Rider 86 when possible, additional analyses of the impact of the proposed rules on the percentage of each hospital type's aggregate HSL that is covered by combined DSH and UC payments conducted during the comment period (see detailed description above) indicated that the equity across different hospital types could be further improved by modifying the UC rule upon adoption. As a result and in response to comments, HHSC has changed the UC rule amendment at §355.8201(f)(2)(C)(i)(I)(-b-) to increase the allocation basis for the large public hospital pool by an amount equal to the IGTs

transferred to HHSC by large public hospitals to support DSH payments to public and private hospitals for the same demonstration year. The original proposal limited this increase to the IGTs transferred to HHSC to support DSH payments to private hospitals. HHSC has also changed the UC rule amendment at §355.8201(f)(2)(C)(i)(II) by adding a similar adjustment for small public hospitals.

With this change in place, HHSC does not agree that the proposed rules failed to address the requirements of Rider 86 when possible. Rider 86 requires that, for FY 2014, HHSC demonstrate progress toward a plan that addresses seven specified areas. The comment listed two of the seven areas and an area (identify an ongoing and stable funding source for DSH) that was not included in Rider 86. HHSC believes that the plan addresses the two areas included in both the comment and Rider 86 as follows.

Item to be addressed: The appropriate balance and a proportional allocation of supplemental hospitals payments, including DSH and UC payments, among large public, small public, and non-public providers taking into consideration the provision of care to Medicaid and low income patient and the ongoing availability of DSH funding support (IGT) provided by large public hospitals.

How addressed by plan: The following features of the plan address this item:

1) The DSH allocation will be based on the sum of each hospital's Medicaid and low-income days as a percentage of all DSH hospitals' sum of Medicaid and low-income days. These two categories of unreimbursed costs are not equal in size. The artificial division of DSH funds which directed 50 percent toward the Medicaid shortfall and 50 percent toward the uncompensated care costs of caring for low-income uninsured individuals is eliminated.

2) UC funds will be allocated to different types of hospitals based on HSL at the pool level and to individual providers within the pools based on total UC. The creation of fixed UC pools eliminates the current advantage to providers that are able to make IGTs for themselves in maximizing their UC funding as opposed to providers that rely upon unrelated entities to IGT for them.

3) The "damage" to public hospitals' HSLs due to the repayment of funds they IGT for their own and others' DSH payments is alleviated when, prior to determining UC pool amounts, the remaining HSL after DSH payments for public hospitals is increased by an amount equal to the amount IGT'ed by these hospitals to support DSH payments for private hospitals and for their own DSH payments (only for purposes of determining pool amounts).

4) Small public hospitals are required to IGT for 50 percent of their Pass 1 and Pass 2 DSH payments, reducing the IGT burden borne by large public hospitals.

Analyses of the plan using 2013 HSLs, Medicaid days and low-income uninsured days illustrate the positive impact of the plan as measured by the rider's goal of "balance". These analyses focused on the percent of initial HSL covered by supplemental payments under the current methodology as compared to the methodology detailed in the plan for various types of hospitals. While under the current methodology, percent of initial HSL covered by supplemental payments for non-Rider 38 hospitals varied from a low of 67.9 percent for private hospitals to a high of 79.1 percent for large public hospitals, under the plan the percentages for the three types of non-Rider 38 hospitals cluster closely around 70 percent.

Item to be addressed: Mechanisms through which Medicaid payments are made through MCOs.

How addressed by plan: It is not possible to address this item through state administrative code rules. MCOs and hospitals negotiate their payments independent of HHSC. DSH and UC are outside of managed care.

Item to be addressed: A plan to transition from supplemental payments to rates that recognize improvements in quality of patient care, the most appropriate use of care, and patient outcomes.

How addressed by plan: Absent any additional legislative direction, declining federal assistance in the DSH program due to DSH allocation reductions required under the Affordable Care Act, and the expiration of the 1115 Texas Healthcare Transformation and Quality Improvement Waiver will radically reduce the availability of supplemental payments and increase Texas' hospitals' reliance on the base Medicaid inpatient and outpatient rates to pay for the care they provide to Medicaid recipients.

HHSC continues to modify its hospital payment structures to recognize improvements in quality of patient care, the most appropriate use of care and patient outcomes. Activities in this area include the following:

1) Potentially Preventable Readmission (PPR) and Potentially Preventable Complication (PPC) Hospital Reimbursement. HHSC applies fee-for-service (FFS) reimbursement adjustments to hospitals based on PPRs and PPCs and Managed Care Organization (MCO) capitation rates are also adjusted based on in-network hospital performance on PPR and PPC rates.

2) Pay-for-Quality Program (P4Q). Effective January 2014, four percent of the MCO's capitation, which is placed at risk, can be earned back or increased based on performance on quality-based measures including PPRs, potentially preventable emergency department visits (PPVs) and potentially preventable hospital admissions (PPAs).

3) Adjusting outpatient Medicaid payments to a fee schedule that is prospective and maximizes bundling of outpatient services. HHSC is in the process of implementing an Enhanced Ambulatory Patient Grouping (EAPG) patient classification system which will allow bundled payments and reduce incentives for overutilization found in the cost-based reimbursement methodology.

4) Beginning September 1, 2013, MCO premiums were reduced to reflect non-payment when a Medicaid client returns to the emergency department for a non-emergency within 36 hours.

5) Beginning September 1, 2013, HHSC implemented a flat rate (125 percent of physician office visit) for non-urgent emergency department visits for FFS and adjusted managed care premiums accordingly.

Rider 86 does not include requirements that HHSC identify an ongoing and stable funding source for DSH; limit UC funds to true safety net hospitals; or modify the allocation of DSH so that it no longer services as a Medicaid subsidy payment. Other than changes made to the allocation process for determining the size of the UC pools described above, no changes were made in response to these comments.

UC Rider 38 Hospital Protections

Comment: Several commenters expressed concern that the proposed rules disproportionately harm non-Rider 38 hospitals in the small public hospital pool by reducing their amount of UC funding and reallocating this UC funding to other hospitals. These commenters proposed that the rules be amended to spread the cost of the Rider 38 protection proportionately between the small public hospital and private hospital UC pools based on their respective share of their total uncompensated costs.

Response: While HHSC agrees that the proposed UC rule had an inequitable impact on non-Rider 38 small public hospitals, HHSC does not agree that the UC Rider 38 hospital protections contained in the proposed rules were the cause of this inequitable impact. Rather, HHSC believes the inequitable impact was caused by failure to increase the allocation basis for the small public hospital pool by an amount equal to the IGTs transferred to HHSC by these hospitals or their governmental entities to support their own DSH payments. HHSC has changed the UC rule amendment at §355.8201(f)(2)(C)(i)(II) to increase the allocation basis for the small public hospital pool by an amount equal to the IGTs transferred to HHSC by such hospitals or their governmental entities to support their own DSH payments. Analyses of the linked models indicate that once this change is incorporated into the UC model, proposed supplemental payments as percent of initial HSL for small public hospitals increase from 65.8 percent to 70.1 percent which is essentially equal to the percent for large public hospitals (70.2 percent) and private hospitals (70.8 percent) under the adopted rules.

Comment: One commenter expressed concern that while the Rider 38 protections incorporated in the UC rule protect rural hospitals from the growth of UC costs by other pools, it does not protect against the overall reduction in aggregate UC pool size. This commenter expressed a general concern about the impact of the overall reduction in aggregate UC pool size on rural hospitals. The commenter indicated that, while the overall reductions in aggregate UC pool size over the five year life of the waiver are intended to be made-up by increases in the size of the DSRIP pool, this is not the case for small rural hospitals with limited DSRIP allocations.

Response: HHSC incorporated protections for Rider 38 hospitals in the proposed rules in recognition of the unique and valuable role they play in support of the rural healthcare safety net in the state. However, because both DSH and UC are limited to fixed pools of funds, further protections for Rider 38 hospitals would come at additional cost to other hospitals that also play a vital role in supporting Texas' healthcare safety net. As a result, HHSC does not agree that Rider 38 hospitals should be protected from reductions in UC funding due to reductions in the size of the aggregate UC pool over time. No changes were made in response to this comment.

Comment: One commenter requested that the UC rules be amended upon adoption to get rural hospitals all the way back to whole, compared to 2013 distributions, in UC.

Response: The amount of supplemental funds available to Texas safety net hospitals through the DSH and UC programs declines from 2013 to 2014 due to both reductions in the size of the aggregate UC pool and the state's Federal Medical Assistance Percentage (FMAP). HHSC incorporated protections for Rider 38 hospitals in the proposed rules in recognition of the unique and valuable role they play in support of the rural healthcare safety net in the state. However, because both DSH and UC are limited to fixed pools of funds, further protections for Rider 38 hospitals would come at additional cost to other hospitals that also play a vital role in supporting Texas' healthcare safety net. As a result, HHSC does not agree that Rider 38 hospitals should be made whole compared to their 2013 UC distributions on an ongoing basis. No changes were made in response to this comment.

State-owned Hospitals

Comment: One commenter requested that the DSH rules be amended upon adoption to reduce payments to state-owned hospitals proportionate with any future reductions in general revenue appropriations to DSH.

Response: A guiding principle throughout the Rider 86 workgroup meetings was that the state-owned hospital DSH allocation to 100 percent of HSL must be preserved. Payment of state-owned hospitals through DSH serves a number of purposes including freeing general revenue funds for other vital state needs and ensuring that the entire DSH allocation is drawn down in the event of a shortage of DSH IGT. No changes were made in response to this comment.

Cash Flow Burden on Small Public Hospitals

Comment: One commenter expressed concern that HHSC's expressed intent to limit 2014 UC payment opportunities to two times per year for each program would cause significant cash flow issues for small public hospitals, including the violation of debt covenants requiring certain cash reserves. This commenter requested that, since the UC pools are separated under the proposed rules, that the funding for public entities be reimbursed before the IGTs for private entities payments are requested.

Response: The UC rules allow for quarterly UC payments and the DSH rule is silent on the number of annual payments. However, HHSC understands the cash flow issues brought up by the commenter and whenever possible, HHSC will make UC payments to public entities before IGTs for private entities are requested. No changes were made in response to this comment.

Eligibility for UC

Comment: One commenter indicated that only health systems with a commitment to ensuring access to care and providing care to those who are uninsured or who are on Medicaid should be allowed to access UC funds.

Response: From its inception, the UC program has been open to all Medicaid hospitals that submit the proper applications, certifications and other required paperwork. The standard terms and conditions of the waiver do not limit access to the UC program and Rider 86 does not speak toward limiting access to UC funds. No changes were made in response to this comment.

UC Pool Allocation Methodology

Comment: Several commenters indicated strong support for the 1115 Waiver as originally designed and negotiated by HHSC and approved by CMS. These commenters requested that no changes be made to the UC methodology until the end of the waiver.

Response: HHSC believes that amendments to the UC methodology are required to meet the Rider 86 requirement that HHSC make progress towards a plan that addresses the appropriate balance and a proportional allocation of supplemental hospital payments, including DSH and UC payments, among large pub-

lic, small public, and non-public providers taking into consideration the provision of care to Medicaid and low income patients and the ongoing availability of DSH IGT provided by large public hospitals. No changes were made in response to this comment.

Comment: Several commenters indicated that, if UC Pools are to be established, they be based on the distribution of UC funds across different types of hospitals in Demonstration Year 2 (FFY 2013) of the waiver.

Response: HHSC does not believe that it is appropriate to lock-in the distribution of UC funds across different types of hospitals from FFY 2013 for the remainder of the waiver as it has no reason to believe that the FFY 2013 distribution was particularly equitable. HHSC believes that a comparison of supplemental payments as a percentage of initial HSL across different types of hospitals is a fair way to measure the equity of the distribution of supplemental payments under the DSH and UC programs. The adopted rules result in almost equal percentages for large public, non-Rider 38 small public and non-Rider 38 private hospitals. No changes were made in response to this comment.

Comment: Several commenters indicated strong support for the 1115 Waiver as originally designed and negotiated by HHSC and approved by CMS. These commenters recommended to HHSC that it include physician, clinic and pharmacy costs in the UC pool allocation methodology rather than limiting the allocation basis to HSL after DSH. These commenters indicated that an allocation based on HSL would be inconsistent with the terms of the waiver, the CMS' Triple Aim and HHSC's goal to provide more care in the community through clinics rather than through hospitals.

Response: HHSC also strongly supports the waiver. The terms of the waiver do not address how UC payments are to be distributed or calculated except to specify that payments to any specific hospital cannot exceed the hospital's HSL plus its uncompensated costs for physician, clinic and pharmacy.

The HSL statistic is common to both the DSH and UC programs while physician, clinic and pharmacy costs are specific to the UC program only. Rider 86, through its requirement that "HHSC make progress towards a plan that addresses the appropriate balance and a proportional allocation of supplemental hospital payments, including DSH and UC payments, among large public, small public, and non-public providers taking into consideration the provision of care to Medicaid and low income patients and the ongoing availability of DSH IGT provided by large public hospitals", indicates that DSH and UC are to be considered together when evaluating any plan.

As well, the guiding principles agreed to by all members of the workgroup of hospital chief executive officers established by HHSC to address the requirements of Rider 86 included the principle that "DSH and UC will be considered together".

Given this background, HHSC believes that the proper allocation statistic for the calculation of the UC pools is HSL. No changes were made in response to this comment.

Comment: Several commenters requested that the HSL adjustment for the large public hospital UC pool be modified to include all funds IGT'ed by these hospitals under the DSH program rather than limiting the adjustment to funds IGT'ed by these hospitals for private hospitals. These commenters indicated that it was unfair to penalize these hospitals for the provision of these IGTs when there is no similar penalty applied to private hospitals.

Response: After consideration of the linked modeling results discussed above which indicated that, under the proposed rules, supplemental payments as a percent of initial HSL equaled 67.7 percent for large public hospitals, 65.8 percent for non-Rider 38 small public hospitals and 72.0 percent for non-Rider 38 private hospitals, HHSC agrees that the proposed HSL adjustment does not result in an equitable outcome. In response to this comment, HHSC has changed the UC rule amendment at §355.8201(f)(2)(C)(i)(I)(-b-) to increase the allocation basis for the large public hospital pool by an amount equal to the IGTs transferred to HHSC by large public hospitals to support DSH payments to public and private hospitals for the same demonstration year. HHSC has also changed the UC rule amendment at §355.8201(f)(2)(C)(i)(II) by adding a similar adjustment for small public hospitals.

Comment: Several commenters requested that costs from hospitals that do not participate in the DSH program be excluded from the calculation of the UC pool allocations. These commenters indicated that only hospitals that participate in the DSH program are true safety-net providers and that the UC allocation should be based only on true safety-net providers.

Response: HHSC does not agree that UC-only hospitals should be excluded from the UC allocation calculations. The waiver standard terms and conditions do not limit participation in the UC program to DSH participants. HHSC believes that the UC provided by these UC-only hospitals, both public and private, should be included in the UC allocation calculations. No changes were made in response to this comment.

Comment: Three commenters requested that HHSC replace the proposed UC allocation methodology with an allocation methodology based upon pro rata FY 2013 gross UC payments for the three categories of hospitals (transferring, small public and private), taking into account the reduction in the UC pool amount.

Response: Analyses of percent of initial HSL covered after applying supplemental payments indicates that the allocation of supplemental funding under the methodology in place for FY 2013 was not necessarily equitable. For FY 2013, the percent of initial HSL covered by supplemental payments for non-Rider 38 hospitals varied from a low of 67.9 percent for private hospitals to a high of 79.1 percent for large public hospitals. Under the adopted rule, modeling results indicate that the percentages for the three types of non-Rider 38 hospitals will cluster closely around 70 percent. No changes were made in response to this comment.

Comment: One commenter requested that the UC methodology allow for accessing unused UC allocations between pools if those UC allocations cannot be utilized by hospitals within the pools.

Response: Allowing access to unused UC allocations in certain pools by hospitals in other pools would be akin to having no pools. The purpose of the pools is to reduce the advantage under UC that currently exists for hospitals that have their own source of IGT as compared to hospitals that have to rely upon unrelated entities to provide IGT for the non-federal share of their payments. If the comment were to be acted upon, public hospitals could gain access to all UC funds by refusing to IGT for private hospitals. No changes were made in response to this comment.

Definition of Non-urban Public Hospital

Comment: One commenter expressed concern about the proposed definition of a non-urban public hospital in §355.8065. The commenter indicated that the inclusion in this definition of

hospitals operating under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county with 500,000 or fewer persons is problematic because non-urban public hospitals are required to fund one-half of the non-federal share of their Pass One and Pass Two DSH payments from Pool Two or face a reduction in their DSH funding intended to be supported by the entity's IGT to the level supported by the IGT.

This commenter indicated that imposing this requirement on all non-urban public hospitals is problematic in some cases, especially where the lease predates the Upper Payment Limit (UPL) program or waiver, or where the governmental entity does not have IGT available to actually fund these amounts. The commenter went on to say that, under such circumstances, the private hospital is being punished for action or the failure of actions by an unrelated governmental entity, which is subject to its own board of elected officials, which can change policy and support annually.

The commenter recommended that HHSC amend the rule upon adoption to allow all hospitals to attest to their classification with an election during the annual DSH/UC survey with the election to be in effect for both the determination within the DSH program and to the extent of the Pools grouping within UC. The commenter suggested that both the private hospital and the governmental entity be required to sign the attestation.

Response: HHSC's intent when it included hospitals operating under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county with 500,000 or fewer persons in its definition of a non-urban public hospital was to ensure that hospitals treated as public hospitals for purposes of Pass 3 in the DSH program were also treated as public hospitals for purposes of DSH Passes 1 and 2 and the UC allocation calculations. However, HHSC agrees with the commenter that there are some hospitals which would meet the proposed definition that will never participate in Pass 3. Since it was not HHSC's intent to require the governmental entities that lease to such private hospitals to provide IGT support to those hospitals in the DSH program, HHSC has added language to the definition of rural public-financed hospital in §355.8065(b)(37) limiting the inclusion of private hospitals to those operating under a lease from a governmental entity that submit attestations signed by both themselves and their associated governmental entity indicating that they wish to be treated as a rural public-financed hospital for all purposes in both the DSH and UC programs.

Definition of Urban Public Hospital

Comment: Lubbock County Hospital District (LCHD) commented that proposed §355.8065 is unfair because it requires LCHD to IGT for 100 percent of the non-general revenue supported Pass 1 and Pass 2 DSH payments to its hospital. This commenter noted that there are many other public hospitals that are not required to IGT for 100 percent of their Pass 1 and Pass 2 DSH payments.

Response: LCHD and Ector County Hospital District (ECHD) had IGT'ed for 100 percent of their own DSH payments as well as contributing IGT to support DSH payments to private hospitals until FY 2013, when they determined that they would no longer provide IGT to support DSH payments to private hospitals.

HHSC cannot compel an entity to IGT for either its own or others payments; however HHSC indicated in the current adopted version of this rule that ECHD and LCHD would not receive Pass 1 or Pass 2 DSH payments unless they provided the non-federal share of these payments for themselves. This was less of an IGT burden than these two hospital districts had borne prior to FY 2013. HHSC believed at that time and still believes that it is inequitable to require large transferring hospitals to IGT for their own payments and for payments to other public hospitals. The proposed rules expanded upon that policy by, for the first time, requiring all public hospitals to IGT funds to support at least 50 percent of their Pass 1 and Pass 2 DSH payments. The other 50 percent will be funded through general revenue appropriations for FY 2014 and 2015. Unless the legislature appropriates additional funds for DSH for FY 2016 and beyond, beginning in FY 2016, all public hospitals will be required to IGT for 100 percent of their own Pass 1 and Pass 2 DSH payments. Even if additional funds are appropriated for DSH for FY 2016, HHSC intends to work with all public hospitals to transition them to providing 100 percent of the IGT required for their Pass 1 and Pass 2 payments. HHSC is not requiring this 100 percent funding in this rule because it is committed to phasing-in this requirement over time for public hospital districts that did not bear this burden previously. Since Lubbock and Ector have historically IGT'ed not only for their own DSH payments but also for private hospital DSH payments, HHSC did not and does not believe that such a phase-in is required for those two hospitals. No changes were made in response to this comment.

Impact of Adjustments to DSH Payments to Recognize IGT Burdens on HSLs used in UC

Comment: One commenter requested that HHSC communicate to stakeholders the impact of §355.8065(h)(3)(A), which assigns each non-urban public hospital a weighting factor to be used in the allocation of DSH funds and which is intended to ensure that there is not a significant reduction in net DSH payments in the aggregate to these hospitals as a result of the requirement that they provide IGTs in support of one-half of their Pass One and Pass Two DSH Payments from Pool Two. The commenter indicated that this feature of the proposed DSH amendment would impact the HSLs used to calculate the UC pool for these hospitals and asked if this impact is adjusted for in the UC allocation data.

Response: HHSC has communicated this information to affected stakeholders. This impact is not adjusted for in the UC allocation data but as indicated in response to comments above, HHSC has changed the UC rule amendment at §355.8201(f)(2)(C)(i)(II) to increase the allocation for small public hospitals by an amount equal to the IGTs transferred to HHSC by these hospitals or their governmental entities to support their own DSH payments. No other changes were made in response to this comment.

Monies Owed to CMS

Comment: One commenter recommended that the state create a negotiation strategy for CMS with a goal of assessing other options for addressing the $466 million UC debt.

Response: The waiver standard terms and conditions explicitly require that HHSC repay $466,091,028 in supplemental payments made to hospitals and physicians in November and December 2011, under the Medicaid State plan. As per the standard terms and conditions, these payments are to be considered as if they were payments under the waiver and will be included in the budget neutrality test, and the amount available as payment from the UC pool. The standard terms and conditions allow the State to count these payments under the UC pool for any of the

five years of the waiver. No changes were made in response to this comment.

In addition to any changes made in response to comments, HHSC has corrected two erroneous references in §355.8065(h)(1) and (j). These subsections erroneously referred to §355.8066(d) in the proposed amendment. HHSC has corrected these subsections to refer to §355.8066(e).

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8065

Statutory Authority

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; 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 (Medicaid) payments under Texas Human Resources Code Chapter 32.

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

§355.8065. Disproportionate Share Hospital Reimbursement Methodology.

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

(b) Definitions.

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

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

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

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

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

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

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

(8) Children's hospital--A hospital within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

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

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

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

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

(13) Governmental entity--A state agency or a political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county, or state entity.

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

(15) Hospital-specific limit--The maximum amount applicable to a DSH program year that a hospital may receive in reimbursement for the cost of providing services to individuals who are Medicaid eligible or uninsured. The hospital-specific limit is calculated using the methodology described in §355.8066 of this title (relating to Hospital-Specific Limit Methodology).

(A) Interim hospital-specific limit--Applies to payments that will be made during the DSH program year and is calculated using the methodology described in §355.8066 of this title using interim cost and payment data from the DSH data year.

(B) Final hospital-specific limit--Applies to payments made during a prior DSH program year and is calculated using the methodology as described in §355.8066 of this title using actual cost and payment data from the DSH program year.

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

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

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

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

(20) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

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

(22) Low-income days--Number of inpatient days attributed to indigent patients.

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

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

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

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

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

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

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

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

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

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

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

(34) Public funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

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

(36) Rural public hospital--A hospital owned and operated by a governmental entity that is located in a county with 500,000 or fewer persons, based on the most recent decennial census.

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

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

(39) State-owned teaching hospital--A hospital owned and operated by a state university or other state agency.

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

(41) Total Medicaid inpatient days--Total number of inpatient days based on adjudicated claims data for covered services for the relevant DSH data year.

(A) The term includes:

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

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

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

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

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

(B) The term excludes:

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

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

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

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

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

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

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

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

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

(44) Urban public hospital--Any of the urban hospitals listed in paragraph (45) or (46) of this subsection.

(45) Urban public hospital - Class one--A hospital that is operated by or under a lease contract with one of the following entities: the Dallas County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Tarrant County Hospital District, the Travis County Healthcare District dba Central Health, or the University Health System of Bexar County.

(46) Urban public hospital - Class two--A hospital that is operated by or under a lease contract with one of the following entities: the Ector County Hospital District or the Lubbock County Hospital District.

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

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

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

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

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

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

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

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

(E) HHSC will consider a merger of two or more hospitals for purposes of the DSH program for any hospital that submits documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application. Otherwise, HHSC will determine the merged entity's eligibility for the subsequent DSH program year. Until the time that the merged hospitals are determined eligible for payments as a merged hospital, each of the merging hospitals will continue to receive any DSH payments to which it was entitled prior to the merger.

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

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

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

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

(2) Low-income utilization rate. A hospital must have a low-income utilization rate greater than 25 percent.

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

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

(ii) Inpatient charity charges in the DSH data year minus the amount of payments for inpatient hospital services received directly from state and local governments, excluding all Medicaid payments, in the DSH data year, divided by the gross inpatient revenue in the same period: (Total Inpatient Charity Charges - Total State and Local Payments)/Gross Inpatient Revenue).

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

(3) Total Medicaid inpatient days.

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

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

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

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

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

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

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

(1) Two-physician requirement.

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

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

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

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

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

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

(3) Trauma system.

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

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

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

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

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

(7) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. If HHSC receives documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to continue receiving DSH payments for the remainder of the DSH program year.

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

(f) Hospital-specific limit calculation. HHSC uses the methodology described in §355.8066 of this title to calculate an interim hospital-specific limit for each Medicaid hospital that applies and qualifies to receive payments during the DSH program year under this section, and a final hospital-specific limit for each hospital that received payments in a prior program year under this section.

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

(1) State-owned teaching hospitals, state-owned IMDs, and state chest hospitals. HHSC may reimburse state-owned teaching hospitals, state-owned IMDs, and state chest hospitals an amount less than or equal to their interim hospital-specific limits, except that aggregate payments to IMDs statewide may not exceed federally mandated reimbursement limits for IMDs.

(2) Other hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in subsection (h) of this section.

(A) The remaining available DSH funds equal the lesser of the funds as defined in subsection (b)(2) of this section less funds expended under paragraph (1) of this subsection or the sum of remaining qualifying hospitals' interim hospital-specific limits.

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

(h) DSH payment calculation.

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

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

(B) an opportunity for hospitals to request HHSC review of disputed data.

(2) Establishment of DSH funding pools. From the amount of remaining DSH funds determined in subsection (g)(2) of this section, HHSC will establish three DSH funding pools.

(A) Pool One.

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

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

(B) Pool Two.

(i) Pool Two is equal to the federal matching funds associated with the intergovernmental transfers that make up the funds for Pool Three; and

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

(C) Pool Three.

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

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

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

(I) Urban public hospitals. Each governmental entity that operates or is under a lease contract with an Urban public hospital is responsible for funding an amount equal to the non-federal share of Pass One and Pass Two DSH payments from Pool Two (calculated as described in paragraphs (4) and (5) of this subsection) to that hospital.

(II) Non-urban public hospitals.

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

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

(III) Urban public hospitals - Class one. Governmental entities that operate or are under a lease contract with an Urban public hospital - Class one, in the aggregate, are responsible for funding the non-federal share of the Pass One and Pass Two DSH payments from Pool Two (calculated as described in paragraphs (4) and (5) of this subsection) to private hospitals.

(3) Weighting factors.

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

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

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

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

(B) All other DSH hospitals not described in subparagraph (A) of this paragraph will be assigned a weighting factor of 1.00.

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

(A) HHSC will calculate each hospital's total DSH days as follows:

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

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

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

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

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

(ii) Multiply each hospital's percentage as calculated in clause (i) of this subparagraph by the amount determined in paragraph (2)(A) of this subsection to determine each hospital's Pass One projected payment amount from Pool One.

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

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

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

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

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

(A) subtract the hospital's projected DSH payment from paragraph (4)(B)(iv) of this subsection plus any previous payment amounts for the program year from its interim hospital-specific limit;

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

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

(i) If the sum of subparagraph (B) of this paragraph is less than or equal to the total excess funds, HHSC will pay all such hospitals up to their interim hospital-specific limit.

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

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

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

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

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

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

(F) The impact on Pass One and Pass Two payments from Pool Two of any shortfall in funding from Urban public hospitals - Class One will be distributed proportionally across all payments intended to be supported by those funds including payments to hospitals operated by or under lease contract with an Urban public hospital - Class one.

(6) Pass One distribution and payment calculation for Pool Three.

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

(i) For each Urban public hospital - Class one and Class two--

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

(II) divide the result from subclause (I) of this clause by the FMAP for the program year; and

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

(ii) For each Non-urban public hospital--

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

(II) divide the result from subclause (I) of this clause by the FMAP for the program year; and

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

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

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

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

(i) Sum the interim hospital-specific limits for all Urban public hospitals - Class one;

(ii) For each Urban public hospital - Class one, divide its individual interim hospital-specific limit by the sum of the interim hospital-specific limits for all Urban public hospitals - Class one from clause (i) of this subparagraph;

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

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

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

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

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

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

(A) subtract the hospital's projected DSH payment plus any previous payment amounts for the program year from its interim hospital-specific limit;

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

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

(i) If the sum of subparagraph (B) of this paragraph is less than or equal to the total excess funds, HHSC will pay all such hospitals up to their interim hospital-specific limit.

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

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

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

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

(8) Pass Three - additional allocation of DSH funds for rural public and rural public-financed hospitals. Rural public hospitals or rural public-financed hospitals that met the funding requirements described in paragraph (2)(C) of this subsection may be eligible for DSH funds in addition to the projected payment amounts calculated in paragraphs (4) - (7) of this subsection.

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

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

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

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

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

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

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

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

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

(9) Reallocating funds if hospital closes, loses its license or eligibility. If a hospital that is receiving DSH funds closes, loses its license, or loses its Medicare or Medicaid eligibility during a DSH program year, HHSC will reallocate that hospital's disproportionate share funds going forward among all DSH hospitals in the same category that are eligible for additional payments.

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

(11) The sum of the annual payment amounts for state owned and non-state owned IMDs are summed and compared to the federal IMD limit. If the sum of the annual payment amounts exceeds the federal IMD limit, the state owned and non-state owned IMDs are

reduced on a pro-rata basis so that the sum is equal to the federal IMD limit.

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

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

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

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

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

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

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

(k) Disproportionate share funds held in reserve.

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

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

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

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

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

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

(i) be sent to HHSC's Director of Hospital Rate Analysis, Rate Analysis Department;

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

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

(B) The review is:

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

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

(iii) not conducted as an adversarial hearing.

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

(l) Recovery of DSH funds. Notwithstanding any other provision of this section, HHSC will recoup any overpayment of DSH funds made to a hospital, including an overpayment that results from HHSC error or that is identified in an audit.

(1) If the overpayment occurred prior to September 19, 2012, recovered funds will be redistributed proportionately to all DSH hospitals that are eligible for additional payments for the program year in which the overpayment occurred.

(2) If the overpayment occurred on or after September 19, 2012, recovered funds will be redistributed proportionately to DSH hospitals that were in the same category or payment pool in the program year in which the overpayment occurred and that are eligible for additional payments for that program year. If there are no hospitals in the same category or payment pool eligible for additional payments for that program year, any remaining funds will be distributed proportionately among all hospitals eligible for additional payments.

(3) If the overpayment was made to a rural public hospital or rural public-financed hospital, and if the overpayment occurred during a period when that hospital received an additional DSH allocation pursuant to subsection (h)(8) of this section, HHSC will recover the amount of the overpayment and redistribute or return the funds as follows:

(A) Recovered funds up to the amount of the additional allocation received by the hospital pursuant to subsection (h)(8) of this section will not be redistributed. Instead, HHSC will return the non-federal share to the governmental entity that owns or leases the hospital and will return the federal share to CMS.

(B) Recovered funds exceeding the amount described in subparagraph (A) of this paragraph will be redistributed as described in paragraph (2) of this subsection.

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

(n) Voluntary withdrawal from the DSH program.

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

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

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

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

(o) Audit process.

(1) Independent certified audit. HHSC is required by the Social Security Act (Act) to annually complete an independent certified audit of each hospital participating in the DSH program in Texas. Audits will comply with all applicable federal law and directives, including the Act, the Omnibus Budget and Reconciliation Act of 1993 (OBRA '93), the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), pertinent federal rules, and any amendments to such provisions.

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

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

(i) The Medicaid cost report;

(ii) Medicaid Management Information System data; and

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

(C) A hospital must provide HHSC or the independent auditor with the necessary information in the time specified by HHSC or the independent auditor. A listing of all information required by the independent auditor is available on HHSC's website.

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

(E) HHSC will recoup any overpayment of DSH funds made to a hospital that is identified in the independent certified audit and will redistribute the recouped funds to DSH providers that are eligible for additional payments subject to their final hospital-specific limits, as described in subsection (l) of this section.

(F) Review of preliminary audit finding of overpayment.

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

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

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

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

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

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

(iii) The review is:

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

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

(III) not an adversarial hearing.

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

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

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

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

1 TAC §355.8201, §355.8202

Statutory Authority

The amendments are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; 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 (Medicaid) payments under Texas 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 adoption.

§355.8201. Waiver Payments to Hospitals for Uncompensated Care.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver payments are available under this section for eligible hospitals described in subsection (c) of this section. Waiver payments to hospitals must be in compliance with the Centers for Medicare and Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions and this section.

(b) Definitions.

(1) Affiliation agreement--An agreement, entered into between one or more privately-operated hospitals and a governmental entity that does not conflict with federal or state law. HHSC does not prescribe the form of the agreement.

(2) Aggregate limit--The amount of funds approved by the Centers for Medicare and Medicaid Services for uncompensated-care payments for the demonstration year that is allocated to each uncompensated-care provider pool, as described in subsection (f)(2) of this section.

(3) Anchor--The governmental entity identified by HHSC as having primary administrative responsibilities on behalf of a Regional Healthcare Partnership (RHP).

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

(5) Clinic--An outpatient health care facility, other than an Ambulatory Surgical Center or Hospital Ambulatory Surgical Center, that is owned and operated by a hospital but has a nine-digit Texas Provider Identifier (TPI) that is different from the hospital's nine-digit TPI.

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

(7) Delivery System Reform Incentive Payments (DSRIP)--Payments related to the development or implementation of a program of activity that supports a hospital's efforts to enhance access to health care, the quality of care, and the health of patients and families it serves. These payments are not considered patient-care revenue and are not offset against the hospital's costs when calculating the hospital-specific limit as described in §355.8066 of this title.

(8) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. This period corresponds to the Disproportionate Share Hospital program year.

(9) Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program that serves a disproportionate share of low-income patients and is eligible for additional reimbursement from the DSH fund.

(10) Governmental entity--A state agency or a political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county, or state entity.

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

(12) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

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

(14) Large public hospital--An urban public hospital - Class one as defined in §355.8065 of this title (relating to Disproportionate Share Hospital Reimbursement Methodology).

(15) Mid-Level Professional--Medical practitioners which include only these professions: Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Dentists, Certified Nurse Midwives, Clinical Social Workers, Clinical Psychologists, and Optometrists.

(16) Private hospital--A hospital that is not a large public hospital as defined in paragraph (14) of this subsection, a small public hospital as defined in paragraph (21) of this subsection or a state-owned hospital.

(17) Public funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(18) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.

(19) RHP plan--A multi-year plan within which participants propose their portion of waiver funding and DSRIP projects.

(20) Rider 38 hospital--A hospital located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated Rural Referral Center, a Sole Community Hospital, or a Critical Access Hospital.

(21) Small public hospital--An urban public hospital - Class two or a non-urban public hospital as defined in §355.8065 of this title.

(22) Transition payment--Payments available only during the first demonstration year to hospitals that previously participated in a supplemental payment program under the Texas Medicaid State Plan. For a hospital participating in the 2012 DSH program, the maximum amount a hospital may receive in transition payments is the lesser of:

(A) the hospital's 2012 DSH room; or

(B) the amount the hospital received in supplemental payments for claims adjudicated between October 1, 2010, and September 30, 2011.

(23) Uncompensated-care application--A form prescribed by HHSC to identify uncompensated costs for Medicaid-enrolled providers.

(24) Uncompensated-care payments--Payments intended to defray the uncompensated costs of services that meet the definition of "medical assistance" contained in §1905(a) of the Social Security Act that are provided by the hospital to Medicaid eligible or uninsured individuals.

(25) Uninsured patient--An individual who has no health insurance or other source of third-party coverage for services, as defined by CMS.

(26) Waiver--The Texas Healthcare Transformation and Quality Improvement Program Medicaid demonstration waiver under §1115 of the Social Security Act.

(c) Eligibility. A hospital that meets the requirements described in this subsection may receive payments under this section. A hospital must notify HHSC Rate Analysis in writing within 30 days of changes in ownership, operation, or affiliation that may affect the hospital's continued eligibility for payments under this section.

(1) Generally. To be eligible for any payment under this section:

(A) a hospital must have a source of public funding for the non-federal share of waiver payments; and

(B) if it is a hospital not operated by a governmental entity, it must have filed with HHSC an affiliation agreement and the documents described in clauses (i) and (ii) of this subparagraph.

(i) The hospital must certify on a form prescribed by HHSC:

(I) that it is a privately-operated hospital;

(II) that no part of any payment to the hospital under this section will be returned or reimbursed to a governmental entity with which the hospital affiliates; and

(III) that no part of any payment under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospital's receipt of the supplemental funds.

(ii) The governmental entity that is party to the affiliation agreement must certify on a form prescribed by HHSC:

(I) that the governmental entity has not received and has no agreement to receive any portion of the payments made to any hospital that is party to the agreement;

(II) that the governmental entity has not entered into a contingent fee arrangement related to the governmental entity's participation in the waiver program;

(III) that the governmental entity adopted the conditions described in the certification form prescribed by or otherwise approved by HHSC pursuant to a vote of the governmental entity's governing body in a public meeting preceded by public notice published in accordance with the governmental entity's usual and customary practices or the Texas Open Meetings Act, as applicable; and

(IV) that all affiliation agreements, consulting agreements, or legal services agreements executed by the governmental entity related to its participation in this waiver payment program are available for public inspection upon request.

(iii) Submission requirements.

(I) Initial submissions. The parties must initially submit the affiliation agreements and certifications described in this subsection to the HHSC Rate Analysis Department on the earlier of the following occurrences after the documents are executed:

(-a-) The date the hospital submits the uncompensated-care application that is further described in paragraph (2) of this subsection; or

(-b-) Thirty days before the projected deadline for completing the IGT for the first payment under the affiliation agreement. The projected deadline for completing the IGT is posted on HHSC Rate Analysis' website for each payment under this section.

(II) Subsequent submissions. The parties must submit revised documentation as follows:

(-a-) When the nature of the affiliation changes or parties to the agreement are added or removed, the parties must submit the revised affiliation agreement and related hospital and governmental entity certifications.

(-b-) When there are changes in ownership, operation, or provider identifiers, the hospital must submit a revised hospital certification.

(-c-) The parties must submit the revised documentation thirty days before the projected deadline for completing the IGT for the first payment under the revised affiliation agreement. The projected deadline for completing the IGT is posted on HHSC Rate Analysis' website for each payment under this section.

(III) A hospital that submits new or revised documentation under subclause (I) or (II) of this clause must notify the Anchor of the RHP in which the hospital participates.

(IV) The certification forms must not be modified except for those changes approved by HHSC prior to submission.

(-a-) Within 10 business days of HHSC Rate Analysis receiving a request for approval of proposed modifications, HHSC will approve, reject, or suggest changes to the proposed certification forms.

(-b-) A request for HHSC approval of proposed modifications to the certification forms will not delay the submission deadlines established in this clause.

(V) A hospital that fails to submit the required documentation in compliance with this subparagraph will not receive a payment under this section.

(2) Uncompensated-care payments. For a hospital to be eligible to receive uncompensated-care payments, in addition to the requirements in paragraph (1) of this subsection, the hospital must:

(A) submit to HHSC an uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC;

(B) submit to HHSC documentation of:

(i) its participation in an RHP; or

(ii) approval from CMS of its eligibility for uncompensated-care payments without participation in an RHP;

(C) be actively enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year; and

(D) have submitted, and be eligible to receive payment for, a Medicaid fee-for-service or managed-care inpatient or outpatient claim for payment during the demonstration year.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to timely receipt by HHSC of public funds from a governmental entity.

(e) Payment frequency. HHSC will distribute waiver payments as follows and on a schedule to be determined by HHSC:

(1) Uncompensated-care payments will be distributed at least quarterly after the uncompensated-care application is processed.

(2) The payment schedule or frequency may be modified as specified by CMS or HHSC.

(f) Funding limitations.

(1) Payments made under this section are limited by the maximum aggregate amount of funds allocated to the provider's uncompensated-care pool for the demonstration year. If payments for uncompensated care for an uncompensated-care pool attributable to a demonstration year are expected to exceed the aggregate amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(5) of this section.

(2) HHSC will establish the following seven uncompensated-care pools: a state-owned hospital pool; a large public hospital pool; a small public hospital pool; a private hospital pool; a physician group practice pool; a governmental ambulance provider pool; and a publicly owned dental provider pool as follows:

(A) The state-owned hospital pool.

(i) The state-owned hospital pool funds uncompensated-care payments to state-owned teaching hospitals, state-owned IMDs and state chest hospitals.

(ii) HHSC will determine the allocation for this pool at an amount less than or equal to the total annual maximum uncompensated-care payment amount for these hospitals as calculated in subsection (g)(2) of this section.

(B) Rider 38 set-aside amounts. HHSC will determine Rider 38 set-aside amounts as follows:

(i) Divide the amount of funds approved by CMS for uncompensated-care payments for the demonstration year by the amount of funds approved by CMS for uncompensated-care payments for the 2013 demonstration year and round the result to four decimal places.

(ii) Determine the small public hospital Rider 38 set-aside amount by multiplying the value from clause (i) of this subparagraph by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all Rider 38 hospitals that are eligible to receive uncompensated-care payments under this section and that meet the definition of a small public hospital from subsection (b)(21) of this section. Truncate the resulting value to zero decimal places.

(iii) Determine the private hospital Rider 38 set-aside amount by multiplying the value from clause (i) of this subparagraph by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all Rider 38 hospitals that are eligible to receive uncompensated-care payments under this section and that meet the definition of a private hospital from subsection (b)(16) of this section. Truncate the resulting value to zero decimal places.

(iv) Determine the total Rider 38 set-aside amount by summing the results of clauses (ii) and (iii) of this subparagraph.

(C) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, and the Rider 38 set-aside amount among the non-state-owned provider pools as described in this subparagraph. The remaining available uncompensated-care funds equal the amount of funds approved by CMS for uncompensated-care payments for the demonstration year less the sum of funds allocated to the state-owned hospital pool under subparagraph (A) of this paragraph and the Rider 38 set-aside amount from subparagraph (B) of this paragraph.

(i) HHSC will allocate the funds among non-state-owned provider pools based on the following amounts:

(I) Large public hospitals:

(-a-) The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all large public hospitals, as defined in subsection (b)(14) of this section, eligible to receive uncompensated-care payments under this section; plus

(-b-) An amount equal to the IGTs transferred to HHSC by large public hospitals to support DSH payments to themselves and private hospitals for the same demonstration year.

(II) Small public hospitals:

(-a-) The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all non-Rider 38 small public hospitals, as defined in subsection (b)(21) of this section, eligible to receive uncompensated-care payments under this section; plus

(-b-) An amount equal to the IGTs transferred to HHSC by small public hospitals to support DSH payments to themselves for Pass One and Pass Two payments for the same demonstration year.

(III) Private hospitals: The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all non-Rider 38 private hospitals, as defined in subsection (b)(16) of this section, eligible to receive uncompensated-care payments under this section.

(IV) Physician group practices: The sum of the unreimbursed uninsured costs and Medicaid shortfall for physician group practices, as described in §355.8202(g)(2)(A) of this title (relating to Waiver Payments to Physician Group Practices for Uncompensated Care).

(V) Governmental ambulance providers: The sum of the uncompensated care costs multiplied by the federal medical assistance percentage (FMAP) in effect during the cost reporting period for governmental ambulance providers, as described in §355.8600 of this title (relating to Reimbursement Methodology for Ambulance Services). Estimated amounts may be used if actual data is not available at the time calculations are performed.

(VI) Publicly-owned dental providers: The sum of the total allowable cost minus any payments for publicly owned dental providers, as described in §355.8441 of this title (relating to Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services). Estimated amounts may be used if actual data is not available at the time calculations are performed.

(ii) HHSC will sum the amounts calculated in clause (i) of this subparagraph.

(iii) HHSC will calculate the aggregate limit for each non-state-owned provider pool as follows:

(I) To determine the large public hospital pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds, from this subparagraph, by the amount calculated in clause (i)(I) of this subparagraph; and

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places.

(II) To determine the small public hospital pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(II) of this subparagraph;

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places; and

(-c-) add the result from item (-b-) of this subclause to the amount calculated in subparagraph (B)(ii) of this paragraph.

(III) To determine the private hospital pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(III) of this subparagraph;

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places; and

(-c-) add the result from item (-b-) of this subclause to the amount calculated in subparagraph (B)(iii) of this paragraph.

(IV) To determine the physician group practice pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(IV) of this subparagraph; and

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places.

(V) To determine the maximum aggregate amount of the estimated uncompensated care costs for all governmental ambulance providers:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(V) of this subparagraph; and

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places.

(VI) To determine the publicly owned dental providers pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(VI) of this subparagraph; and

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places.

(3) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which a hospital is eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Application.

(A) Cost and payment data reported by the hospital in the uncompensated-care application is used to:

(i) calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection; and

(ii) reconcile the actual uncompensated-care costs reported by the hospital for the data year with uncompensated-care waiver payments, if any, made to the hospital for the same period. The reconciliation process is more fully described in subsection (i) of this section.

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

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

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

(C) If a hospital withdraws from participation in an RHP, the hospital must submit an uncompensated-care application reporting its actual costs and payments for any period during which the hospital received uncompensated-care payments. The application will be used for the purpose described in paragraph (1)(A)(ii) of this subsection. If a hospital fails to submit the application reporting its actual costs, HHSC will recoup the full amount of uncompensated-care payments to the hospital for the period at issue.

(2) Calculation. A hospital's annual maximum uncompensated-care payment amount is the sum of the following components:

(A) The interim hospital specific limit, calculated as described in §355.8066 of this title, except that an IMD may not report cost and payment data in the uncompensated-care application for services provided during the data year to Medicaid-eligible and uninsured patients ages 21 through 64, less any payments to be made under the DSH program for the same demonstration year, calculated as described in §355.8065 of this title;

(B) Other eligible costs for the data year, as described in paragraph (3) of this subsection; and

(C) Cost and payment adjustments, if any, as described in paragraph (4) of this subsection.

(D) In no case can the sum of payments made to a hospital for a demonstration year for DSH and uncompensated-care payments, less the payments described in paragraph (3) of this subsection, exceed a hospital's specific limit as determined in §355.8066 of this title after modifications to reflect the adjustments described in paragraph (4) of this subsection.

(3) Other eligible costs.

(A) In addition to cost and payment data that is used to calculate the hospital-specific limit, as described in §355.8066 of this title, a hospital may also claim reimbursement under this section for uncompensated care, as specified in the uncompensated-care application, that is related to the following services provided to Medicaid-eligible and uninsured patients:

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

(ii) pharmacy services; and

(iii) clinics.

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

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

(A) A hospital:

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

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

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

(C) In addition to being subject to the reconciliation described in subsection (i)(1) of this section which applies to all uncompensated-care payments for all hospitals, uncompensated-care payments for hospitals that submitted a request as described in subparagraph (A)(i) of this paragraph that impacted the interim hospital-specific limit described in paragraph (2)(A) of this subsection will be subject to the reconciliation described in subsection (i)(2) of this section.

(D) Notwithstanding the availability of adjustments impacting the interim hospital-specific limit described in this paragraph, no adjustments to the interim hospital-specific limit will be considered for purposes of Medicaid DSH payment calculations described in §355.8065 of this title.

(5) Reduction to stay within uncompensated-care pool aggregate limits. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for any uncompensated-care pool described in subsection (f)(2) of this section, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the pool to exceed the aggregate limit for the pool and will reduce the maximum uncompensated-care payment amounts providers in the pool are eligible to receive for that period as required to remain within the pool aggregate limit.

(A) Calculations in this paragraph will be applied to each of the uncompensated-care pools separately.

(B) HHSC will calculate the following data points:

(i) For each provider, prior period payments to equal prior period uncompensated-care payments for the demonstration year.

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

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

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

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

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

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

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

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

(i) HHSC will calculate a capped payment amount equal to the product of the provider's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the pool-wide ratio calculated in subparagraph (B)(v) of this paragraph.

(ii) If the payment period is not the final payment period for the demonstration year, the revised maximum uncompensated-care payment for the payment period equals the lesser of:

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

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

(iii) If the payment period is the final payment period for the demonstration year:

(I) HHSC will calculate an IGT-supported maximum uncompensated-care payment for the payment period equal to the amount of the maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph that is supported by an IGT commitment.

(-a-) For hospitals and physician group practices, HHSC will obtain from each RHP anchor a current breakdown of IGT commitments from all governmental entities, including governmental entities outside of the RHP, that will be providing IGTs for uncompensated-care payments for each hospital and physician group practice within the RHP that is eligible for such payments for the payment period.

(-b-) Ambulance and dental providers will be assumed to have commitments for 100 percent of the non-federal share of their payments. The non-federal share for ambulance providers is provided through certified public expenditures (CPEs); for ambulance providers, references to IGTs in this subsection should be read as references to CPEs.

(II) HHSC will calculate an IGT-supported maximum uncompensated-care payment for the demonstration year to equal the IGT-supported maximum uncompensated-care payment for the payment period from subclause (I) of this clause plus the provider's prior period payments from subparagraph (B)(i) of this paragraph.

(III) For providers with an IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause that is less than or equal to their capped payment amount from clause (i) of this subparagraph,

the provider's revised maximum uncompensated-care payment for the payment period equals the IGT-supported maximum uncompensated-care payment amount for the payment period from subclause (I) of this clause. For these providers, the difference between their capped payment amount from clause (i) of this subparagraph and their IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause is their unfunded cap room.

(IV) HHSC will sum all unfunded cap room from subclause (III) of this clause to determine the total unfunded cap room for the pool.

(V) For providers with an IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause that is greater than their capped payment amount from clause (i) of this subparagraph, the provider's revised maximum uncompensated-care payment amount for the payment period is calculated as follows:

(-a-) For each provider, HHSC will calculate an overage amount to equal the difference between the IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause and their capped payment amount for the demonstration year from clause (i) of this subparagraph. Unfunded cap room from subclause (IV) of this clause will be distributed to these providers based on each provider's overage as a percentage of the pool-wide overage.

(-b-) For each provider, the provider's revised maximum uncompensated-care payment amount for the payment period is equal to the sum of its capped payment amount from clause (i) of this subparagraph and its portion of its pool's unfunded cap room from item (-a-) of this subclause less its prior period payments from subparagraph (B)(i) of this paragraph.

(E) Once reductions to ensure that uncompensated-care expenditures do not exceed the aggregate limit for the demonstration year for the pool are calculated, HHSC will not re-calculate the resulting payments for any provider for the demonstration year, including if the IGT commitments upon which the reduction calculations were based are different than actual IGT amounts.

(F) Notwithstanding the calculations described in subparagraphs (A) - (E) of this paragraph, if the payment period is the final payment period for the demonstration year, to the extent the payment is supported by IGT, each Rider 38 hospital is guaranteed a payment at least equal to its interim hospital specific limit from paragraph (2)(A) of this subsection multiplied by the value from subsection (f)(2)(B)(i) of this section for the demonstration year less any prior period payments. If this guarantee will cause payments for a pool to exceed the aggregate pool limit, the reduction required to stay within the pool limit will be distributed proportionally across all non-Rider 38 providers in the pool based on each provider's resulting payment from subparagraphs (A) - (E) of this paragraph as compared to the payments to all non-Rider 38 hospitals in the pool resulting from subparagraphs (A) - (E) of this paragraph.

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

(7) Advance payments.

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

(B) The amount of the advance payments will be a percentage, to be determined by HHSC, of the annual maximum uncompensated-care payment amount calculated by HHSC for the preceding demonstration year.

(C) Advance payments are considered to be prior period payments as described in paragraph (5)(B)(i) of this subsection.

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

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

(h) Payment methodology.

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

(A) the payment amount for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for a hospital to receive the amount described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to a hospital will be determined based on the amount of funds transferred by the affiliated governmental entity or entities as follows:

(A) If the governmental entity transfers the maximum amount referenced in paragraph (1) of this subsection, the hospital will receive the full payment amount calculated for that payment period.

(B) If a governmental entity does not transfer the maximum amount referenced in paragraph (1) of this subsection, HHSC will determine the payment amount to each hospital owned by or affiliated with that governmental entity as follows:

(i) At the time the transfer is made, the governmental entity notifies HHSC, on a form prescribed by HHSC, of the share of the IGT to be allocated to each hospital owned by or affiliated with that entity and provides the non-federal share of uncompensated-care payments for each entity with which it affiliates in a separate IGT transaction; or

(ii) In the absence of the notification described in clause (i) of this subparagraph, each hospital owned by or affiliated with the governmental entity will receive a portion of its payment amount for that period, based on the hospital's percentage of the total payment amounts for all hospitals owned by or affiliated with that governmental entity.

(C) For a hospital that is affiliated with multiple governmental entities, in the event those governmental entities transfer more than the maximum IGT amount that can be provided for that hospital, HHSC will calculate the amount of IGT funds necessary to fund the hospital to its payment limit and refund the remaining amount to the governmental entities identified by HHSC.

(3) Final payment opportunity. Within payments described in this section, a governmental entity that does not transfer the maxi-

mum IGT amount described in paragraph (1) of this subsection during a demonstration year will be allowed to fund the remaining payments at the time of the final payment for that demonstration year. The IGT will be applied in the following order:

(A) To the final payment up to the maximum amount;

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

(i) Reconciliation. Beginning in the third demonstration year, data on the uncompensated-care application will be used to reconcile actual costs incurred by the hospital for the data year with uncompensated-care payments, if any, made to the hospital for the same period:

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

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

(3) Transition payments are not subject to reconciliation under this subsection.

(4) If a hospital submitted a request as described in subsection (g)(4)(A)(i) of this section that impacted its interim hospital-specific limit, that hospital will be subject to an additional reconciliation as follows:

(A) HHSC will compare the hospital's adjusted interim hospital-specific limit from subsection (g)(4)(A)(i) of this section for the demonstration year to its final hospital-specific limit as described in §355.8066(c)(2) of this title for the demonstration year.

(B) If the final hospital-specific limit is less than the adjusted interim hospital-specific limit, HHSC will recalculate the hospital's uncompensated-care payment for the demonstration year substituting the final hospital-specific limit for the adjusted interim hospital-specific limit with no other changes to the data used in the original calculation of the hospital's uncompensated-care payment other than any necessary reductions to the original IGT amount and will recoup any payment received by the hospital that is greater than the recalculated uncompensated-care payment. Recouped funds may be redistributed to other hospitals that received payments less than their actual costs.

(j) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the hospital will be returned to the entity that owns or is affiliated with the hospital.

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

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

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

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

(k) Penalty for failure to complete Category 4 reporting requirements for Regional Healthcare Partnerships. Hospitals must comply with all Category 4 reporting requirements set out in Chapter 354 of this title, Subchapter D (relating to Texas Healthcare Transformation and Quality Improvement Program). If a hospital fails to complete required Category 4 reporting measures by the last quarter of a demonstration year:

(1) the hospital will forfeit its uncompensated-care payments for that quarter; or

(2) the hospital may request from HHSC a six-month extension from the end of the demonstration year to report any outstanding Category 4 measures.

(A) The fourth-quarter payment will be made upon completion of the outstanding required Category 4 measure reports within the six-month period.

(B) A hospital may receive only one six-month extension to complete required Category 4 reporting for each demonstration year.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403670
Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Effective date: September 1, 2014
Proposal publication date: June 27, 2014
For further information, please call: (512) 424-6900

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DIVISION 23. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

1 TAC §355.8441

Statutory Authority

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; 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 (Medicaid) payments under Texas Human Resources Code Chapter 32.

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Jack Stick
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 424-6900

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TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 12. WEIGHTS AND MEASURES

SUBCHAPTER G. SERVICE TECHNICIANS

4 TAC §12.60

The Texas Department of Agriculture (department) adopts an amendment to §12.60, concerning examination fees for service technicians licensed by the department to service and calibrate weighing and measuring devices, without changes to the proposed text published in the June 20, 2014, issue of the *Texas Register* (39 TexReg 4719). The amendment is adopted to reduce examination fees from $100 per class to $60 per class, due to cost savings resulting from outsourcing service technician exams. The department has determined that contracting exam services through a proctored computer-based system will provide a greater convenience for service technicians at a lower cost by offering: 1) more testing locations throughout the state; 2) testing opportunities of at least five days per week; and 3) 24-hour online exam registration. Through outsourcing service technician exams, the department will be able to reduce expenditures during fiscal year 2014 below the amount appropriated for the purpose of administering service technician exams. As a direct result of this cost savings, the department is adopting an amendment to §12.60 to decrease fees for service technician exams by forty percent. Additionally, this amendment will comply with changes made to the weights and measures program by the 82nd Texas Legislature, which required that all of the costs of administering this program be entirely offset by revenue generated for the program, including other direct and indirect expenses, and has authorized the agency to collect fees accordingly.

A comments was received from the Texas Retailers Association generally in support of the proposal.

The amendment to §12.60 is adopted under the Texas Agriculture Code (the Code), 13.021, which provides the department with the authority to adopt rules to establish standard weights and measures and bring about uniformity between the standards established under Chapter 13, and the standards established by federal law; the Code, and §13.453, which provides the department with the authority to adopt rules for licensing service technicians and service companies, and rules necessary for the regulation of device maintenance activities and §13.457, which provides the department with the authority to set a fee for licensing of a service technician.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403672
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Effective date: August 31, 2014
Proposal publication date: June 20, 2014
For further information, please call: (512) 463-4075

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TITLE 13. CULTURAL RESOURCES

PART 1. TEXAS STATE LIBRARY AND ARCHIVES COMMISSION

CHAPTER 6. STATE RECORDS

SUBCHAPTER A. RECORDS RETENTION SCHEDULING

13 TAC §§6.3, 6.4, 6.6

The Texas State Library and Archives Commission adopts amendments to 13 TAC §§6.3, 6.4, and 6.6, regarding records retention scheduling, without changes to the proposed text as published in the June 20, 2014, issue of the *Texas Register* (39 TexReg 4726). The amendments are adopted pursuant to the Government Code §441.185(e). The amendments increase the recertification cycle for submitting state agency records retention schedules from 3 to 5 years. Additionally, §6.4(1) regarding submission of amendments and §6.4(3) regarding decertification are amended to reflect current procedures and practices.

Two comments were received regarding the amendments during the comment period. Both comments were in favor of the amendments to the rules.

The amendments are adopted under Government Code §441.185(e), that grants authority to the Texas State Library and Archives Commission to adopt rules concerning the submission of records retention schedules.

The amended sections affect Government Code §441.185(e).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403769
Edward Seidenberg
Deputy Director
Texas State Library and Archives Commission
Effective date: September 3, 2014
Proposal publication date: June 20, 2014
For further information, please call: (512) 463-5459

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CHAPTER 7. LOCAL RECORDS

SUBCHAPTER D. RECORDS RETENTION SCHEDULES

13 TAC §7.125

(Editor's note: In accordance with Texas Government Code, §2002.014, which permits the omission of material which is "cumbersome, expensive, or otherwise inexpedient," the figure in 13 TAC §7.125(a)(10) is not included in the print version of the Texas Register. The figure is available in the on-line version of the August 22, 2014, issue of the Texas Register.)

The Texas State Library and Archives Commission adopts amendments to 13 TAC §7.125, regarding local government retention schedule for Records of Elections and Voter Registration (Schedule EL), with changes to the proposed text as published in the June 20, 2014, issue of the *Texas Register* (39 TexReg 4728). Section 7.125(a)(10) is amended pursuant to the Government Code §441.158(a). The amendment makes revisions necessary to update the retention schedule due to changes in the Election Code that affected the retention of several record series. HB 2817 (82nd Legislature) separated the retention periods for election records not involving a federal office from those involving a federal office.

Comments were received regarding the amendment during the comment period. These comments and the resulting changes are identified in this preamble.

Comment: A state official from the Office of Secretary of State recommended adding a remark to EL3100-01c (Early, Absentee, and Restricted Ballot Voting Records - Federal post card applications requesting absentee ballot), to include a cross-reference to EL3150-03a (Voter Registration Applications and Associated Documentation - Voter registration applications), because the Federal post card applications requesting absentee ballots can serve as the voter registration application.

Response: Agency agrees with recommendation and cross-reference is added.

Comment: A state official from the Office of Secretary of State recommended changes to the record description of EL3150-01 (Challenge to Registration Records).

Response: Agency agrees with recommendation. Records description is changed.

Comment: A state official from the Office of Secretary of State recommended changes to the retention period of EL3150-01b (Challenge to Registration Records) and addition reference to Election Code.

Response: Agency agrees with recommendation. Retention period is changed and Election Code reference is added.

Comment: A state official from the Office of Secretary of State recommended adding changes to the record description of EL3150-03a (Voter Registration Applications and Associated Documentation - Voter registration applications).

Response: Agency agrees with recommendation. Record description is changed.

Comment: A state official from the Office of Secretary of State recommended that EL3150-03f (Voter Registration Applications and Associated Documentation - Periodic reports from the Secretary of State on deceased persons in a county) be removed or retention period changed to AV, administrative value, because this record series is obsolete.

Response: Agency agrees with recommendation. Retention period is changed to AV and a note is included that this is an obsolete record.

Comment: A state official from the Office of Secretary of State recommended a change to the retention period and record description to EL3150-04c (Voter Registration Certificates) to better reflect the statutory requirement.

Response: Agency agrees with recommendation. Retention period and record description are changed.

Additional changes to the proposed text are non-substantive corrections to typographical errors identified by staff (correction to Record Number for EL3100-04a and correction to reference to EL3100-10a in retention period for EL3100-04a(1)).

The amendment is adopted under Government Code §441.158 that grants authority to the Texas State Library and Archives Commission to provide records retention schedules to local governments and Government Code §441.160 that allows the commission to revise the schedules.

The amended section affects Government Code §441.158 and §441.160.

§7.125. Records Retention Schedules.

(a) The following records retention schedules, required to be adopted by rule under Government Code §441.158(a) are adopted.

(1) Local Schedule GR: Records Common to All Local Governments, Revised 4th Edition.
Figure: 13 TAC §7.125(a)(1) (No change.)

(2) Local Schedule PW: Records of Public Works and Other Government Services, 2nd Edition.
Figure: 13 TAC §7.125(a)(2) (No change.)

(3) Local Schedule CC: Records of County Clerks, 3rd Edition.
Figure: 13 TAC §7.125(a)(3) (No change.)

(4) Local Schedule DC: Records of District Clerks, 3rd Edition.
Figure: 13 TAC §7.125(a)(4) (No change.)

(5) Local Schedule PS: Records of Public Safety Agencies, 3rd Edition.
Figure: 13 TAC §7.125(a)(5) (No change.)

(6) Local Schedule SD: Records of Public School Districts, Revised 2nd Edition.
Figure: 13 TAC §7.125(a)(6) (No change.)

(7) Local Schedule JC: Records of Public Junior Colleges, 2nd Edition.
Figure: 13 TAC §7.125(a)(7) (No change.)

(8) Local Schedule LC: Records of Justice and Municipal Courts, 2nd Edition.
Figure: 13 TAC §7.125(a)(8) (No change.)

(9) Local Schedule TX: Records of Property Taxation, 3rd Edition.
Figure: 13 TAC §7.125(a)(9) (No change.)

(10) Local Schedule EL: Records of Elections and Voter Registration, 3rd Edition.
Figure: 13 TAC §7.125(a)(10)

(11) Local Schedule HR: Records of Public Health Agencies, 2nd Edition.
Figure: 13 TAC §7.125(a)(11) (No change.)

(12) Local Schedule UT: Records of Utility Services, 2nd Edition.

Figure: 13 TAC §7.125(a)(12) (No change.)

(b) The retention periods in the records retention schedules adopted under subsection (a) of this section serve to amend and replace the retention periods in all editions of the county records manual published by the commission between 1978 and 1988. The retention periods in the manual, which were validated and continued in effect by Government Code §441.159, until amended, are now without effect.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Edward Seidenberg
Deputy Director
Texas State Library and Archives Commission
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For further information, please call: (512) 463-5459

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TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 25. SUBSTANTIVE RULES APPLICABLE TO ELECTRIC SERVICE PROVIDERS

SUBCHAPTER J. COSTS, RATES AND TARIFFS

DIVISION 1. RETAIL RATES

16 TAC §25.245

The Public Utility Commission of Texas (commission) adopts new §25.245, relating to Recovery of Expenses for Ratemaking Proceedings, with changes to the proposed text as published in the February 7, 2014 issue of the *Texas Register* (39 TexReg 571). The rule establishes criteria for review of utilities' and municipalities' requests for recovery of or reimbursement for rate-case expenses. Project Number 41622 is assigned to this proceeding.

The commission received written initial and/or reply comments on the new rule from the Alliance of Local Regulatory Authorities (the Alliance); AEP Texas Central Company, AEP Texas North Company, CenterPoint Energy Houston Electric LLC, Cross Texas Transmission LLC, El Paso Electric Company, Electric Transmission Texas LLC, Entergy Texas, Inc., Lone Star Transmission LLC, Oncor Electric Delivery Company, Sharyland Utilities LP, Southwestern Electric Power Company, Southwestern Public Service Company, Texas-New Mexico Power Company, and Wind Energy Transmission Texas LLC (collectively, Joint Utilities); Steve Baron; City of El Paso (El Paso); City of Houston (Houston); the Lower Colorado River Authority (LCRA); Office of Public Utility Counsel (OPUC); the REP Group; State of Texas' agencies and institutions of higher education (State Agencies); the Steering Committee of Cities Served by Oncor (Oncor Cities); Texas Industrial Energy Consumers (TIEC); the Texas Municipal League (TML), and Aqua Texas, Canyon Lake Water Service Company, and SouthWest Water Company (collectively, Water IOUs).

Public Hearing

On April 3, 2014, at the request of OPUC and Water IOUs, commission staff conducted a public hearing in this proceeding. Parties' statements at the public hearing were generally similar to their filed written comments. Comments that were new or additional are noted below.

General Comments

State Agencies commented that although the commission's discretion to approve rate-case expenses is necessarily one that must be made on a case-by-case basis, and need not be justified by a rule, State Agencies appreciate the commissioners' proposal to outline some concepts and considerations that will guide their discretion. OPUC and TIEC similarly commended the commission's efforts to create a rule governing rate-case expense recovery, but opined that there may be policy issues to consider in determining which expenses to allow or disallow and that the rule as published unnecessarily restricts the commission's discretion, in contrast with the commission's broad authority in Public Utility Regulatory Act (PURA), Texas Utilities Code Annotated §36.061(b) (Vernon 2007 and Supp. 2013).

Steve Baron expressed similar comments by stating that the commission should adopt a rate-case expense rule that provides meaningful guidance without being overly prescriptive, and he noted that PURA §36.061(b)(2) articulates "reasonableness" as a single, general standard for recovery of rate-case expenses. Mr. Baron stated that this general "reasonableness" standard gives the commission broad discretion to determine recovery of rate-case expenses, that the commission has exercised that discretion on a case-by-case basis, and that the courts have confirmed that the commission in doing so may consider a variety of factors. Mr. Baron commented that the rule should provide guidance regarding "reasonableness" without being overly prescriptive in a way that could constrain the commission's exercise of discretion and result in an arbitrary allowance or disallowance in a particular case.

TIEC noted that its members pay for both the utilities' and municipalities' rate-case expenses, in addition to their own legal and consulting fees. TIEC noted that, given this fact, it is in a unique position to offer comments regarding the appropriate framework for considering utility and municipalities' rate-case expenses, and TIEC expressed support for rule revisions that would incentivize municipalities and utilities to act more like self-funded litigants. TIEC commented that although many of the positions articulated by the utilities and the municipalities presume that recovery of rate-case expenses is a right, PURA §36.061 provides only that the commission "may allow" a utility's "reasonable costs of participating in a proceeding under this title not to exceed the amount approved by the regulatory authority." TIEC stated that, similarly, PURA §33.023(b) states that an electric utility shall reimburse the governing body of the municipality for the "reasonable cost of the services" of persons engaged in rate case proceedings "to the extent the applicable regulatory authority determines is reasonable." TIEC submitted that existing law, therefore, gives the commission broad discretion to determine the reasonableness of rate-case expenses and whether they should be recovered; consistent with this existing legal princi-

ple, and regardless of whether the proposed rule is adopted, the commission has broad authority to determine whether rate-case expenses are unrecoverable for a variety of reasons, including litigation of well-settled issues, frivolous positions, flawed analysis, over-lawyering, or other policy considerations. TIEC submitted that the commission does not need a new rule to carry out its statutory duties regarding rate-case expenses, and nothing in the proposed rule should be applied in a way that would limit this existing discretion and authority.

State Agencies noted that in proceedings prior to publication of the proposed rule, commission staff was urged to draw on the collective wisdom of other state agencies in Texas as well as surrounding states, and gave the example of how the Texas Railroad Commission has a rate-case expense rule (16 Texas Administrative Code §7.5530) that provides guidelines for the commission's exercise of discretion without curtailing its power to react to specific circumstances. State Agencies noted that Rule 1.04 of the Texas Disciplinary Rules of Professional Conduct (TDRPC) also offers parameters for measuring the reasonableness of attorney fees that are worthy of consideration by the commission. State Agencies stated that the commission's proposed new §25.245 commendably incorporates guidelines similar to the Railroad Commission's rule, but State Agencies expressed its belief that other concepts from that rule should be included in the commission's proposed rule--specifically, the criterion allowing comparison of the rate relief that was requested to that which was ultimately awarded.

State Agencies further commented that the rule should remove the qualifier that would restrict the commission's consideration of methods for evaluating rate-case expense that go beyond "bean counting" individual invoices. State Agencies submitted that for those cases where individual invoices must be scrutinized, the proposed rule lacks an essential standard for evaluating costs incurred for travel, lodging and meals, and therefore proposed the use of an existing objective standard: the ceiling on expenses that state employees and officials must observe when on official business.

El Paso commented that in any discussion about municipal rate-case expenses, the commission must consider that pursuant to Chapter 33 of PURA, the municipalities have original jurisdiction over the rates, operations, and services of electric utilities in areas in the municipality. El Paso noted that a rate case must be filed with the municipality, which has the obligation to evaluate the rate increase request, and therefore, it is improper to characterize the statutory role of the municipality as challenging or opposing portions of the request, and it is similarly inappropriate to provide guidance on the reasonableness of municipal expenses on the basis of either issues or amounts successfully or unsuccessfully challenged. El Paso commented that because the commission has the authority to disallow expenses that it does not find reasonable, portions of the rule other than those that codify prior commission practices and precedents are unnecessary. Houston and the Alliance expressed similar comments, with Houston stating that it does not believe that reductions in rate-case expense should equate to a reduction in the level of proper and necessary review performed by the municipal regulator. Houston stated that if the proposed rule limits a city's ability to perform a comprehensive review in any rate proceeding, whether directly or indirectly, the rule ultimately interferes with that city's ability to effectively perform its legislatively mandated obligations as municipal regulator. The Alliance commented that municipalities have a statutory right to participate in rate cases and noted that no other party has that right. The Alliance also commented that its members fully recognize that it is its citizens and businesses that ultimately bear the costs of rate cases, and that the City Attorney offices, the City Manager offices, the Financial Directors, the members of the Alliance's city councils and city commissions are ever vigilant over fees and expenses incurred for the cities' active participation in rate-making proceedings. The Alliance commented that its participation has achieved savings for its citizens and business that far outweigh the total municipal rate-case expenses.

Oncor Cities commented that the language of PURA §33.023 makes clear that it is both a grant and a limitation, as it affords municipal intervenors the authority to recover their reasonable costs of participating in a ratemaking proceeding, but not expenses in excess of that amount. Oncor Cities stated that while the commission's proposed rule appropriately focuses on ensuring that only reasonable rate-case expenses are approved and recovered, the statute also requires that the rule not hinder or even prevent the quantification and recovery of reasonable expenses.

Houston stated that at this time, it does not believe the proposed rule is necessary, as it believes the current long-standing process for reviewing and determining the amount of reasonable and necessary rate-case expenses has proven sufficient and effective. Houston commented that it is not aware of any instance in which comments by other parties suggested that the current process was ineffective or defective in a material manner. Houston further opined that the current two-tier process provides for an extensive and transparent review, and includes the State Office of Administrative Hearing (SOAH) and the commission; the process also allows for the intervention of interested and affected parties, and while rate-case expenses may have increased over the past few decades, the complexity of filings and number of issues presented have also increased. Houston stated that the regulatory process is not immune to standard inflation-related increases, and it is concerned that a rule focused on reducing overall rate-case expenses without a more thorough review, inclusive of a cost/benefit analysis, could have a significant and negative impact on the overall ratemaking process and could hinder the municipal regulator's effective participation in rate proceedings.

Joint Utilities commented that under PURA and the Third Court of Appeals' decision in *Oncor Electric Delivery Company LLC v. Public Utility Commission of Texas,* 406 S.W.3d 253 (Tex. App.--Austin 2013, no pet.) (*Oncor),* all reasonable and necessary rate-case expenses incurred by utilities or municipalities are recoverable. Joint Utilities stated that to give effect to PURA and the court's decision, the proposed rule should (1) establish the criteria that utilities and municipalities must meet in order to establish the reasonableness of their expenses, (2) apply those criteria equally to both utilities and municipalities, (3) ensure utilities and municipalities have an opportunity to seek recovery of their reasonable and necessary expenses, and (4) ensure that, if the utility or municipality meets its burden of proof, all reasonable costs are recoverable. Joint Utilities opined that subsections (a) - (c) of the proposed rule include language that appropriately addresses these standards, but for reasons discussed below, Joint Utilities urged the commission to modify subsection (c) and (d).

Similar to Houston, LCRA stated that it believes the existing method of determining the reasonableness of rate-case expenses has worked well to date and the proposed rule's subsections (a) - (c) effectively describe those steps. LCRA averred, however, that proposed subsection (d) introduces new mechanical approaches that purport to measure the reason-

ableness of rate-case expenses by application of formulaic methodologies rather than a reasoned review of the pertinent facts in any given case, and LCRA believes these proposed new approaches are therefore incompatible with PURA. LCRA also stated that it believes the comments filed by Joint Utilities constitute a comprehensive and correct assessment of the proposed rule as a whole and offer the best roadmap for the commission to follow as it decides what parts, if any, of the proposed rule should be adopted. LCRA commented that the commission already has authority and discretion to disallow expenses (including rate-case expenses) that are not just and reasonable, or on which a party has not carried its burden of proof, and that therefore this rule is largely unnecessary. LCRA commented that to the extent the proposed rule was prompted by the facts of any given rate case it may be more reasonable to deal with the specific facts of that case rather than establish a general rule whose applicability to many utilities is questionable, particularly when many of the proposed subsections of the rule simply add complexity and possible confusion rather than clarity. LCRA submitted that to the extent that a rate-case expenses rule adds more requirements to describe, segregate, or account for certain expenses in a particular fashion, it virtually invites additional litigation from parties who claim utilities did not present rate-case expenses correctly, or from utilities that assert they did and are entitled to full recovery of all rate-case expenses. LCRA stated that, given the foregoing considerations, it respectfully questions the necessity for this rule, but at the very least believes subsection (d) of the proposed rule should be rejected in its entirety if the commission believes any new rule is necessary at all.

State Agencies commented that contrary to the assertions of Joint Utilities and Mr. Baron, the *Oncor* decision did not establish a mandate for approval of a utility's incurred rate-case expenses. State Agencies submitted that the rate-case expenses at issue in that case were from 2004 and 2005 rate cases, not previously recovered, and had been stipulated by the parties to be both reasonable and necessary, but that the commission held that it had no jurisdiction in a later 2009 rate case to consider those costs from earlier proceedings because Oncor failed to obtain approval to seek them in a later proceeding. State Agencies commented that the commission determined that it had no jurisdiction to consider earlier rate-case expenses because the right to seek them had not been preserved; thus, the principal issue before the Court of Appeals was not the reasonableness of the 2004 and 2005 rate-case expenses, given that that had been stipulated, but whether the commission acted arbitrarily and capriciously by imposing on Oncor the requirement for "prior authorization" to seek earlier rate-case expenses in its later rate case. State Agencies commented that the court discussed the evidence showing that this prior authorization requirement was a departure from the commission's prior practice and focused specifically on the violation of Oncor's due process rights inherent in the commission's decision, and that there is nothing in the *Oncor* case holding that PURA §36.051 somehow removes the commission's discretion under PURA §36.061(b)(2) to approve or disapprove rate-case expenses, and nothing that changed the requirement that these costs cannot be recovered unless they were proven to be reasonable and necessary.

Water IOUs expressed concern that the proposed rule creates a possibility that the commission may see fit to adopt a similar rule for water/wastewater rate cases after the September 1, 2014 jurisdictional transfer. Water IOUs commented that if a rate-case expense rule is adopted, it should follow well-established Texas law for determining reasonableness and necessity of attorney's fees and apply similar criteria for other types of rate-case expenses, and Water IOUs opined that proposed §25.245 does not accomplish this, but instead proposes various levels of criteria that are at best problematic and at worst will pave the way for arbitrary disallowance of rate-case expenses that should be recoverable. Water IOUs cited the test laid out by TDRPC §1.04(b) in conjunction with the precedent from *Arthur Andersen & Co. v. Perry Equipment Corp.,* 945 S.W.2d 812 (Tex. 1997) *(Andersen)* as relatively simple criteria that are universally accepted in the Texas courts for determining reasonable and necessary attorneys' costs. OPUC responded that while some of these factors may be instructive in determining the extent of reasonable fees, they are too narrow to apply generally to utility rate proceedings; further, some of these factors are simply not relevant to determining whether the ratepayers should be responsible for paying the utility's rate-case expenses. OPUC stated that, for instance, the "nature and length of the professional relationship with the client" may be relevant to the client, *i.e.,* the utility, but it does not go to whether the expenses are reasonable and in the public interest, and thus, appropriate for recovery from the rate payers.

Water IOUs also expressed concern about the possibility of any version of the specific provisions in proposed §25.245(d) being applied to them in future rate cases. Water IOUs pointed out that water customer counts are relatively small when compared to electric utilities and have a smaller denominator for rate-case expense surcharge calculations, and that there is a potential for unnecessarily inflating the resulting rate-case-expense surcharge because of increased litigation costs directly resulting from rate-case expense disallowance efforts under the proposed rule. Water IOUs stated that PURA has a similar statutory requirement to Texas Water Code §13.183(a), which specifies that the return on a utility's invested capital used and useful in rendering service to the public must be (1) over and above its reasonable and necessary operating expenses and (2) sufficient to preserve the financial integrity of the utility. Water IOUs noted that PURA §36.051 contains similar language, and that in the recent Court of Appeals opinion in the *Oncor* case, the court found that disallowance of reasonable and necessary rate-case expenses violates this requirement. Water IOUs commented that the effect of disallowing reasonable and necessary expenses is to charge those expenses to the utility's stockholders instead of to its ratepayers, thus reducing the return the utility earns on its rate base. Water IOUs submitted that the requirement for a reasonable return is only satisfied if the utility's return on capital is sufficient to ensure confidence in the financial integrity of the utility to enable it to maintain its credit and attract capital, and that therefore, regulatory agencies cannot arbitrarily disallow reasonable and necessary expenditures, or confiscation will result.

Commission response

The commission agrees with the several parties who commented that the rule should not hinder or limit the commission's broad discretion under PURA §36.061(b) and §33.023(b) with respect to rate-case expenses. The adopted rule maintains the commission's discretion in this regard while also articulating more specific criteria by which the commission may determine disallowances. While recognizing that the commission retains broad discretion to review and evaluate rate-case expenses under PURA's "reasonableness" standard, the commission also agrees with the comments of Mr. Baron that the rate-case expense rule should provide meaningful guidance to the parties regarding specific rate-case expense requests, including the evidence parties must submit to meet their burden to establish

the reasonableness of any requested rate-case expenses. In light of the comments from the parties, the commission has made several changes to the published rule in order to further clarify the evidence necessary to establish reasonable rate-case expenses and the criteria the commission will utilize in reviewing and determining the reasonableness of particular expenses. As discussed more fully in the responses to the comments on particular subsections below, the commission finds that subsections (a) - (c) of the rule, as adopted, now provide adequate guidance to the parties regarding the commission's process for evaluating rate-case expenses.

The commission notes that several parties, including LCRA, asserted that subsection (d) of the proposed rule introduced mechanical approaches and/or formulistic methodologies that were inconsistent with the commission's broad discretion to review the reasonableness of rate-case expenses. The commission emphasizes that the methodologies in subsection (d) of the proposed rule only apply in circumstances in which the requesting party submitted insufficient evidence to quantify rate-case expenses and are not exhaustive or mandatory. Nevertheless, as discussed in the responses to the comments on subsection (b) below, the commission has now further clarified the requirements for claiming recovery of or reimbursement for rate-case expenses in the adopted rule. In light of these revisions to the evidentiary requirements in the adopted rule, the commission is persuaded by the comments of various parties that in most circumstances, the calculation of the disallowance of particular rate-case expense amounts should be based directly upon the amount of rate-case expenses found to be unreasonably incurred. The commission is persuaded that sufficient evidence will be presented in most circumstances, in part, because, if a utility company or municipality fails to provide evidence supporting the reasonableness of its rate-case expenses as required under subsection (b)(6) of the adopted rule, the adopted rule provides reasonable alternatives to the presiding officer in order to allow for efficient processing of the application. If the evidence provided is insufficient to meet the requirements of the rule, the commission anticipates that such an application would likely need to be supplemented or be rejected as insufficient and the applicant would be required to file the information required under the rule. In addition, the commission would retain the authority to disallow a portion of the party's rate-case expenses pursuant to subsection (d)(3) of the adopted rule as discussed below.

As discussed in greater detail below, the commission has revised subsection (d) of the rule to provide that, in most circumstances, the presiding officer will disallow or recommend disallowance of recovery of rate-case expenses equal to the amount shown to have not been reasonably incurred using the criteria in subsection (c). The remaining methodologies in subsection (d) will now only apply in two specific circumstances: (1) the methodology stated in subsection (d)(3) of the adopted rule (the Issue Specific Method) may be applied when the applicant has not specified the amount of rate-case expenses reasonably associated with a particular issue under subsection (b)(6) of the rule as adopted; or (2) the methodology stated in subsection (d)(2) of the adopted rule (the Results Oriented Method) may be applied when the commission finds that the rate-case expenses as a whole were disproportionate, excessive, or unwarranted in relation to the nature and scope of the rate case under subsection (c)(5) of the rule as adopted.

Consistent with comments by TIEC regarding PURA §36.061, the commission concludes that adopting clear evidentiary standards and specific criteria for the review and determination of the reasonableness of rate-case expenses will incentivize utilities and municipalities to act more like self-funded litigants, while still providing for recovery of reasonable rate-case expenses. The commission emphasizes that it retains broad discretion and flexibility when reviewing requests for recovery of or reimbursement for rate-case expenses. The commission further anticipates that in evaluating specific rate-case expense requests, the presiding officer will apply the specific criteria established in the adopted rule in light of the overall "reasonableness" standard for rate-case expense recovery.

Regarding the concerns expressed by Water IOUs about the possibility of any version of the specific provisions in proposed subsection (d) being applied to them in future rate cases, the commission notes that §25.245 will only apply to electric utility companies. The commission will begin regulation of water utility companies on September 1, 2014, and currently has open a rulemaking proceeding in Project No. 42191 that transfers the existing Texas Commission on Environmental Quality (TCEQ) rules to the commission with only minimal substantive revisions. Included in the transferred rules is 30 Texas Administrative Code §291.28(7) - (9), which will continue to address water utilities' recovery of rate-case expenses after the commission assumes jurisdiction over water utilities on September 1, 2014. The commission notes, however, that it may in the future consider additional rulemaking proceedings for water utilities, including a possible rulemaking that specifically addresses the criteria for recovery of rate-case expenses, but that is beyond the scope of this proceeding.

With regard to parties' comments on specific subsections of the rule--such as, for example, State Agencies' comments regarding the proposed rule's similarities to guidelines in the Railroad Commission's rules--the commission responds in greater detail below. Also below, the commission addresses Mr. Baron's and Joint Utilities' assertions on the court decision in the *Oncor* case.

Response to Commission Questions

In addition to the published proposal, the commission requested that parties submit responses to the following questions:

1. Should the proposed rule, if adopted, explicitly allow for allocation of rate-case expenses to a utility's shareholders?

The Alliance, OPUC, State Agencies, TIEC, and TML responded that, yes, explicitly allowing for allocation of rate-cases expenses to a utility's shareholders is appropriate. OPUC and State Agencies commented that, as a practical matter, the effect of disallowing any requested cost is that the utility and its shareholders are responsible for those costs, not the ratepayers. OPUC and State Agencies noted, however, that if the commission chooses for policy reasons to assign a portion of rate-case expenses under certain circumstances to a utility's shareholders, expressly stating this in the rule serves as additional notice to the utilities of the commission's intent.

OPUC further commented that if a utility knew that it would be responsible for some portion of its rate-case expenses, it might give more consideration to the costs and benefits of raising certain issues. OPUC stated that this could include decisions to challenge established commission precedent, whether to bring multiple lawyers to a proceeding, or whether to pursue certain procedural or discovery disputes that have a low probability of success. OPUC stated that requiring utilities and their shareholders to be at least partially accountable for the costs of these

activities would increase the incentive to employ a more reasonable and cost-effective litigation strategy.

State Agencies commented that approval or disapproval of rate-case expenses is necessarily dependent upon the facts of a case and the overall history of a utility's filing at the commission, and that well-managed utilities that control their costs and run efficient operations--which obviate the need for frequent, repetitive rate-case filings--can make a more persuasive case that a greater portion of their requested rate-case expenses is necessary.

The Alliance commented that in the vast majority of cases, the utility is the entity that initiates a case to seek a rate increase. The Alliance stated that while the utility and its board of directors owe a fiduciary duty to the utility's shareholders to maximize profits, it is only fair that the shareholders pay for some or all of the utility's rate-case expenses.

TIEC similarly commented that utility shareholders benefit from rate increases and should therefore share in the cost of obtaining a rate increase. TIEC opined that giving utility shareholders "skin in the game" for rate-case expenses would limit overlawyering, encourage negotiation during the litigation process, and discourage utilities from incurring excessive and imprudent rate-case expenses to litigate well-settled issues or frivolous positions. TIEC submitted that PURA §36.061 provides that the commission "may allow" a utility's "reasonable costs of participating in a proceeding under this title not to exceed the amount approved by the regulatory authority," and that this provision plainly gives the commission authority to allocate a portion of rate-case expenses to the utility's shareholders. TIEC also stated that a rule that explicitly allows rate-case expenses to be allocated to a utility's shareholders would give utilities an incentive to better manage their rate-case expenses and act more like private litigants. TIEC commented that the proposed rule would offer a useful framework and guidelines in the consideration of rate-case expenses, but the rule should not be misconstrued as limiting the commission's existing authority and discretion in any way.

Houston similarly stated that it is not opposed to allowing for allocation of rate-case expenses to a utility's shareholders.

Water IOUs and Mr. Baron responded that the rule should not explicitly allow for allocation of rate-case expenses to a utility's shareholders. Mr. Baron commented that rate-case expenses should be disallowed not on a "shareholders benefit" theory, but on the evidentiary record applied to the factors and criteria for reasonableness. Mr. Baron stated that, by statute, a utility must follow all applicable rate-case procedures and thereby unavoidably incur rate-case expenses, and that under this framework, it is reasonable and appropriate to deny recovery of expenses shown by the facts to be excessive and unnecessary, but difficult to justify disallowances on a "shareholders benefit" theory that disregards the evidentiary record.

LCRA commented that none of the arguments made by the Alliance, State Agencies, OPUC, and TIEC are valid bases for denying recovery of legitimate expenses such as rate-case expenses, and more to the point, none of those arguments square with the applicable sections of PURA that state that a utility that carries its burden of proof is entitled to its reasonable and necessary expenses and a reasonable return on investment. Like Joint Utilities, LCRA submitted that the Austin Court of Appeals recently decided these principles in the *Oncor* case.

Joint Utilities and Water IOUs similarly commented that if rate-case expenses are reasonable and necessary, the commission should allow recovery. These parties stated that regulated utilities must apply to increase rates when needed to maintain their legal right to recover reasonable and necessary O&M costs, plus return on invested capital, and that rate-case expenses are required by regulatory processes imposed upon utilities and not by shareholder interests. Joint Utilities commented that the commission has discretion under PURA--and under subsections (b) and (c) of the published rule--to determine whether a party has met its burden of proof that its requested rate-case expenses are reasonable. Joint Utilities stated that to the extent the commission determines rate-case expenses are not reasonable or necessary, those disallowed expenses are effectively assigned to the shareholders; however, under the *Oncor* decision, the commission cannot presume that rate-case expenses are unreasonable just for the sake of requiring shareholders to "pay" for the presumed benefit of filing a rate case. Similarly, Water IOUs submitted that there should not be allocation to shareholders of such expenses by making reasonable and necessary rate-case expenses partially unrecoverable through retail rates in the manner this question suggests.

Joint Utilities additionally commented that assigning reasonable rate-case expenses to a utility's shareholders essentially punishes the utility and its shareholders for requesting their reasonable and necessary operating expenses, thereby reducing their commission-approved return by the cost of requesting their expenses. Joint Utilities further stated that this fails to account for the fact that a utility does not always determine whether or when it files a statement of intent, given that a municipality or the commission can initiate a rate-case proceeding as well and thus requiring a utility to expend funds to defend its existing cost of service. Joint Utilities submitted that requiring shareholders to pay to litigate a utility's cost of service also incents other parties to inflate litigation costs as a tactic to discourage utilities from changing rates or encourage utilities to settle for less than their actual cost of service to avoid litigation expense. Joint Utilities stated that the commission must reject certain commenters' proposal to systematically disallow utility rate-case expenses for "policy" reasons without regard to their reasonableness. Joint Utilities submitted that both PURA and the Third Court of Appeals ruling in *Oncor* dictate that a utility's reasonable rate-case expenses are recoverable, and any rule adopted in this proceeding must comply with the *Oncor* analysis. Joint Utilities stated that, notably, none of these commenters even address *Oncor* and its clear requirements, but that instead, commenters point to the broad discretion granted the regulatory agency in *City of Port Neches v. Railroad Commission of Texas,* 212 S.W.3d 565 (Tex. App.--Austin 2006, no pet.) *(City of Port Neches),* which addresses post-test year adjustments, and *City of El Paso v. Public Utility Commission of Texas,* 916 S.W.2d 515 (Tex. App.--Austin 1995, writ dism'd by agr.), which expressly requires that a utility be reimbursed for its reasonable rate-case expenses, consistent with *Oncor.*

OPUC commented that Joint Utilities advance a far too narrow interpretation of the commission's authority by asserting that the recent decision in the *Oncor* case requires that all reasonable and necessary rate-case expenses be recoverable. OPUC contended that the commission has broad discretion to determine recovery of expenses in a ratemaking proceeding, and cited *City of Port Neches.* OPUC stated that PURA §36.061 reflects this authority and states that the regulatory authority may allow as a cost or expense the "reasonable costs of participating in a proceeding under this title not to exceed the amount approved by the regulatory authority." OPUC stated that this language indi-

cates that the commission can approve some amount that is less than reasonable costs and can take into account other considerations, and without this discretion, rate-case expense proceedings would be rendered mere accounting exercises. OPUC further stated that the courts have made clear that the commission's authority is not limited to line item disallowances or charges related to underlying unreasonable costs, and cited the case of *City of Amarillo v. Railroad Commission of Texas,* 894 S.W.2d 491, 496-97 (Tex. App.-Austin 1995, writ denied), in which the court upheld the Railroad Commission's decision to reduce the uncontested rate-case expenses related to one analyst's charges by 20% due to insufficiency of support. OPUC noted that the Third Court of Appeals also confirmed that it is within the agency's discretion to find rate-case expenses to be unreasonable even if the underlying cost item in the rate case is found to be reasonable. The court stated in *City of Port Neches* that:

It is true that, in order to include . . . costs as an "expense or cost of service" in TGS's rate calculation, TGS was required to demonstrate that those costs were reasonable and necessary. But the leap cannot be made from this fact to TGS's conclusion that any fee incurred by TGS in presenting its "cost of service" argument is automatically recoverable as a rate-case expense. This is where the Commission's discretion . . . plays an integral role. 212 S.W.3d 565, 581.

OPUC contended that the commission therefore has significant discretion in determining recovery of rate-case expenses.

OPUC also stated that contrary to Joint Utilities' comments, the acknowledgment that certain rate-case expenses may be assigned to a utility's shareholders does not serve as a punishment of the utility and its shareholders. Rather, it recognizes the reality that a utility's shareholders reap benefits from implementing rate increases and that the utility's board of directors owes a fiduciary duty to the utility's shareholders to maximize profits. OPUC agreed with TIEC's comments that a rule that explicitly allows rate-case expenses to be allocated to a utility's shareholders provides to utilities an incentive to better manage their rate-case expenses and act more like private litigants, and this incentive is essential given that the utilities in large part control the expenses incurred for a rate case. OPUC submitted that a utility, properly acting as a prudent gatekeeper of rate-case expenses, should make decisions about whether to incur certain rate-case expenses as if it were ultimately the party responsible for paying them.

Commission response

The commission agrees with comments filed by OPUC, the Alliance, State Agencies, TIEC, TML, and Houston that the commission can explicitly provide in the rule for allocation of rate-case expenses to a utility's shareholders. However, the commission also agrees with the comments of Mr. Baron and others that the disallowance of rate-case expenses should be based, to the extent practicable, on the evidentiary record as applied to the factors and criteria for reasonableness. As discussed in greater detail below, the commission has now further clarified the requirements for claiming recovery of or reimbursement for rate-case expenses in the adopted rule, as well as the criteria for evaluating rate-case expense requests. In light of these revisions to the evidentiary requirements in the adopted rule, the commission is persuaded by the comments of various parties that in most circumstances, the calculation of the disallowance of specific rate-case expense amounts should now be based directly upon the amount of rate-case expenses found to be unreasonably incurred. As discussed in greater detail below, the commission has revised subsection (d) of the rule to provide that in most circumstances, the presiding officer will disallow or recommend disallowance of recovery of rate-case expenses equal to the amount shown to have not been reasonably incurred under the criteria in subsection (c). In light of these changes, and as discussed more fully below, the commission concludes that it is not necessary to adopt subsection (d)(1) of the proposed rule (the 50/50 Method) at this time, but the commission maintains that adoption of that methodology is within the commission's discretion.

The commission agrees with TIEC's comments that the possibility that a utility and its shareholders may be held accountable for rate-case expenses increases the utility's incentive to undertake cost-effective and efficient litigation strategies, and encourages the utility to act more like a private litigant. As discussed more fully below, the commission has added subsection (c)(5) to the criteria for evaluating the reasonableness of rate-case expenses in the adopted rule to permit the commission to disallow rate-case expenses that are, as a whole, disproportionate, excessive, or unwarranted to the nature and scope of the rate case at issue. The commission finds that this provision, along with the other criteria in subsection (c) of the adopted rule, provides the proper incentives for utilities to monitor their costs and avoid unreasonable expenditures.

The commission agrees with Joint Utilities' comments that any rule adopted in this proceeding must comply with the *Oncor* precedent and concludes that the adopted rule is consistent with that precedent. The commission further agrees with Joint Utilities that the commission cannot presume that rate-case expenses are unreasonable just for the sake of requiring shareholders to pay for the presumed benefit of filing a rate case. However, without stating a definitive interpretation of the *Oncor* precedent, the commission finds that it continues to retain substantial discretion under PURA §36.061 to disallow utility rate-case expenses even after the *Oncor* decision. At a minimum, the commission finds that the *Oncor* decision does not, even if interpreted in the broadest possible fashion, mandate that utilities be permitted to recover unreasonably incurred rate-case expenses.

As noted by TIEC, PURA §36.061 provides that the commission "may" allow a utility's reasonable rate-case expenses. Consistent with the commission's authority to permit recovery of "reasonable" rate-case expenses, subsections (b) and (c) of the adopted rule set forth the general requirements for establishing and evaluating the reasonableness of rate-case expense requests. Subsection (d) then provides that the presiding officer shall disallow or recommend the disallowance of only those rate-case expenses that the commission has found to be not reasonably incurred. Subsection (d) then provides two specific methodologies to quantify such a disallowance in circumstances in which either the overall rate-case expenses were disproportionate, unwarranted or excessive, or when the presiding officer cannot reasonably determine the appropriate disallowance of unreasonable rate-case expenses associated with a particular issue. The commission finds that this approach is entirely consistent with the *Oncor* decision, and the commission declines to make any changes to the published rule on this basis.

2. Should rate-case expenses incurred for purposes of reducing a utility's commission-authorized Texas jurisdictional retail revenue requirement be allocated to and collected from ratepayers in a manner different from the allocation and collection of rate-cases expenses incurred for the purpose of shifting costs among

Texas jurisdictional retail customer groups? If so, how should the commission determine the amount and recovery method of the costs associated with these categories of expenses?

Water IOUs, State Agencies, the Alliance, OPUC, El Paso, TML, and Oncor Cities responded "no" to this question. State Agencies commented that there is no advantage to allocating rate-case expenses any differently among the classes on a functional basis and, additionally, doing so would add unnecessary complications and disputes to a review of rate-case expenses. The Alliance commented that the great majority of the municipal rate-case expenses are on revenue-requirement issues, which benefit all ratepayers, and trying to segregate rate design expenses from revenue-requirement expenses is inefficient and could increase the overall costs. The Alliance also noted that its participation in rate-making proceedings is not limited to a particular class of customers; rather, members of the Alliance participate in ratemaking proceedings with the interests of all ratepayers. OPUC commented that with regard to the way this question applies to a utility company, rate-case expenses related to shifting costs among customer groups should be paid by all classes. OPUC stated that utilities typically bring each class to cost in the cost-of-service study, only rarely applying other ratemaking principals such as gradualism. OPUC stated that the utility's interest is in recovering its costs, not in ensuring that a certain class is allocated costs in a certain way, and that carving out costs related to the allocation of expenses among the Texas retail rate classes would only add to the costs of the rate case and to its litigiousness, and where the line would be drawn is equally ambiguous.

With regard to these issues, OPUC raised the following points: Would one class be assigned more rate-case-expense costs because it has more intra-class issues at stake? If a class has more sub-classes, would that warrant a greater proportion of the costs because testimony would have to cover more topics? Would more costs be assigned to the class with the biggest rate increase? Would the calculation be based on the actual dollars or would it be based on who was furthest from unity? What if the utility proposed an intra-class allocation issue that was controversial and resulted in significant discovery, testimony, and briefing? OPUC stated that such issues vary from case to case, and that there is not a sufficient policy reason to justify treating these rate-case expenses differently from any other expense. OPUC submitted that the cost allocation derived in the rate case and approved by the commission is based upon the cost to serve each of the classes, and that no further delving down is necessary or appropriate. OPUC opined that applying the allocation from the rate case to the rate-case expenses is sufficient to ensure an equitable allocation of costs among the classes.

OPUC further stated that applying such a standard could also have a chilling effect on settlement negotiations if some parties feel hamstrung regarding their ability to negotiate without penalty. OPUC commented that a prudent attorney would have to consider whether to risk having rate-case expenses allocated more heavily to her class before asking the utility questions or engaging in negotiations with them.

OPUC also commented that the question also arises as to how it would be decided in any given case which class or classes would share these costs, as no set standard could reasonably be set forth in a rule because the focus may shift from case to case. OPUC stated that adding a new requirement of a different allocation of rate-case expenses for the portion related to cost allocation among classes would inevitably lead to a more adversarial litigation process, both in the rate case itself and in any rate-case expense docket.

Oncor Cities and the Alliance echoed these points, noting that as part of litigating rate-case expense amounts, parties would then need to propose (and respond to) possible allocation of those expenses within the classes. The Alliance also noted that tracking rate-case expenses related to specific issues would likely result in the expenditure of added expenses for little or no gain. Oncor Cities submitted that the current approach--allocation of the expenses to all retail customer classes in proportion to each class's share of the total revenue requirement--is straightforward, reasonable, and should continue.

El Paso commented that the question is predicated on two incorrect assumptions. The first incorrect unstated basis of this question assumes that a municipality represents an interest or interest of particular classes over other classes, rather than a fair allocation of costs among all customer classes. El Paso commented that the only statutory party charged with representing the interest of a particular class is OPUC, which is charged with representing the interest of residential and small commercial customers. Municipalities, particularly when considered with the statutory function of the regulator with original jurisdiction, do not specifically represent one class or group of customer classes. El Paso stated that the second incorrect unstated basis assumes that a party that disagrees with the position put forward by the company is attempting to shift costs among customer classes or groups, and that the utility is itself not attempting to shift costs. The assumption that one party or another is attempting to "shift costs" rather than recommend or pursue an allocation of costs that results in just and reasonable rates is never explicit in any evidentiary proceeding. El Paso stated that, moreover, it is probable that no witness on allocation of costs ever testifies that the proposed allocation results in anything other than just and reasonable rates.

Oncor Cities stated that rate-case expenses should be allocated and collected system-wide, regardless of whether the expenses were directed toward the utility's revenue requirement or toward cost allocation or rate design issues. Oncor Cities commented that, currently, municipal rate-case expenses are treated as a regulatory expense and are allocated to all retail customer classes in proportion to each class's share of the total revenue requirement, and that it is not clear how allocation of rate-case expenses to particular classes might work in some other manner, particularly given the fact that most participants in rate cases have accounts in several different rate classes.

Oncor Cities also commented that this question could be premised on the notion that municipal rate-case expenses in the cost-allocation and rate design phase of a case should be assigned to the classes in which municipal accounts are found, and that if so, that understanding of the issues fails to account for the complexity of the rate design issues in a rate case. Cities stated that municipal intervenors typically have delivery points in the lighting, small and large secondary, and even primary and transmission classes; but at the same time, Oncor Cities participate in rate cases to protect the interests of the residential, commercial, and even industrial customers within city limits. Oncor Cities additionally stated that municipal accounts are usually not the only accounts within a particular class, meaning that a city's efforts and success will also benefit non-city customers, and for these reasons, it makes little sense to allocate municipal rate-case expenses to particular classes based on a purported benefit to cities.

Oncor Cities further commented that if this question contemplates directly assigning cost-allocation and rate design rate-case expenses only to customers in participating municipalities, the case for such an allocation is even weaker. Oncor Cities stated that a city position that benefits a particular rate class benefits all customers in the class, not just the city accounts within that class, and that it would be inequitable to require customers within participating cities' boundaries to bear the expense of litigating that position alone. Oncor Cities noted that multiple other customers are usually found within all of a utility's rate classes, not just city accounts, and that this can even be the case in the lighting class, where other institutions or governmental bodies have accounts for different kinds of lighting. Oncor Cities submitted that a direct assignment of rate-case expenses only to customers in participating cities would be a punitive deterrent against city participation in ratemaking proceedings; also, allocating city rate-case expenses only to customers within the participating municipalities' boundaries would create a free rider problem because a city declining to participate in the case would exempt that city's ratepayers from the cost of participation, while all ratepayers within the rate class would still benefit from the work of any cities who do participate.

Oncor Cities also commented that collecting municipal rate-case expenses only from customers found within city limits would impair and needlessly complicate the retail electric market. Oncor Cities noted that in the Energy Efficiency Cost Recovery Factor cases processed in 2012, the commission considered whether to directly assign municipal intervenors' rate-case expenses to customers within the participating cities. Oncor Cities pointed out that the commission ultimately declined to allocate rate-case expenses in this manner, and in the course of that deliberation, Retail Electric Providers (REPs) filed a brief outlining their concerns. Oncor Cities stated that, according to the REPs, direct assignment of municipal rate-case expenses would "increase costs to all customers . . . by creating complexity and new administrative costs that all customers will pay," and that same dynamic would exist with respect to direct assignment of the cost of litigating cost-allocation and rate design issues, as doing so would create a patchwork of different city-by-city rate-case expense surcharges that would be costly and difficult for the retail electric market to navigate.

Oncor Cities also responded by noting that the question may be suggesting that the cost of pursuing cost allocation/rate design issues that are lost should only be recovered from the rate classes of the party pursuing such issues. Oncor Cities stated that the commission's current practice approximates the kind of allocation to which this question appears to be directed, and as noted above, the commission's current practice is to allocate rate-case expenses to the classes in proportion to their share of the revenue requirement. Oncor Cities commented that when a party litigates and loses a cost allocation/rate design issue, the relevant rate class bears a larger portion of the revenue requirement than if that party won the issue; accordingly, losing a cost allocation/rate design issue leads to the relevant class bearing a larger portion of the rate-case expense reimbursement. Oncor Cities submitted that much of what this question could portend is therefore already part of the commission's current practice on the allocation and collection of rate-case expenses.

TIEC expressed its position that all municipality rate-case expenses should be allocated and collected from customers solely within the corporate boundaries of the intervening cities. TIEC stated that customers outside cities have no ability to influence either the positions taken by intervening municipalities or the expenses incurred in advocating them, and while there may be benefits to other customers from revenue requirement adjustments identified by cities, there are many issues that industrial customers identify and litigate that also benefit other customers, but the costs of litigating these issues are not collected from other customers that are not TIEC members. TIEC stated that the commission should align the costs and benefits of each litigant's participation by assigning the costs of participation for cities to the customers that reside within those cities that have control over the participation; otherwise, municipality rate-case expenses act as an indirect tax for customers located outside the municipality's jurisdiction. TIEC commented that if the commission continues, however, to allocate municipalities' rate-case expenses to customers that are not within the municipality, this should apply only to revenue requirement issues, and not issues that shift costs from one class to another. TIEC noted that Oncor Cities primarily represent the interests of residential and commercial customers, who are often at odds with industrial customers on cost allocation issues; nonetheless, large customers pay municipality rate-case expenses for litigation and settlement of cost allocation and rate design issues. TIEC contended that to determine the amount of rate-case expenses associated with revenue requirement issues versus cost allocation issues, the commission should require municipalities to submit time records that track litigation costs by category, with sufficient detail for effective review. TIEC stated that as long as consultants and counsel are on notice of this requirement up front, it should not be difficult for municipalities to identify which litigation costs relate to revenue requirement disallowances, and which related to cost allocation and rate design.

TIEC further stated that, contrary to the statements of some municipalities in their initial comments, it is not accurate that municipalities represent the interests of all customer classes. TIEC pointed out that for various reasons related to siting, municipal fees and ordinances, and other issues, most industrial facilities are located outside municipal limits, and as a result, municipalities' interests have historically been biased in favor of residential and small commercial customers, and municipal cost allocation and rate design proposals have historically disadvantaged large, energy-intensive industrial customers. TIEC expressed its belief that while municipalities' rate-case expenses should all be borne by customers within the city limits, as discussed above, municipalities' disparate representation of smaller customers makes it particularly appropriate for any rate-case expenses related to cost allocation and rate design to be borne by municipal customers, rather than shifted to other customer classes to whom the municipalities' interests are adverse.

Houston and OPUC stated strong disagreement with TIEC on these points, with Houston stating that allocating municipal rate-case expenses solely to customers in intervening cities is unjust, discriminatory, and would harm all ratepayers. OPUC noted that TIEC's position ignores the benefits that customers outside municipal boundaries receive when municipalities participate in rate cases. Houston and El Paso additionally commented that if a rate case is filed with a city exercising its regulatory authority, the city is obligated to evaluate the rate-change request. Houston also pointed out that if a rate application is filed in which the utility seeks system-wide rates, municipal regulators have no option but to consider and review the rate filing package inclusive of both environs and municipal customers, and Houston stated it is not aware of any claims that the overall worth of municipal actions in rate proceedings does not provide benefits to all ratepayers.

Joint Utilities stated that to the extent utilities or municipalities unreasonably incur rate-case expenses in the rate design portion of a proceeding, those unreasonable costs can be disallowed based on the factors provided in subsection (c) of the proposed rule. Joint Utilities stated, however, that the commission should retain the discretion to allocate reasonable rate-case expenses to particular customers if there are compelling reasons to do so. Joint Utilities argued that, for example, if a municipality participates in a commission proceeding for the sole purpose of pursuing a theory of allocation of costs that would benefit only its citizens, the commission should retain the discretion to allocate that municipality's rate-case expenses to the citizenry of that municipality; similarly, if a non-municipal intervenor pursues frivolous arguments causing the utility or municipalities to incur additional rate-case expenses, the commission should have the discretion to assign the utility's or municipality's rate-case expenses incurred to defend against such claims to the customer classes represented by the party causing such expense. Joint Utilities commented that the commission may retain its discretion to make such allocation decisions by either addressing that issue in each case as needed and not addressing it in the rule, or by adding appropriate language to the rule.

Oncor Cities commented in reply that Joint Utilities cannot have it both ways by expressing a willingness to have cities' rate-case expenses directly assigned in a manner to which Joint Utilities object when it comes to their own rate-case expenses.

Commission response

The commission agrees with the comments of TIEC that municipal participants often favor the interests of certain customers or customer classes over others, and may incur significant rate-case expenses litigating positions that do not benefit all ratepayers. Requiring the collection of municipal rate-case expenses related to revenue allocation and rate design issues from all customers may, in some cases, introduce significant inequities. Accordingly, in some cases, it may be preferable to assign the cost of litigating certain issues to in-city customers.

However, the commission finds that these issues should be assessed on a case-by-case basis. Accordingly, the commission declines to mandate a specific treatment for the allocation and collection of rate-case expenses based upon a division between revenue requirement-related expenses and allocation-related expenses in the adopted rule. The commission agrees with Joint Utilities that the commission should retain the discretion to allocate reasonable rate-case expenses to particular customers if there are compelling reasons to do so. The commission finds that it continues to possess the broad discretion to allocate rate-case expenses to particular customer groups in individual proceedings in which such treatment may be appropriate under the rule as adopted.

The commission disagrees with the comments of OPUC, Oncor Cities, and the Alliance that it would be unduly burdensome to require the segregation of and accounting for rate-case expenses based upon a division between revenue requirement issues and allocation issues in all proceedings. As discussed below, the commission has determined that it is appropriate to incorporate a new subsection (b)(6) into the adopted rule, that requires the parties to specify those rate-case expenses reasonably associated with each issue in a proceeding.

3. Should the commission require that rate-case expenses be evaluated in the proceeding in which they are incurred unless the commission authorizes their consideration in a future proceeding?

OPUC, State Agencies, El Paso, and Houston generally responded affirmatively to this question. OPUC and Houston commented that in some proceedings, especially those that end in settlement, inclusion of rate-case expenses is appropriate; in other cases in which the rate-case expenses would be better evaluated in a separate docket, commission authorization is appropriate. OPUC stated that, depending on the facts of a particular case, there can be appropriate circumstances for either considering the rate-case expenses in the same proceeding in which they occurred or in a future proceeding, and it is appropriate for the commission to adopt a rule that retains the flexibility to handle either situation.

OPUC, El Paso, and Houston stated that requiring commission authorization to defer consideration of rate-case expenses until a future proceeding reduces uncertainty and is appropriate because of the inequities at risk in deferring expenses to the future. El Paso and Houston opined that it should be less costly to determine the expenses in the context of the proceeding for which they are incurred, rather than an additional proceeding convened expressly for that purpose.

State Agencies commented that because the commission has determined that it will not allow rate-case expense based upon estimates of future costs, and costs continue to accrue through the hearing and post-hearing proceedings, the commission generally authorizes the severance of rate-case expenses into a separate proceeding. State Agencies commented that while this allows costs to be fully explored through the ordinary discovery process, parties can and should retain the ability to settle rate-case expenses as part of a total rate-case resolution.

The Alliance stated that it believes that the current process, where the commission defers the review of rate expenses to a later proceeding, has worked well. The Alliance commented that the current process allows the parties and the fact finder to focus on completing the rate case, rather than simultaneously reviewing the rate-case expenses as well; furthermore, the final tally of the rate-case expenses for the proceeding before the commission is not available until well after the record is closed, given that parties file briefs, exceptions, and motions for rehearing. The Alliance suggested that should the commission move to a process where rate-case expenses are evaluated in the proceeding in which they are incurred, the commission should revisit its current practice of not allowing recovery of estimated rate-case expenses. TML agreed with this point.

Oncor Cities commented that the commission's current practice is to consider parties' rate-case expense requests in a severed proceeding, separate from the underlying rate case, and that since 2011, municipalities are not permitted to recover amounts that are estimated to be necessary to complete a case or to participate in the appellate process. Oncor Cities commented that under the prior practice, rate-case expenses were an issue in the actual rate case, with the commission quantifying an estimate for municipal intervenors to complete the case (and participate in any appeals) subsequent to a specified quantification date. Oncor Cities commented that intervenors in such cases did not receive any of the estimated reimbursement amounts until the associated work was performed and the invoices were submitted to the utility; instead, the estimate represented a budget for that work that was found to be reasonable in the underlying rate case. Oncor Cities expressed its continued support for this pre-2011 approach to quantifying rate-case expenses, and

stated that, provided that municipal intervenors may quantify a cost estimate for work completed after the rate-case expense quantification date, this approach results in no further litigation of parties' rate-case expenses and resolves all related issues in one proceeding. Oncor Cities submitted that the current practice of severing expenses into a separate proceeding conducted after the underlying rate case prolongs litigation and increases parties' expenses, and it provides no feasible means of recovery of the cost of municipal intervenors' participation in the appellate process, a cost which is recoverable pursuant to PURA §33.023(a)(2). Oncor Cities stated that without quantification of a reasonable estimate for such work, municipal intervenors must wait until the utility's next rate case to seek recovery of their appellate expenses related to the utility's last case, and in the current era of the commission, the time between rate cases can be significant, leaving municipal intervenors no means to recover the cost of appealing those cases in the intervening time. Oncor Cities noted that instances of municipalities initiating a rate case via a show cause proceeding are relatively rare, consisting of approximately four such cases, and if municipal intervenors would otherwise be required to wait a number of years between rate cases filed by the utility that serves them, those municipalities might be compelled to initiate rate cases simply to recover their reasonable rate-case expenses from the utility's prior case. Oncor Cities stated that quantification of reasonable rate-case expenses during the underlying rate case, and allowance of an estimate, is preferable to this costly and involved route.

LCRA and Water IOUs stated that while they believe the better practice is to require that rate-case expenses be evaluated in the proceeding in which they are incurred, it is not necessarily always the best approach. Water IOUs recommended that the commission refrain from making this a requirement in the rule. LCRA stated that this general approach has been followed in its three most recent rate cases and has worked efficiently, but noted that in two of these three cases, the commission also authorized consideration of certain rate case related expenses in a future rate proceeding to the extent these rate-case-related expenses were incurred after a specific date established by the commission. LCRA and Water IOUs commented that despite what may be considered a better practice, unforeseen circumstances may require the consideration of rate-case expenses not previously authorized and a utility should be given the opportunity to demonstrate in a separate proceeding--however difficult that may be--that its rate-case expenses are reasonable. LCRA stated that the commission should not enact a hard and fast rule that precludes consideration of post-hearing rate-case expenses.

Mr. Baron commented that the commission should consider the converse of the approach indicated in the question--that is, the commission should direct that rate-case expenses be evaluated in a follow-up proceeding unless the commission authorizes otherwise. TML agreed with this point, and the Alliance commented that the commission should retain the option of reviewing rate-case expenses in a separate proceeding once all the rate-case expenses are quantifiable.

Joint Utilities responded "no" to the question, stating that rate-case expenses can be incurred in proceedings before municipal regulators, in cases before the commission, or in courts on appeal of rate decisions. Joint Utilities noted that, as discussed in *Oncor,* PURA provides for recovery of reasonable rate-case expenses in each of these scenarios, and while some rate-case expenses incurred at the commission can be evaluated in the proceeding in which they are incurred (although sometimes even those expenses are intentionally severed for consideration at a later time), some rate-case expenses are not available for review by the commission until they are presented in a later proceeding--as is the case in municipal proceedings that do not get appealed to the commission (which was the subject of the *Oncor* case), or in appeals of rate decisions to the courts (that may or may not result in a remand proceeding where those expenses can be reviewed).

Joint Utilities submitted that the simplest solution to address the various scenarios in which reasonable rate-case expenses can be incurred is for the commission to include language in the proposed rule that allows a utility to either seek recovery of rate-case expenses in the proceeding in which they were incurred or create a regulatory asset for those expenses and defer cost recovery until the next general rate case or a proceeding brought solely to review rate-case expenses. Joint Utilities opined that this approach would allow utilities the opportunity to recover their reasonable rate-case expenses regardless of the scenario in which they were incurred, consistent with *Oncor* and PURA.

El Paso commented that the commission should reject Joint Utilities' proposal for a regulatory asset, and argued that if the utility takes the position that it will not reimburse the municipality until a finding of reasonableness by the commission, that municipality can be left waiting years for a proceeding to finish and get reimbursed. El Paso stated that under Joint Utilities proposal, the utility earns a return on the time value of its funds, but the municipalities are left waiting, with no compensation for the wait.

The REP Group did not take a position on whether the commission should evaluate rate-case expenses in the original proceeding or authorize a future docket for their consideration, but stated that if the commission chooses to authorize the consideration of such expenses in a future proceeding, the filing utility should be required to provide adequate notice of the resulting rate-case expenses. The REP Group recommended that the affected utility provide notice to REPs of the approved rates not later than the 45th day before the date the rates take effect, as a 45-day notice requirement will allow REPs to incorporate the new rate-case expense amount into their invoices to end-use customers. The REP Group noted that 45 days has been generally recognized in commission rules as providing a sufficient amount of time for to REPs to adjust business processes and prices to incorporate rate revisions. The REP Group additionally commented that the time periods in which changes in rates for rate-case expense can take effect should be limited, and that any approved rate-case expenses should be implemented on a semi-annual basis at most. The REP Group stated that a limitation of rate-case expense implementation to a semi-annual basis would help limit the number of times that a REP may revise its rates as a result of changes to the rate schedule of a utility, and suggested that the appropriate schedule for any rate-case expense adjustments would be March l and September l, consistent with the regularly scheduled semi-annual Transmission Cost Recovery Factor (TCRF) updates.

Commission response

The commission declines at this time to mandate that rate-case expenses be evaluated in the proceeding in which they are incurred. Conversely, the commission also declines to adopt the comment by Mr. Baron that the commission direct recovery of rate-case expenses in a follow-up proceeding unless the commission otherwise authorizes. The commission agrees with the comments of a number of parties that the issue of whether rate-case expenses should properly be considered in the same pro-

ceeding or in a separate, future proceeding depends on the specific circumstances of the request. Accordingly, the commission declines to adopt any changes to the published rule that would limit its general flexibility in addressing the appropriate process of reviewing and awarding rate-case expenses.

The commission also declines to adopt Joint Utilities' proposal to amend the published rule to authorize the creation of a regulatory asset for those expenses and defer cost recovery until the next general rate case or a proceeding brought solely to review rate-case expenses. The commission agrees with El Paso that such a mechanism could potentially allow utilities to earn a return on the time value of its funds while potentially delaying municipalities from recovering their own reasonable rate-case expenses with similar interest. The commission also reiterates that it retains the authority to authorize the creation of these types of regulatory assets if the circumstances warrant, but does not conclude that a general rule is appropriate at this time.

4. Is it appropriate for intervening municipalities to be subject to P.U.C. SUBST. R. §25.245(d)(3)(B) as proposed?

El Paso, State Agencies, Oncor Cities, the Alliance, and Houston responded "no" to this question. El Paso, Houston, and the Alliance noted that because the municipality has the obligation to evaluate all the issues in a proceeding, such a rule would controvert the statutory responsibility of the municipalities. El Paso additionally commented that the complexity of the case as well as the determination of rate-case expenses will actually cause more expenses that must be tracked issue-by-issue. State Agencies and Oncor Cities commented that tying municipal rate-case expenses to success in achieving a specific outcome runs counter to PURA, and that the legislature has determined that municipal regulatory authorities should be provided with resources to review a rate filing and *shall* be entitled to have their reasonable expenses reimbursed. State Agencies, Houston, and Oncor Cities noted that restricting a municipality's ability to be reimbursed for its costs of reviewing and litigating its position would put it at a disadvantage that the legislature did not intend, with Oncor Cities further noting that the rule would penalize cities merely for losing issues in a case. Houston further noted that the rate-case expenses borne by ratepayers are typically minimal compared to the benefits achieved through municipal intervention.

The Alliance commented that municipalities do not control the issues raised by a utility, but respond to the proposed increases, and that penalizing the municipalities for trying to minimize increased costs for ratepayers is unfair. The Alliance stated that a more equitable approach is to maintain the status quo, where the finder of fact decides on a fact-specific basis whether the municipalities' rate-case expenses are reasonable.

Mr. Baron responded that the proposed subsection (d)(3)(B) is not needed and should be omitted if the rule requires utilities and municipalities to track their actual rate-case expenditures by issue. Mr. Baron stated that if a municipality unreasonably litigates an issue with no reasonable basis in law, policy, or fact, the municipality's litigation expenses can and should be disallowed. El Paso expressed general agreement with these points, and stated that a municipality's expenses should not be subject to the formulaic concepts in proposed subsection (d).

Joint Utilities, LCRA, and Water IOUs responded "yes" to this question, although these commenters expressed the position that subsection (d) should not be adopted. These commenters stated that if the commission adopts subsection (d), it and all other provisions in the rule should be applied equally to utilities and municipalities. Joint Utilities noted that, consistent with PURA, the *Oncor* decision establishes that both utilities and municipalities are entitled to recover their reasonable rate-case expenses. Joint Utilities further commented that although PURA provides that utilities "may" recover their reasonable expenses, the court in *Oncor* interprets PURA as *requiring* that utilities be allowed to recover those expenses pursuant to the mandate in PURA §36.051 that utilities *shall* recover their overall revenues necessary to earn a return over their reasonable and necessary expenses. Joint Utilities stated that there is therefore no distinction between utilities and municipalities under PURA once reasonableness is established, and there should be no distinction under the commission's rules in determining the reasonableness of those expenses.

Commission response

As discussed in the commission's response to comments on subsection (b) below, the commission concludes that it is appropriate for utilities and municipalities to track their rate-case expenses by issue and provide, as part of their application to recover rate-case expenses, the specific issue or issues in the rate case and the amount of rate-case expenses reasonably associated with each issue. The commission further agrees with the comments of Mr. Baron that the proposed subsection (d)(3)(B) is generally not needed in such circumstances. The commission disagrees, however, that such a provision is not needed altogether. Instead, as discussed more fully below, the commission revises the rule such that the Issue Specific Method, as set forth in subsection (d)(3)(B), may be applied to a municipality only in those circumstances in which the commission finds a disallowance of certain municipal rate-case expenses is appropriate and the municipality has failed to specify the amount of rate-case expenses reasonably associated with that particular issue or issues.

The commission disagrees with those commenters that suggest that applying the Issue Specific Method to municipalities would controvert the statutory responsibility of municipalities in rate proceedings. The commission again notes that the Issue Specific Method may only be applied in circumstances in which a municipality has both unreasonable expenses and has failed to specify the amount of rate-case expenses reasonably associated with the particular issue or issues for which the commission has determined a disallowance is appropriate. Further, in evaluating the reasonableness of a party's rate-case expenses, the rule, as revised, explicitly directs the presiding officer to consider the relevant factors listed in subsection (b) and any other factor shown to be relevant in a proceeding. As such, municipalities remain free under the commission's rule to argue in each proceeding that their expenses were reasonable given their statutory obligations or the nature of the utility's particular filing. Finally, the commission notes that the Issue Specific Method is discretionary, and the commission anticipates that it will be applied solely in circumstances in which the application of this methodology will result in the disallowance of unreasonable municipal rate-case expenses.

The commission also disagrees with State Agencies and Oncor Cities that the application of subsection (d)(3)(B) to a municipality would violate PURA §33.023(b), which states that municipalities shall be entitled to have their reasonable rate-case expenses reimbursed. As discussed above, the Issue Specific Method would only be applied to a municipality in the quantification of unreasonably incurred rate-case expenses in situations in which the municipality failed to specify the issue or issues with which those

rate-case expenses were reasonably associated. Conversely, subsection (d)(3)(B) would not be used to disallow any reasonable rate-case expenses. Accordingly, the commission finds that subsection (d)(3)(B), as adopted by the commission, is consistent with PURA §33.023(b).

The commission further agrees with other commenters such as the Alliance that the commission's rule should require the determination on a fact-specific basis whether a municipality's rate-case expenses are reasonable. Again, the rule as adopted retains the commission's flexibility in evaluating the reasonableness of a municipality's rate-case expenses in each proceeding. At the same time, however, the rule as adopted also puts those municipalities on notice that municipal rate-case expenses could potentially be subject to reductions based on the value of specific issues in a proceeding if the municipalities fail to present sufficient evidence under the adopted subsection (b)(6) for the commission to determine the issue or issues with which their unreasonable rate-case expenses were reasonably associated. The commission agrees with Joint Utilities, LCRA, and Water IOUs that it is appropriate for the commission to retain the discretion to apply the Issue Specific Method to requests filed by municipalities, as well as utilities, in these circumstances.

Comments on Specific Sections of the Rule

Section (a) Application.

This section applies to municipalities and utilities requesting recovery of or reimbursement for rate-case expenses pursuant to Public Utility Regulatory Act (PURA) §33.023 or 36.061(b)(2).

Mr. Baron suggested the reference in subsection (a) of the proposed rule to PURA §33.023 should specifically reference subsection (b) of that section of PURA and suggested restating the first sentence of the subsection to read as follows: "This section applies to electric utilities requesting recovery of expenses for ratemaking proceedings (rate-case expenses) pursuant to Public Utility Regulatory Act (PURA) §36.041(b)(2) and to municipalities requesting reimbursement for rate-case expenses pursuant to PURA §33.023(b)." Mr. Baron further commented that his proposal to provide "rate-case expenses" as a defined term would clarify that the term "rate-case expenses" refers specifically to expenses incurred in ratemaking proceedings, a term that is defined in PURA §11.003(17). Mr. Baron also commented that subsection (a) should be modified to clarify that the new rule will apply to rate-case expenses incurred in rate cases initiated on or after 90 days following the date on which the rule is adopted in order to provide parties with adequate advance notice of the rule's requirements.

State Agencies responded that Mr. Baron's suggested 90-day delay for applying the rule is unwarranted. State Agencies commented that the commission's order in *Application of Entergy Texas, Inc. for Rate Case Expenses Pertaining to Docket No. 39896,* Docket No. 40295 (Docket No. 40295) and the rulemaking process leading up to publication of this proposed rule indicate that utilities and municipalities have already been on notice regarding the proposed rule.

Commission response

The commission agrees with Mr. Baron that the reference in subsection (a) of the proposed rule to PURA §33.023 should properly reference subsection (b) of that section of PURA. The commission also adopts Mr. Baron's more precise statement of the entities affected by the new rule and the applicable provisions of PURA by striking the sentence in the published version of subsection (a) and replacing it with the following sentence: "This section applies to utilities requesting recovery of expenses for ratemaking proceedings (rate-case expenses) pursuant to Public Utility Regulatory Act (PURA) §36.061(b)(2) and to municipalities requesting reimbursement for rate-case expenses pursuant to PURA §33.023(b)." As recommended by Mr. Baron, the commission finds that this change clarifies that the term "rate-case expenses" refers specifically to expenses incurred in ratemaking proceedings, a term that is defined in PURA §11.003(17).

The commission declines to adopt any other proposed changes to this section. The commission agrees with State Agencies that an additional 90-day delay after the effective date of this rule is unnecessary to put parties on notice regarding the new rule's requirements. Additionally, the commission notes that the proposed rule will only apply to applications filed after the effective date of the rule and will not be applied retroactively.

Section (b) Requirements for claiming recovery of or reimbursement for rate-case expenses.

In any rate proceeding, a utility or municipality requesting recovery of or reimbursement for its rate-case expenses pursuant to PURA §33.023 or §36.061(b)(2) shall have the burden to prove the reasonableness of such rate-case expenses by a preponderance of the evidence. In order to establish its rate-case expenses, each utility or municipality shall detail and itemize all rate-case expenses and shall provide evidence, verified by testimony or affidavit, showing the reasonableness of the cost of all professional services, including but not limited to:

Mr. Baron recommended changes to subsection (b) that would define how a utility or municipality would establish its prima facie case. Mr. Baron also proposed deleting "In any rate proceeding" and "pursuant to PURA §33.023 or 36.061(b)(2)" from the first sentence of subsection (b) as published and to restate the second sentence as follows: "To establish its prima facie case, each utility or municipality shall detail and itemize all rate-case expenses for which recovery or reimbursement is requested, including but not limited to costs for attorney and other professional services, lodging, meals and beverages, and transportation." Mr. Baron proposed further changes to the third sentence of this paragraph to delete "including but not limited to" and replace it with the following language: "The evidence shall address" Mr. Baron commented that these changes would clarify that a utility or municipality must present evidence addressing, at a minimum, the issues listed in subsection (b).

Mr. Baron further commented that a more complete list of the evidence that must be provided to determine reasonableness and allowed expenses should be consolidated from subsections (b) and (c) into one subsection. Mr. Baron commented that some references to relevant evidence appear in subsection (b) while some appear in subsection (c). Mr. Baron proposed to better specify in subsection (b) the list of issues that an application must address. Specifically, Mr. Baron's proposed subsection would instruct the municipality or utility to provide evidence addressing (1) the extent of responsibilities assumed by the attorney or other professional in the rate case; (2) the time and labor required and expended by the attorney or other professional; (3) the rates or other consideration paid to the attorney or other professional for the services rendered; (4) the benefits to the client from the services rendered; and (5) the nature and scope of the rate case, including the size of the utility and number and type of customers served, the amount of money or value of property at stake, the novelty and complexity of the issues addressed, the amount of discovery, and the occurrence and length of a hearing. As dis-

cussed below, Mr. Baron proposed retaining subsection (c) as a list of bases for the presiding officer to recommend a disallowance.

Joint Utilities replied that they are not opposed to Mr. Baron's revisions that clarify the rule by appropriately focusing on the evidence presented, the parameters of the reasonableness inquiry, and the calculation of disallowances based strictly on the amount of expenses actually incurred and shown to be reasonable and necessary by the record evidence as applied to the factors and criteria in subsections (b) and (c) with changes to certain provisions of his proposed rule language.

OPUC also replied that by revising the language to state that the utility or municipality establishes its prima facie case by submitting certain evidence, Mr. Baron's proposal essentially shifts the burden of proof from the utility or municipality to the other parties to show that certain rate-case expenses should not be recovered. OPUC argued that this momentous shift is poor public policy in that it removes part of the incentive for the utility or municipality to submit thorough, comprehensive evidence of its expenses; instead the utility or municipality could merely show that it has met the minimum requirements to submit *some* evidence on each factor, regardless of its adequacy, and the burden would then be on the other parties to point out the deficiencies. OPUC pointed out that Mr. Baron's proposed change is contrary to the direction taken in recent commission cases where it has requested more information from the parties on expenses, indicating that sufficient information is not initially being submitted.

State Agencies replied that Mr. Baron's significant changes to the commission's proposed rule would effectively neutralize the meaningful review that the proposed rule was designed to effectuate and that his revisions, taken as whole, would detrimentally restrict the discretion of the commission to review rate-case expenses that will ultimately be borne by ratepayers. State Agencies argued that Mr. Baron's suggested revisions to subsection (b) first act to shift the burden of proof by establishing (without explanation) what amounts to a presumption that rate-case expenses are reasonable, a "prima facie" case achievable simply through filing a laundry list of information along with an affidavit, with no presiding officer determining whether the preponderance-of-evidence standard has been met. State Agencies pointed out that having set up a "prima facie case" presumption, Mr. Baron's subsequent revisions narrow the reasons that a presiding officer may rely upon to review and disallow any of the costs included in the "prima facie case" and that these revisions simultaneously raise the ratepayers' burden of proof.

State Agencies noted that as an example, under Mr. Baron's proposal, travel-related expense can be disallowed only if "extreme or excessive," notwithstanding any evidence that it was unnecessary to use higher cost alternatives because lower cost alternatives were readily available. State Agencies commented that none of Mr. Baron's proposals, limited only to reviewing the reasonableness of costs, incorporate the essential analysis of whether claimed rate-case expenses were also *necessary* for participation in a rate case and that in any event, customers' responsibilities for costs should generally be far below that which rises to the level of "extreme or excessive." State Agencies argued that substitution of Mr. Baron's proposal for the commission's would not be in the public interest, because his revisions create a presumption that costs are reasonable and heighten the standard of evidence required for disallowance while also infringing on the commission's discretion to assess whether rate-case expenses are both reasonable and necessary, and the flexibility to address disallowances as the facts of a particular case may warrant.

With respect to subsection (b), the Joint Utilities recommended deleting Mr. Baron's proposed subsection (b)(5)(A), which lists "the size of the utility and number and type of customers," on the basis that a utility's size or customer count has no bearing on the reasonableness or necessity of the expenses incurred.

Mr. Baron further proposed that subsection (b) would include an additional sentence requiring that documents and other evidence be organized and detailed to enable a determination of the amount of expenses incurred for each major issue litigated in the rate case. Mr. Baron noted that such a requirement would provide accuracy in the event the commission were to disallow litigation costs related to a specific issue. Mr. Baron noted that, for example, if this information had been presented in Docket No. 40295, it would not have been necessary for the commission to resort to the application of the Issue Specific Method.

Joint Utilities requested that, if the commission chooses to require that documents and other evidence be organized and detailed to enable a determination of the amount of expenses incurred for each major issue litigated in the rate case, that the commission limit this provision by inserting the phrase "to the extent practical."

Houston replied that it recognizes and appreciates the concerns Mr. Baron's proposed record-keeping requirement attempts to address, but that the recommendation presents a concern because requiring such a level of detail in each instance would be extremely burdensome and is not practical. Houston expressed concern that the proposed record keeping-requirement would potentially increase rate-case expenses and that due to the often abbreviated time-frame for review, requiring the allocation of additional time to record keeping, above and beyond the current level, would potentially interfere with the municipality's ability to conduct a comprehensive review of the rate filing package. Houston argued that the proposal does not consider that many activities are not related to a specific issue (*e.g.,* reading the filing), and that some efforts do not always result in an issue being raised for litigation purposes *(e.g.,* an issue turns out to be cost ineffective to pursue further or there is insufficient time available to adequately develop the issue). Houston further noted that the time to retain attorneys and consultants, review the filing, identify potential issues, develop information requests, review responses, perform analyses and develop written testimony is very limited due to the schedules mandated by state law and if attorneys and consultants are required to allocate time for each major issue during the review and analysis of a rate filing package, the potential result is a less comprehensive review and an increase in overall rate-case expenses. Houston pointed out that Mr. Baron's comments do not identify, nor is Houston aware of, any meaningful historical problem in this area applicable to the municipal regulator.

Oncor Cities replied that Mr. Baron's proposal is unnecessary, costly, and nearly impossible to accurately implement because not all time is spent by attorneys or even experts working on discrete issues in isolation and that large amounts of time are required to perform work not directly linked to a specific, major issue. Oncor Cities cited examples like an expert reviewing a utility's rate filing package in its entirety before issues are even fully developed or an expert preparing basic discovery requests to ask for clarification or supporting documentation for portions of the rate filing package. Oncor Cities pointed out similar examples for attorneys performing work not associated with particular

substantive issues like preparation of lists of issues, negotiating procedural schedules, attending prehearing conferences, conducting settlement negotiations, and counseling intervenor cities on their exercise of original jurisdiction prior to consolidation of the city-level case with the associated commission appeal. Oncor Cities argued that even in other more issue-oriented tasks, parceling out total time spent into specific issue categories would be burdensome, such as attempting to track time spent on a wide-ranging, day-long deposition of an expert that addresses a number of issues. Oncor Cities noted that many ratemaking issues are complex and interconnected, and it would be difficult if not impossible to determine how to divide up the associated time spent. For those reasons, Oncor Cities recommended against the adoption of Mr. Baron's proposal on this point.

El Paso replied that Mr. Baron seeks to impose a requirement that is inconsistent with the type of review that must be accomplished by municipalities, or for that matter, the process by which a utility assembles a case. El Paso noted that the municipality is presented with a rate case filing that includes the testimony of many witnesses, a large number of schedules and many volumes of material that must be reviewed as a part of its analysis of the case. El Paso argued that the matters that may need to be more carefully evaluated, and perhaps disallowed, are often not evident until such time as the discovery process is far along and that Mr. Baron's proposal does not limit expenses, but instead it makes the process of record keeping more difficult and will add to the expense if adopted. El Paso stated that the reasonableness question has arisen in potential detail in instances in which an argument or position may have been brought in violation of SOAH Rule §155.303, should that occur and that for the same reasons that proposed subsection (d) should not be adopted, Mr. Baron's proposed amendment to subsection (c) should not be adopted.

LCRA opposed Mr. Baron's proposal for several reasons, the first of which was that while some issues can be considered "major" from the beginning of a rate case, others become "major issues" when other parties choose to litigate them later in the course of the proceeding, and so a utility may not be able to organize its rate-case expenses at the beginning of a case in a manner that is consistent with the issues that ultimately become "major" issues only after litigation begins. LCRA also replied that requiring that every person who works on a rate case to record his or her time by issue would affect the number of time records that would need to be kept and increase the chances that a legitimate expense could be waived or forfeited simply because it was misfiled in the wrong category or given a more general description. LCRA argued that not only is it unreasonable to require the amount of effort necessary to describe activities by "major issue," but mandating such detailed information on invoices, and then requiring that those invoices be filed or produced in discovery during a case could provide a roadmap to counsel's litigation strategy by providing a window into the time and effort a party's outside counsel or experts are spending on certain issues while the those issues are still being adjudicated. LCRA stated that this is inappropriate and the commission should reject recommendations that documents and evidence related to rate-case expenses be kept by issue.

Water IOUs replied that Mr. Baron's proposal is impractical, unwieldy, and unworkable since multiple issues are often worked on simultaneously.

State Agencies replied that Mr. Baron inaccurately perceives that the utility's problem in Docket No. 40295 was simply the failure to document specific costs for specific issues "because the utility lacked notice of any requirement to segregate costs by issue." State Agencies argued that this issue-allocation becoming part of the "prima facie case" that Mr. Baron proposed has a surface appeal. State Agencies noted that the primary objective of such record-keeping is expressly stated by Mr. Baron: to "obviate the need" for the commission to use an important tool in the exercise of its discretion, the "Issue Specific" method in subsection (d) of the proposed rule. However, State Agencies stated that, leaving aside the practical problems of whether and how that could be done, this record-keeping exercise plainly would increase rate-case expenses.

OPUC recommended deleting or limiting the provision allowing expenses to be proven or verified by affidavit. OPUC pointed out that if the costs supported by affidavit become an issue, allowing affidavits to suffice as support impairs the other parties' ability to question the sponsor of the evidence through discovery and cross-examination and that under the Texas Rules of Evidence, affidavits are hearsay. OPUC recognized that there may be circumstances in which affidavits might prove useful, for instance if the commission wishes to allow the use of affidavits in order to increase the efficiency of the process and reduce costs. OPUC commented that the rule should include a provision allowing parties who contest the evidence verified by affidavit to have discovery answered by the affiant or an expert witness and be allowed to cross-examine the affiant or an expert witness who can adopt the statements made by the affiant. OPUC suggested that in the alternative, the rule could include a provision allowing for verification by affidavit when the rate-case expense request is unopposed.

Joint Utilities commented that they support language in the rule that allows a utility or municipality to support its evidence by affidavit but that they do not oppose a requirement that the affiant be made available for cross-examination.

Commission response

Comments relating to the burden of proof in rate-case expense proceedings

The commission declines to adopt the additional language proposed by Mr. Baron that relates to the establishment of a prima facie case for the recovery of rate-case expenses. The commission agrees with OPUC and State Agencies, which stated that Mr. Baron's proposed language shifts the burden of proof from the utility or municipality to the other parties to show that certain rate-case expenses should not be recovered. The commission agrees with OPUC and State Agencies that Mr. Baron's proposed changes could unduly restrict the commission's discretion to consider the full range of evidence necessary to evaluate the reasonableness of a particular request for the recovery of rate-case expenses by in essence establishing a limited list of evidence necessary to present a "prima facie" case. The result would be to shift the burden to parties challenging the reasonableness of particular expenses and potentially preclude the commission from disallowing certain items that have met the threshold test but would be unreasonable upon full consideration of all relevant evidence.

The commission instead adopts the following sentence in place of the second sentence of subsection (b) of the published rule: "A utility or municipality seeking recovery of or reimbursement for rate-case expenses shall file sufficient information that details and itemizes all rate-case expenses, including, but not limited to, evidence verified by testimony or affidavit, showing," which, as

discussed below, will be followed by a list of evidence that must be presented in order for an application to be considered to be sufficient for further processing. The commission finds that this change specifies clearly that the burden of proof to establish the reasonableness of particular rate-case expenses is not shifted away from the party requesting recovery of or reimbursement for its rate-case expenses and better notifies parties of the evidence necessary to constitute a sufficient application. While recognizing the comments provided by parties who indicated that some of the language proposed by Mr. Baron was unduly restrictive, the commission finds that adoption of this provision does not restrict the commission's discretion. The commission notes that subsection (b) as adopted now merely lists the evidence that must be presented in a complete application, but subsection (c) states that the presiding officer shall consider all relevant factors, including those not listed in subsection (b).

New criteria adopted in subsections (b)(1) - (5)

The commission finds that many of Mr. Baron's proposed changes to the list of evidentiary requirements in subsection (b) are meritorious. Mr. Baron proposed deletion of the list present in the published version of subsection (b) and adoption of his proposed list of evidentiary requirements. Mr. Baron's proposed list would instruct the municipality or utility to provide evidence addressing (1) the extent of responsibilities assumed by the attorney or other professional in the rate case; (2) the time and labor required and expended by the attorney or other professional; (3) the rates or other consideration paid to the attorney or other professional for the services rendered; (4) the benefits to the client from the services rendered; and (5) the nature and scope of the rate case, including: (A) the size of the utility and number and type of customers served, (B) the amount of money or value of property at stake, (C) the novelty and complexity of the issues addressed, (D) the amount of discovery, and (E) the occurrence and length of a hearing.

The commission adopts item (1) from Mr. Baron's proposed list but rewords it to state "the nature, extent, and difficulty of the work done by the attorney or other professional in the rate case" in order to better reflect the range of factors regarding which evidence should be submitted. The commission adopts item (2) from Mr. Baron's proposed list. The commission also adopts item (3), but, for the same reasons discussed regarding subsection (c)(1) of the proposed rule, the word "rates" is changed to "fees." Additionally, the commission adopts item (5) as proposed by Mr. Baron but changes "the amount of discovery" to "the amount and complexity of discovery" in order to better clarify that both the amount and complexity of discovery are both relevant factors for the presiding officer's consideration.

The commission agrees with Mr. Baron, who stated that that these changes consolidate into one subsection a more complete list of the evidence that must be provided relating to the factors that will be considered. The commission finds that the revised evidentiary requirements require the presentation of all of the factors listed in the rule as published, except for the issue of the benefits to clients from the services rendered, but explains in better detail and with more clarity precisely which issues a complete application will address.

Additionally, the commission declines to include in the first two sentences of subsection (b) Mr. Baron's proposed language referring to costs for attorney and other professional services, lodging, meals and beverages, and transportation. Instead, the commission inserts the requirement to present evidence regarding costs for attorney and other professional services, lodging, meals and beverages, and transportation as subsection (b)(4) in order to more clearly communicate to parties that each of these categories of expenses is an issue that must be addressed in a party's application. This clarification aids in the achievement of the commission's goal of providing clear evidentiary standards and specific criteria for the review and determination of the reasonableness of rate-case expenses.

State Agencies commented that none of Mr. Baron's proposals, limited only to reviewing the reasonableness of costs, incorporate the essential analysis of whether claimed rate-case expenses were also necessary for participation in a rate case. As discussed above, PURA provides an overall "reasonableness" standard for rate-case expense recovery. The rule as adopted complies with the "reasonableness" standard required by PURA. The commission expects that nearly all unnecessary expenses will be found to have been unreasonably incurred using the criteria provided by the rule and will be appropriately disallowed. Accordingly, the commission disagrees with State Agencies' contention that those proposed evidentiary criteria, as adopted by the commission, are not in the public interest.

Requirement that rate-case expenses be reasonably segregated by issue

The commission has determined that it is appropriate to adopt the requirement that the rate-case expenses are tracked and identified according to each litigated issue from the underlying rate case with which they are reasonably associated, as proposed in Mr. Baron's comments. The commission finds that adoption of this requirement will aid in the efficient processing of rate-case expense proceedings and will decrease the likelihood that a methodology, such as those found in subsection (d) of the adopted rule, will be required. The commission finds that, in most cases, the calculation of the disallowance of specific rate-case expenses should be based directly upon the amount of rate-case expenses found to be unreasonably incurred. This goal is more likely achieved following the adoption of this provision. Although Mr. Baron proposed a new sentence following the list of factors in subsection (b) that would state this requirement, the commission opts to insert this provision as subsection (b)(6) of the adopted rule. The commission finds that inclusion of this provision as part of the list of evidence that must be provided by a utility or municipality further clarifies that a sufficient application must include evidence necessary to associate rate-case expenses with each litigated issue from the underlying rate case. The commission finds that including all of the evidentiary requirements for a complete application in a single list aids in the efficiency of administration of the rule. Accordingly, the commission adopts a new subsection (b)(6), which states that the evidence presented with a request for rate-case expenses must show the specific issue or issues in the rate case and the amount of rate-case expenses reasonably associated with each issue.

The commission disagrees with parties, such as Houston, Oncor Cities, El Paso, LCRA, Water IOUs, and State Agencies, who stated that the requirement to comply with subsection (b)(6) is unduly burdensome or that adoption of this provision would increase litigation costs by imposing more burdensome requirements for tracking rate-case expenses. The commission disagrees that this requirement imposes an undue burden and emphasizes the flexibility that should be used when determining which issues in an underlying rate case merit having their associated rate-case expense amounts specified. For example, clearly some issues contain sub-issues that are not significant enough

to warrant requiring a party to further subdivide its rate-case expense request. The commission expects that the presiding officer will require a reasonable but not burdensome level of detail when conducting a proceeding. The commission also emphasizes the broad discretion granted to the presiding officer when conducting a proceeding in which recovery of or reimbursement for rate-case expenses may be awarded. The commission notes that the rule should be interpreted to provide the presiding officer all necessary flexibility when determining whether a failure to provide sufficient evidence pursuant to subsection (b)(6) of the adopted rule should result in a finding that the application is not sufficient for further processing. In addition, the presiding officer is authorized to recommend a disallowance calculated pursuant to subsection (d)(3) of the adopted rule. The commission also notes that other courts in Texas have imposed a similar obligation on litigants. For example in *Tony Gullo Motors I, L.P. v. Chapa,* 212 S.W.3d 299 (Tex. 2006), because litigation costs may be recoverable for one issue but not another issue within the same proceeding, the Supreme Court of Texas stated that "claimants have always been required to segregate fees between claims for which they are recoverable and claims for which they are not." *Id.* at 311. Accordingly, the commission finds that adoption of subsection (b)(6) will provide for better efficiency in the processing of rate-case expense proceedings while allowing the presiding officer the flexibility necessary to avoid unduly burdening any party.

Joint Utilities also requested that, if the commission chooses to require that documents and other evidence be organized and detailed to enable a determination of the amount of expenses incurred for each major issue litigated in the rate case, that the commission limit this provision by inserting the phrase "to the extent practical." The commission declines to adopt this change, as the commission wishes to avoid unnecessary litigation regarding a party's claimed excuses for failing to comply with subsection (b)(6) as adopted. As discussed above, the commission rejects the argument that the adoption of subsection (b)(6) imposes an undue burden on any party or that Joint Utilities' change is necessary to avoid such a burden. The commission notes that the presiding officer is granted the discretion and flexibility to provide for the efficient processing of each rate-case expense proceeding.

Other proposed changes to this paragraph

The commission agrees with Mr. Baron's clarifying changes to the first sentence of subsection (b), which entails deleting "In any rate proceeding" and "pursuant to PURA §33.023 or 36.061(b)." The commission finds that these changes more clearly state the requirements of subsection (b).

Additionally, the commission disagrees with OPUC and declines to delete or limit the provision in the published rule permitting the verification of rate-case expenses by affidavit. Parties have supported rate-case expense amounts through affidavit on a number of occasions in contested proceedings before the commission. The commission finds that this process has contributed to the efficient handling of rate-case expense proceedings, particularly in situations where the requested amounts are small or not in dispute. Accordingly, the commission retains this option in the rule. However, the inclusion of an affidavit option in the new rule should not be interpreted to prevent a party from requesting discovery regarding an affiant's statement or to prevent a party from objecting to the admissibility of an affidavit when the affiant is not made available for examination as provided by the Texas Rules of Evidence.

Additionally, the commission adopts further changes to subsection (b) which are discussed in further detail below.

With respect to subsection (b), the Joint Utilities recommended deleting Mr. Baron's proposed subsection (b)(5)(A), which lists "the size of the utility and number and type of customers," based on the contention that a utility's size or customer count has no bearing on the reasonableness or necessity of the expenses incurred. The commission notes that the utility's size and number of customers can be relevant in determining whether the magnitude of rate-case expenses is reasonable. The commission finds that the size of a utility is frequently correlated with the amount of rate-case expenses it incurs. As discussed in more detail regarding subsection (c)(5) as adopted, the commission finds that the presiding officer should consider in each case whether a party's rate-case expenses as a whole are disproportionate, excessive, or unwarranted in relation to the size of the utility, among other factors.

Section (b)

(1) time and labor required;

As discussed above, Mr. Baron's comments proposed incorporation into his proposed subsection (b)(2) of language similar to subsection (b)(1) as published. Specifically, Mr. Baron's proposal would require the submission of evidence regarding the time and labor required and expended by the attorney or other professional.

Commission response

For the reasons discussed above, the commission has adopted Mr. Baron's proposal to incorporate into subsection (b)(2) this modified version of subsection (b)(1) as published. The commission finds that this organizational change improves the clarity of the requirements of the adopted rule.

Section (b)

(2) nature and complexities of the case;

As discussed above, Mr. Baron's comments proposed incorporating similar language to subsection (b)(2) as proposed into subsection (b)(5)(C) of the adopted rule. Mr. Baron's proposed subsection (b)(5)(C) would require the submission of evidence regarding the novelty or complexity of the issues addressed.

Commission response

For the reasons discussed above, the commission has adopted Mr. Baron's proposal to incorporate into subsection (b)(5)(C) this modified version of subsection (b)(2) as published. The commission finds that this organizational change improves the clarity of the requirements of the adopted rule.

Section (b)

(3) amount of money or value of property or interest at stake;

As discussed above, Mr. Baron's comments proposed incorporating this language as subsection (b)(5)(B) of the adopted rule.

Commission response

For the reasons discussed above, the commission has adopted Mr. Baron's proposal to incorporate into subsection (b)(5)(B) the language found in subsection (b)(3) of the published rule. The commission finds that this organizational change improves the clarity of the requirements of the adopted rule.

Section (b)

(4) extent of responsibilities the attorney or professional assumes; and

OPUC commented that the phrase "extent of responsibilities the attorney or professional assumes" is ambiguous and not sufficiently tied to the rate-case expenses for which recovery is sought. OPUC suggested that if the intent is to take into consideration the nature, extent, and difficulty of the work done by the attorney or professional, the rule should clearly state so and that similar language can be found in the Railroad Commission's rule on rate-case expenses.

As discussed above, Mr. Baron proposed incorporating the following language as subsection (b)(1): "the extent of responsibilities assumed by the attorney or other professional in the rate case." Mr. Barron indicated that adoption of his proposal would replace subsection (b)(4) as published.

Commission response

The commission agrees that the change proposed by OPUC clarifies the commission's intent to focus on the nature, extent, and difficulty of the work done by the attorney or professional in evaluating the overall reasonableness of rate-case expenses in a particular proceeding. Accordingly, the commission adopts as subsection (b)(1) a modified version of the language proposed by Mr. Baron, which is reworded to state "the nature, extent, and difficulty of the work done by the attorney or other professional in the rate case." This change more accurately states the range of topics upon which parties seeking recovery of or reimbursement for rate-case expenses should submit evidence. This language is substantially similar to the language found in the Railroad Commission rule referenced by OPUC, 16 Texas Administrative Code §7.5530(a)(3) and better reflects the potential nexus between the complexity or number of issues in a proceeding and the reasonableness of a particular amount of rate-case expenses.

Section (b)

(5) benefits to the client from the services.

City of Houston proposed striking subsection (b)(5) from the rule as published arguing that it is unclear or not necessary. Houston argued that as applied to a utility, it is presumed that the "client" is the utility's shareholder and that since the utility has a fiduciary responsibility to its shareholders, it is expected that the utility would not file testimony that breaches that responsibility. Houston commented that as the proposed rule might apply to a municipality, it must be noted that a municipality's "client" is the public interest and that it is expected that a municipality would not file testimony that would breach the public interest. Houston noted that under any situation, the trier of facts would already be expected to recognize and address any unusual circumstances.

OPUC commented that the commission should omit this subsection of the rule because it is irrelevant to the statutory standards required for recovery of rate-case expenses, including the public interest and the reasonable and necessary standards. OPUC agreed that if something did not benefit the client, it should not be recovered, but OPUC disagreed that the reverse is true. OPUC pointed out that the commission, in proposing to expressly state that certain expenses should be borne by shareholders, has acknowledged that not all expenses are appropriate for recovery from ratepayers and that the question as to whether it benefitted the client, *i.e.,* the utility, does not answer the question regarding how inclusion of the expense is reasonable and necessary or in the public interest. OPUC suggested that if the commission wishes to consider a factor regarding the benefits inured due to the service provided, the beneficiary in question should not be the client, it should instead be the rate case proceeding or the commission's ability to consider all relevant facts when making its decision. OPUC commented that the Railroad Commission includes a similar consideration in subsection (b) of its rule, stating that a factor to be considered is "whether the work was relevant and reasonably necessary to the proceeding."

TIEC recommended that subsection (b)(5) either be removed or modified to include a cost-effectiveness standard and to consider the likelihood of success on a given issue, rather than simply referencing "benefits to the client" irrespective of the costs incurred or the likelihood of success on a particular issue. TIEC argued that whether an expenditure provides "benefits to the client" is a very broad standard that almost all rate-case expenses would meet and that not all costs of professional services that provide "benefits to the client" are necessarily reasonable costs. TIEC commented that the costs expended in pursuit of such "benefits" may far exceed the potential savings to be obtained, or may not be justified based on the probability of winning the issue. TIEC noted that, for example, it may "benefit" a utility to engage in long-shot discovery objections or judicial appeals of well-settled commission precedent, but those are not necessarily reasonable rate-case expenses. TIEC urged that subsection (b)(5) is overly broad and should either be deleted from the proposed rule or substantially revised to incorporate a "cost-effectiveness" standard and to account for the likelihood of success. TIEC suggested that, at a minimum, this section be revised to require proof of "benefits to the client from the services sufficient to justify the costs expended considering the likelihood of success."

Joint Utilities replied that one of the rate-case expense review criteria listed by the Third Court of Appeals in *City of El Paso v. Public Utility Comm'n of Texas,* 916 S.W.2d 515 (Tex. App.--Austin 1995, writ dism'd by agr.) was "benefits to the client from the services" and that this criterion should be retained, as a basic evaluation of whether the work performed needed to be performed for that particular client. Joint Utilities provided as an example the instance where an attorney bills the client for reading a beginner's book on utility ratemaking because the attorney is not familiar with the ratemaking process, that that may or may not have been beneficial to the client and that if the "benefits to the client from the services" criterion is deleted, it is not clear what criterion would be used to address these types of billings.

Commission response

Houston, OPUC, and TIEC urged deletion of subsection (b)(5) as published, stating that the wording of this subsection is overly broad and not necessary or relevant. In particular, the commission agrees with TIEC, which stated that the concept of benefit to the client is a broad standard that almost all rate-case expenses could be argued to satisfy. Accordingly, the commission finds that it does not need to require examination of this criterion in all cases, but instead parties should raise this issue on a case-by-case basis as appropriate.

Joint Utilities commented that the commission should retain this criterion in order to direct the presiding officer to consider whether the work performed needed to be performed for that particular client. However, the commission notes that subsection (b) merely lists the minimum amount of evidence that must be filed for a request to be sufficient for the purpose of substantive review. Although the commission has decided that this criterion should not be required in all cases, a utility or municipality is permitted to provide any additional evidence

supporting the reasonableness of its rate-case expenses, and other parties are likewise permitted to challenge any evidence or argue that such expenses are unreasonable given the circumstances of a particular request. The commission finds that it is most efficient to decline to require consideration of this issue in each proceeding, but instead permit parties to raise this issue as needed on a case-by-case basis.

Other comments related to subsection (b):

State Agencies agreed with the proposed rule that utilities and municipalities have the burden of proof and suggested three additional requirements that should be provided at inception in order to avoid additional time and expense in discovery: a justification for the need and cost of outside consultants who have not given testimony in the rate case, copies of any contracts or agreements that include charges for services that underlie rate-case expenses, and an explanation for the presence of attorneys at a hearing at a time when they did not actively participate. State agencies explained that the first two items are typically requested by Staff and intervenors. OPUC supported State Agencies' suggestions.

LCRA replied that normally, non-testifying consulting experts and their work product are not discoverable and that a party's attorneys may acquire the services of non-testifying consulting experts to help prepare for hearing, to assist with cross examination, to assist with briefing, or all of the above. LCRA argued that State Agencies' proposed rule requiring justification of non-testifying consulting experts would require the production of privileged information and is impermissible. LCRA also replied that requiring an explanation for the presence of attorneys at a hearing who did not "actively participate" in the hearing is inappropriate because conceivably, in any given situation, one attorney may be charged with drafting the brief and would benefit from observing the hearing or an aspect of the hearing, another attorney may be preparing to cross examine a different witness on the same topic and would have a need to observe the answers of a witness on the stand, and yet another attorney may be in charge of the overall presentation of the case. LCRA pointed out that all of those lawyers are involved in the litigation though they may not be "actively participating" in the hearing to the satisfaction of State Agencies, and it should not be State Agencies' concern to know why there are multiple attorneys present at any one time. LCRA argued that requiring an explanation for the number of attorneys who attend a hearing at any given time is a matter of trial strategy, and should generally be regarded as privileged.

Joint Utilities opposed State Agencies' proposal to include language in the rule that requires utilities and municipalities to specifically justify costs related to non-testifying consultants and non-participating attorneys who attend hearings because it suggests the imposition of a higher standard on these rate-case participants. Joint Utilities pointed out that it is not only reasonable and necessary but common for utilities and municipalities to employ non-testifying consultants during rate-case proceedings and that it is also reasonable, necessary, and common for attorneys to attend a hearing without actually putting on a witness. Joint Utilities commented that this is made necessary by not only the number of contested issues and the depth and complexity of the subject matter, but also by the uncertainty as to how issues will be addressed at the hearing and to what extent other issues will arise that must be addressed by other witnesses. Joint Utilities also noted that the witness schedule at the hearing can be unpredictable and that the next witness on the schedule (and his or her attorney) may wait in the hearing room for hours before that witness is called to testify. Joint Utilities pointed out that oftentimes a witness incurs the expense to travel to the hearing and waits at the hearing to testify, but is then passed at the last moment without any cross-examination at all. Joint Utilities commented that utilities and municipalities already have a burden under subsection (b) to present evidence of the reasonableness of their rate-case expenses, and the commission can determine the reasonableness of those costs pursuant to the factors listed in proposed subsection (c). Joint Utilities noted that information about non-testifying consultants is typically not discoverable, and to the extent State Agencies is challenging the long-standing consulting expert privilege, that would not only be unprecedented but would lead to more discovery and more expense.

LCRA commented that the categories listed on the proposed rule appear to be reasonable items for inspection, but that the commission should provide for appropriate redaction of attorney and consultant invoices particularly during the pendency of the proceeding given that invoices might be specific enough that a review of un-redacted invoices could reveal case strategy or violate client confidentiality.

Mr. Baron proposed insertion of a new subsection, "Purpose," which would establish the burden of proof, filing requirements, criteria, and procedures for determining the reasonableness of rate-case expenses. Mr. Baron noted that numerous substantive rules include a short statement of purpose and that inclusion of this new subsection would conform to that practice.

Water IOUs urged the commission to adopt the test laid out by TDRPC §1.04(b) in conjunction with the precedent from the *Andersen* case to determine the reasonableness and necessity of rate-case expenses as that standard was adopted by the Texas Supreme Court and has been time tested in numerous types of cases and contexts. Water IOUs commented that the least problematic part of the proposed rule is subsection (b) as this portion of the rule captures some of the *Andersen* criteria, but should be modified to adopt all of the *Andersen* considerations in line with Texas law. Water IOUs noted that *Andersen* is a simple standard so there is no need to adopt a more complicated set of rules like the ones proposed. Water IOUs noted that rate-case expense recovery should be simplified - not complicated - and that any time a complicated set of rules is adopted, that alone will increase the cost to litigate rate-case expenses.

OPUC replied that while some of the *Andersen* factors may be instructive in determining the extent of reasonable fees, they are too narrow to apply generally to utility rate proceedings and some of the factors are simply not relevant to determine whether rate payers should be responsible for paying the utility's rate-case expenses. OPUC noted that some factors may be relevant to the client, *i.e.,* the utility, but do not go to whether the expenses are reasonable and in the public interest and appropriate for recovery. OPUC urged the commission to reject the proposal of the Water IOUs.

Commission response

The commission finds that the utility or municipality has the burden of proof to establish that its rate-case expenses are reasonable and necessary. The commission has broad discretion to consider the totality of the circumstances and evidence submitted. The commission expects that the utility or municipality will provide sufficiently detailed evidence that meets its burden

of proof and that will allow the commission to make a determination of reasonableness and necessity.

The commission declines to adopt State Agencies' proposal to include in subsection (b) the requirement that utilities submit evidence specifically relating to a justification for the need and cost of outside consultants who have not given testimony in the rate case, copies of any contracts or agreements that include charges for services that underlie rate-case expenses, and an explanation for the presence of attorneys at a hearing at a time when they did not actively participate. The commission agrees with Joint Utilities that consulting experts are commonly used by parties. Additionally, due to the unpredictable nature of live hearings, as well as the interconnected nature of many issues, it is common for attorneys to be present at a hearing even when they are not actively participating. The commission does not believe that evidence relating to these three issues necessarily must be provided in order for the presiding officer to conduct a full review of a party's rate-case expenses. However, no provision of this rule shall be construed to prevent a party from conducting discovery regarding these issues or from challenging the reasonableness of certain rate-case expenses using evidence relating to these issues based on the specific factual circumstances in a particular proceeding.

The commission further declines to adopt LCRA's proposal that the proposed rule be amended to explicitly authorize the redaction of attorney and consultant invoices. The commission notes that any party may request the entry of a protective order and that, to the extent that the invoices in question contain confidential information, parties may assert that documents are subject to a claim of confidentiality pursuant to the commission's rules. Accordingly, the commission finds that it would be redundant to provide for treatment of confidential documents in subsection (b) of the proposed rule.

The commission declines to adopt the *Andersen* criteria proposed by Water IOUs in lieu of the proposed criteria in the commission's published rule. The commission agrees with OPUC that the *Andersen* factors, while perhaps informing the commission's analysis of the reasonableness of rate-case expenses in certain circumstances, are too narrow to apply to rate-case expense proceedings generally. The commission has determined that the factors listed in the rule as adopted are appropriate given the nature of commission proceedings addressing the recovery of rate-case expenses.

Furthermore, the commission declines to adopt the "Purpose" subsection proposed by Mr. Baron. The commission finds that adoption of this new subsection is unnecessary because it does not aid in the understanding or interpretation of the rule. While Mr. Baron notes that numerous substantive rules include a purpose subsection, the commission notes that numerous substantive rules do not include such a subsection. Accordingly, the commission finds that it is not necessary or mandatory in this case to include such a subsection.

Section (c) Criteria for review.

In determining the reasonableness of the rate-case expenses, the presiding officer shall consider all relevant factors, including but not limited to those set out previously, and shall also consider:

State Agencies suggested that the introductory paragraph should be clarified by replacing the phrase "including but not limited to those set out previously" with "including but not limited to those set out in subsection (b)."

Mr. Baron proposed several changes to subsection (c). Mr. Baron proposed a change to the first sentence of subsection (c) to clarify that the list of factors for the presiding officer's consideration are listed in subsection (b) of the rule and any factor shown to be relevant to the specific case. Mr. Barron stated that this change to the first sentence in subsection (c) is intended to make it clear that the factors the presiding officer is required to consider are found in subsection (b) without precluding the possibility that the parties will raise other relevant issues in the proceeding. Mr. Baron also proposed a new second sentence to be inserted, which would state: "The presiding officer shall disallow or recommend disallowance of recovery of rate-case expenses as unreasonable if and to the extent the evidence shows that . . . ." Mr. Baron stated that these changes would state that the list found in subsection (c) are the bases upon which the presiding officer may recommend or impose disallowances.

Mr. Baron also commented that, for completeness, it should be made clear that all types of rate-case expenses, including expenses for travel and not just expenses for attorney and other professional services, are subject to disallowance if and to the extent found unreasonable. Mr. Baron proposed inserting a new item in the list of factors that would state that expenses incurred for lodging, meals and beverages, transportation, or other services or materials that are extreme or excessive may be disallowed. Mr. Baron proposed inserting this requirement as a new subsection (c)(2) while renumbering the succeeding list items accordingly.

Water IOUs urged the commission not to adopt subsection (c) and argued that it should instead apply the tests in *Andersen/*TDRPC. Water IOUs commented that subsection (c) is objectionable and unnecessary if the *Andersen/*TDRPC criteria are used to determine recoverable rate-case expenses based on reasonableness and necessity. Water IOUs noted that several parts of proposed subsection (c) are already covered by *Andersen/*TDRPC factors or, in some instances, proposed subsection (b) and proceeded to list several examples where they perceived overlap between them. Water IOUs commented that allowing consideration of "all relevant factors" eviscerates the establishment of any prescribed set of criteria and will lead to arbitrarily reduced recovery of reasonable and necessary rate-case expenses.

Commission response

The commission agrees with State Agencies and Mr. Baron, who both stated that subsection (c) as published should be clarified to better state the commission's intent. Both commenters stated that the commission should explicitly refer to subsection (b) instead of instructing the presiding officer to consider factors that were set out previously. The commission modifies the first sentence of subsection (c) to be consistent with Mr. Baron's proposed language, which would read "In determining the reasonableness of the rate-case expenses, the presiding officer shall consider the relevant factors listed in subsection (b) of this section and any other factor shown to be relevant to the specific case." The commission concludes that this change more specifically states what criteria will be considered by the presiding officer while also stating that no party is precluded from asserting that some other factor is relevant to a particular proceeding.

The commission declines to adopt the second sentence as proposed by Mr. Baron, which states: "The presiding officer shall disallow or recommend disallowance of recovery of rate-case expenses as unreasonable if and to the extent the evidence shows that" before the list of criteria provided in subsection (c). Mr.

Baron's proposed language implies that the factors found in subsection (c) are the only grounds for the disallowance of a party's rate-case expenses. The commission intends to conduct a comprehensive review with reasonableness as the standard for allowances and disallowances and adopts subsection (c) as a list of factors that guide that inquiry. As subsection (d)(1) as adopted states, whether the rate-case expenses were actually and reasonably incurred is the ultimate question. Accordingly, the commission adopts a less restrictive version of the second sentence of subsection (c), which now reads as follows: "The presiding officer shall decide whether and the extent to which the evidence shows that" before the list of criteria provided in subsection (c). The commission finds that this change better communicates to the parties that subsection (c) lists criteria that guide the presiding officer's inquiry and that, while some disallowances may be said to be recommended pursuant to a particular paragraph in subsection (c), the ultimate inquiry in a rate-case expense proceeding is whether the rate-case expenses are reasonably incurred.

Mr. Baron proposed changes to subsection (c) of the proposed rule in an attempt to clarify that all types of rate-case expenses, including expenses for travel and not just expenses for attorney and other professional services, are subject to disallowance if and to the extent that they are found unreasonable. Mr. Baron proposed inserting a new item in the list of factors that would instruct the presiding officer to consider whether expenses incurred for lodging, meals and beverages, transportation, or other services or materials that are extreme or excessive. The commission has incorporated Mr. Baron's recommendations in subsection (c) of the rule. Specifically, the commission adopts a new subsection (c)(2) and renumbers the succeeding paragraphs accordingly. These changes provide an increased degree of specificity with respect to the information necessary for a determination of reasonableness while retaining the presiding officer's flexibility to consider all relevant factors and while putting parties on notice regarding certain factors that will be considered in the evaluation of all requests for recovery of or reimbursement for rate-case expenses.

The commission rejects Water IOUs' proposal to delete subsection (c) and adopt the *Andersen* criteria instead. As stated above, the commission has determined that the *Andersen* criteria are too narrow to apply to rate-case expense proceedings generally. Accordingly, the commission retains subsection (c), which is appropriate given the nature and complexity of issues decided before the commission. The commission emphasizes that the presiding officer shall consider all relevant factors when determining the reasonableness of rate-case expenses.

Section (c)

(1) whether the rates paid to, tasks performed by, and time spent on each task by an entity were extreme or excessive;

OPUC commented that in order to prevent confusion of the term "rates," as it is intended to be used in this section, with the "rates" charged by the utility, this provision should be clarified by changing "rates" to "fees," "billing rates," or another similar term if the intent is to look at whether what the expert or attorney charged was extreme or excessive.

Houston commented that the proposed reference to "each" task is unclear and potentially unfeasible, noting that if the term "each" is taken literally, it would place an impractical and costly requirement on all parties without generating a compensating benefit to ratepayers. Houston argued that trying to keep track of "each" task, rather than the general task performed imposes an impractical constraint on all involved. Houston noted that if the witness were required to keep track of "each" such task, not only would it be extremely disruptive to the process, it would greatly increase the cost incurred to perform an analysis and diminish the investigation of that and other issues in the case. Houston recommended changing the word "each" to "a" in this subsection.

Mr. Baron provided several changes to add clarity when interpreting subsection (c)(1). Specifically, Mr. Baron proposed inserting "attorney or other professional or" before the word "entity," replacing the word "and" with "or," and deleing the phrase "on each task."

Commission response

OPUC, Mr. Baron, and Houston each proposed clarifying changes to subsection (c)(1) as published. The commission agrees that OPUC's proposal to change the word "rates" in subsection (c)(1) to "fees" would prevent confusion and better clarify the effect of the rule. Accordingly, OPUC's proposed change is adopted.

The commission also agrees with Houston's proposal to change "each task" to "a task" in the proposed rule. The commission finds that this change clarifies that the presiding officer is not expected to review evidence regarding each and every task performed by any entity, but does direct the presiding officer to consider whether unreasonable or excessive rate-case expenses are associated with any task..

The commission further agrees with Mr. Baron regarding his proposals to change "and" to "or" and modify subsection (c)(1) to make reference to attorneys as well as other professionals. The commission finds that these clarifying changes aid in the understanding of the new rule. However, the commission disagrees with Mr. Baron's suggested deletion of "on each task." The commission finds that this change would decrease the level of review required by subsection (c)(1) by expanding the focus from whether the fees or time spent on any single task is excessive to whether the fees or time spent by the professional overall is excessive. As discussed above, the commission has changed "each task" to "a task" in order to address Houston's concerns. Accordingly, the commission finds that it is appropriate to retain this phrase as modified.

After incorporating the changes described above, subsection (c)(1) now reads as follows: "the fees paid to, tasks performed by, or time spent on a task by an attorney or other professional were extreme or excessive."

Section (c)

(2) whether there was duplication of services or testimony;

Water IOUs stated that the language in proposed (c)(2), "whether there was duplication of services or testimony," invites substitution of subjective opinions in lieu of sound professional judgments, but is arguably also subsumed by the "time and labor required" component of proposed subsection (b) and the *Andersen*/TDRPC factors.

Commission response

The commission rejects Water IOUs' suggestion to delete subsection (c)(2) as published. Water IOUs stated that the proposed subsection invites substitution of subjective opinions in lieu of sound professional judgments and is redundant if the commission adopts the *Andersen* criteria or the "time and labor required"

component of subsection (b). For the reasons stated above, the commission declines to adopt the *Andersen* criteria. Accordingly, this subsection is not made redundant by the *Andersen* criteria.

Additionally, whether there was duplication of services or testimony is one of many criteria that the commission has considered in the evaluation of rate-case expenses in the past. The commission determines that unreasonable duplication of services or testimony is a valid consideration when considering the reasonableness and necessity of such expenses. The commission further finds that it is entirely appropriate for the presiding officer to determine whether particular expenses are "unreasonable" because they were unnecessarily duplicative. Parties remain free to present any evidence they deem necessary to establish the reasonableness of any testimony or service, including detailed evidence of how such testimony or services reflect the exercise of a particular parties' sound professional judgment. Accordingly, the commission retains the instruction that the presiding officer shall consider this factor.

Consistent with the reorganization of subsection (c), this paragraph has been renumbered as subsection (c)(3), and the word "whether" is removed.

Section (c)

(3) the novelty of the issues addressed, including, but not limited to, (A) whether a legal or factual contention advanced in a rate proceeding is warranted by existing law or policy or by a nonfrivolous argument for the extension, modification, or reversal of existing law or policy or the establishment of a new law or policy; or

Mr. Baron urged that the standard for disallowing expenses related to litigating a specific issue should be sharpened by stating a single basis for disallowance that combines parts (A) and (B) in proposed rule subsection (c)(3). Mr. Baron commented that the commission must balance two competing interests. He argued that the rule should discourage utilities and municipalities from raising issues that are plainly without merit on the hope that litigating might nonetheless yield some financial or strategic benefit. Mr. Baron stated that the rule must also not cast a chill on good-faith arguments, having a legitimate basis in law or policy, that seek to change established precedent based on the specific facts of a case or reconsideration of prior policies. Mr. Baron argued that his proposed language strikes this balance by stating a single basis for disallowance that borrows in part from the definition of "groundless" in Chapter 9 of the Texas Civil Practice and Remedies Code which governs frivolous pleadings and claims, and Rule 13 of the Texas Rules of Civil Procedure, which governs the filing of court pleadings by attorneys and parties. Mr. Baron stated that subsection (c)(3) as published is not preferable because it would invite dispute regarding which commission precedents are clearly established and it fails to adequately strike the necessary balance between discouraging meritless arguments and between not chilling meritorious arguments.

State Agencies commented that the reference to "existing law" in subsection (c)(3)(A) is troublesome because the commission cannot reverse or modify a statute or court decision and to the extent a statute or court decision constitutes "existing law" any position that urged them to do so is frivolous *per se.* State Agencies contended that adoption of the rule as proposed would result in additional costly disputes to determine what constitutes a "non-frivolous argument" and that the absence or presence of frivolity is not relevant to determining whether an entity should be allowed to recover costs associated with re-litigating issues that have already been decided by the commission. State Agencies commented that the proposed language would create more problems that it would solve because it will create additional litigation over what it means.

Joint Utilities proposed that to avoid the possibility that some may interpret subsection (c)(3) as conflating two discrete criteria for reasonableness, the rule should be separated into two subsections that separately address the litigation of "novel" issues and the engagement in "frivolous" litigation tactics. Joint Utilities argued that there is an important distinction between novel issues and frivolous arguments and that when an issue is truly "novel" in that it presents as an issue of first impression or addresses new facets of an existing issue, parties should be encouraged to bring those issues before the commission in order to obtain a decision on them. Joint Utilities commented that parties should not be penalized if they choose to raise novel issues so long as they have a reasonable basis in law and fact. Joint Utilities urged the commission to modify subsection (c)(3) to just address novel issues and add a new (c)(4) to separately address frivolous arguments. Joint Utilities' proposed replacing subsection (c)(3) with "the novelty of the issues address;" and inserting a new subsection (c)(4) stating whether the claim, defense or other legal contention is warranted by existing law or policy or by a nonfrivolous argument for the extension, modification, or reversal of existing law or policy or the establishment of a new law or policy." Joint Utilities stated that their proposal incorporated language taken from section 10.001 of the Civil Practice & Remedies Code concerning frivolous arguments since the courts have already interpreted this language and that would reduce litigation over its meaning. TIEC replied that it does not oppose this proposed change.

El Paso replied that the provision may not be required as the parties are already under a similar duty imposed by SOAH Procedural Rule §155.303 which states "The signatures of parties or authorized representatives constitute certification that they have read the pleading and that, to the best of their knowledge, information, and belief formed after reasonable inquiry, the pleading is neither groundless nor brought in bad faith." El Paso argued that given the certification implied in the pleadings, the commission currently has the ability to find expenses incurred in connection with a position brought in bad faith unreasonable.

Water IOUs concurred with Joint Utilities that care should be taken not to conflate novel arguments with frivolous ones and noted that novel legal arguments are expressly contemplated under the *Andersen* standard.

Commission response

The commission agrees with Mr. Baron that the commission's review of the reasonableness of expenses related to the litigation of specific issues should strike a balance by discouraging parties from litigating issues without merit while not discouraging litigation of arguments made in good faith. The commission finds that the language proposed by Mr. Baron appropriately distinguishes between meritorious and unreasonable claims. Accordingly, the commission deletes subsection (c)(3) as published and adopts Mr. Baron's proposed replacement, which states "the utility's or municipality's proposal on an issue in the rate case had no reasonable basis in law, policy, or fact and was not warranted by any reasonable argument for the extension, modification, or reversal of commission precedent." The commission agrees with Mr. Baron that this paragraph as adopted sharpens the standard for reviewing expenses related to litigating a specific issue. The new language is simpler while enhancing the focus of the com-

mission's review on the essential reasonableness of the party's positions. The rule discourages utilities and municipalities from raising issues that are plainly without merit on the hope that litigating might nonetheless yield some financial or strategic benefit. The commission equally expects that the adopted rule will not cast a chill on good-faith arguments that have a legitimate basis in law or policy or that seek to change established precedent based on the specific facts of a case or reconsideration of prior policies.

State Agencies stated that the reference to "non-frivolous" in subsection (c)(3)(A) as proposed is troublesome because it could result in additional costly disputes to determine what constitutes a "non-frivolous argument." The commission notes that this paragraph, as proposed by Mr. Baron and as adopted by the commission, makes no reference to the word "non-frivolous," and, therefore, addresses State Agencies' concerns. However, the commission does not intend for the new rule to be interpreted in a way that will permit the recovery of rate-case expenses that are associated with the presentation of frivolous arguments. Parties remain free to raise this issue in each proceeding on a case-by-case basis.

Joint Utilities recommend splitting subsection (c)(3) into two paragraphs in order to avoid the possibility that some may interpret subsection (c)(3) as conflating two discrete criteria for evaluating the reasonableness of rate-case expenses: novelty and frivolity. The proposed subsection (c)(3)(A) states clearly that the presiding officer shall consider whether arguments that seek extension, modification, or reversal of existing law or policy are frivolous when evaluating the novelty of the issues addressed in a proceeding and ultimately, the reasonableness of a particular request for rate-case expenses. The commission declines to adopt Joint Utilities' proposed language. The commission finds that the language proposed by Mr. Baron more explicitly expresses the commission's intent in adopting subsection (c). As discussed above, the commission has deleted the reference in the rule to the word "non-frivolous," which is present in the Joint Utilities' proposed language. The commission finds that the language proposed by Mr. Baron better puts parties on notice regarding the review that will be conducted by the presiding officer, and, accordingly, that language is adopted instead of the Joint Utilities' proposal.

The commission disagrees with El Paso, which stated that subsections (c)(3)(A) as proposed may not be necessary because it is already addressed by SOAH Procedural Rule §155.303. The commission notes that the SOAH rule would not govern matters that are not referred by the commission to SOAH and does not provide explicitly for the disallowance of rate-case expenses.

Finally, for the same reasons as stated previously, the commission declines to adopt the *Andersen* standard as proposed by Water IOUs.

Consistent with the reorganization of subsection (c), this paragraph has been renumbered as subsection (c)(4), and the word "whether" is removed.

Section (c)

(3)(B) whether an entity's proposal on any issue is contrary to clearly established commission precedent, so long as that precedent is no longer subject to any appeal;

State Agencies pointed out that the reference to "clearly established" precedent will create disputes about when commission precedent becomes "clearly" established. State Agencies also commented that the proposed rule does not discourage re-litigation of settled issues because the qualifier "no longer subject to any appeal" is overly broad and precedent can be "appealed" by any utility through litigation in any subsequent rate case. State Agencies stated that, because precedent is arguably appealed by litigation in any subsequent rate case, the proposed rule is inconsistent with statutes that give effect to commission decisions unless stayed or reversed. State Agencies proposed a substitute for subsections (c)(3)(A) and (B), which would remove the reference to whether an issue is subject to any appeal.

Mr. Baron commented that the proposed rule language, with its separate parts (A) and (B) of subsection (c)(3), would independently place at risk expenses for any rate-case issue or proposal found contrary to clearly established commission precedent. Mr. Baron argued that the phraseology proposed therein would invite after-the-fact litigation over whether commission precedent is "clearly established" and if so, whether a utility's or municipality's position was "contrary to" it. Mr. Baron noted that with no linkage to part (A), part (B) would discourage utilities and municipalities from making a case for reconsideration of precedent even when their arguments are presented in good faith and have some reasonable basis in law, policy, or the facts. Mr. Baron argued that the commission should want the opportunity to consider such arguments and that his proposed revisions would help to mitigate these concerns and would avoid *post hoc* litigation over the meaning of "clearly established" and "contrary to," and would assure utilities and municipalities that they will not be penalized for making good-faith arguments having a reasonable basis in law, policy or fact. Mr. Baron proposed a new paragraph that would replace subsection (c)(3) entirely and specify that a party's rate-case expenses may be disallowed if the party's proposal had no basis in law, policy, or fact, or was not warranted by any reasonable argument for the extension, modification, or reversal of commission precedent. State Agencies replied that Mr. Baron's proposal actually invites the continuation of costs and ensures further costs to litigate whether there was a "reasonable basis" for repeated litigation.

OPUC commented that it is concerned that this provision goes further than intended and that the language in this provision as drafted unintentionally creates a never-ending opportunity to have the expense included. OPUC noted that in order to prevent rate-case expenses related to a challenge of clear commission precedent from being found unreasonable, the entity could merely file an appeal of the rate case itself, including the issue in question, thereby creating an appeal that would be "pending" at the time of a separate rate-case expense proceeding. OPUC argued that when the commission determines an issue in a contested case, the precedent is set on that issue and the commission applies this precedent to future cases until reversed by the Courts or the commission changes course in future cases due to a change in law or circumstances. OPUC contended that if and until the Court reverses the commission on a disallowance, the precedent should be followed in the next case or rate-case expense proceeding, regardless of whether an appeal is pending and that the commission should retain its discretion to determine when an issue is contrary to clearly established commission precedent. OPUC noted that this does not preclude the utility from bringing the issue forward; it merely requires that the utility and its shareholders pay for the precedent-challenging issue, not ratepayers.

TIEC commented that the qualifier "so long as that precedent is no longer subject to appeal" in subsection (c)(3)(B) should be deleted from the proposed rule because, if approved, this

qualifier would leave this provision with very little practical meaning. TIEC noted that appeals process can last many years, and it is not uncommon for a utility or municipality to appeal a decision even though it is well-settled in commission precedent. TIEC noted that a utility could also easily add a losing issue to an appeal for the sole purpose of recovering rate-case expenses related to that issue. TIEC argued that the commission should retain discretion to determine when an issue is contrary to clearly established commission precedent, and the commission can consider the impact of any pending appeals as part of that determination without including this specific language in the rule.

Joint Utilities replied that litigating "settled" precedent is not always unreasonable and to the extent it is unreasonable, the commission can make that determination based on the factors in subsections (b) and (c). Joint Utilities pointed out that if the commission follows its above suggested changes to subsection (c)(3), including the adoption of a new subsection (c)(4) concerning frivolous arguments that address situations where the commission believes a party should not have litigated "clearly established commission precedent," the language in subsection (c)(3)(B) should be deleted to avoid confusion over what standard should apply.

Commission response

Mr. Baron, State Agencies, and OPUC all expressed concern regarding use of the concept of clearly established commission precedent in subsection (c)(3)(B) as published. These commenters stated that this criterion was not clear and would invite voluminous litigation regarding whether any commission precedent is clear. Additionally, TIEC noted that the exception in subsection (c)(3)(B) as published for issues that are subject to an appeal is ambiguous and arguably exempts all issues from consideration. As noted previously, the commission has replaced subsection (c)(3)(B) as published by replacing all of subsection (c)(3) with the language proposed by Mr. Baron. Accordingly, the commission addresses these concerns by removing any instruction to the presiding officer to consider whether a commission precedent is clearly established. However, the commission maintains that the overall question when evaluating rate-case expenses is one of reasonableness, and parties should be discouraged from presenting unreasonable challenges to existing commission precedent.

The commission declines to adopt Joint Utilities' proposed new subsection (c)(4). Joint Utilities states that subsection (c)(3)(B) is unnecessary if Joint Utilities' proposed change to subsection (c)(3)(A) is adopted. For the same reasons as those stated above, the commission declines to adopt Joint Utilities' proposed changes to subsection (c).

Accordingly, subsection (c)(3)(B) is deleted from the rule.

Section (c)

(4) the amount of discovery;

State Agencies noted that in addition to the amount of discovery, opposition to it is also a driver of costs because of the time expended to file objections and motions to compel. State Agencies proposed modification to subsection (c)(4) to reflect this consideration.

Joint Utilities replied that they have noted throughout this project that discovery is a primary driver of rate-case expenses and therefore, consideration of the amount of discovery a utility or municipality must respond to is an obvious and reasonable factor to consider when evaluating the reasonableness of rate-case expenses. Joint Utilities argued that contrary to State Agencies' position related to consideration of the extent to which utilities challenge discovery, neither utilities nor municipalities should be punished for challenging discovery as long as those challenges are reasonable, which can already be considered within the context of the commission's reasonableness inquiry pursuant to the factors listed in proposed subsections (b) and (c).

Houston proposed striking subsection (c)(4) because the "amount of discovery" is an issue-specific situation that is often driven by the level of information presented by the utility. Houston argued that putting the "amount of discovery" *per se* at issue in rate-case expense recovery contradicts the public interest as it creates an incentive for the utility to be less than fully forthcoming in its filing. Houston commented that if a utility chooses to present limited or only summary information in support of its request, the result can lead to extensive discovery and that to the extent a blanket numerical limit on requests for information is established or implied for an entire case or even a single issue, a utility would have every incentive to limit the corresponding information presented in its filing. Houston argued that limiting the number of requests for information acts as a *disincentive* to the utility to be comprehensive and transparent in its initial filing and could potentially result in less responsive utility discovery responses to whatever limited discovery is allowed. Houston noted that a municipality can only meet its mandate to serve the public interest when discovery is permitted that corresponds to the specific facts and circumstances of a particular case and attempts to establish discovery limitations should be discouraged. Houston urged that the trier of fact in a case can and should consider abuses of all types, including discovery abuses, but without a pre-established *per se* numerical discovery limit that acts as a *de facto* limitation to effective participation.

OPUC commented that considering the amount of discovery without context would not present the commission or ALJs with sufficient information with which to determine the reasonableness of rate-case expenses since rate cases vary in size, complexity and controversy. OPUC noted that discovery is necessary because rate proceedings often involve large rate increases and complex issues (*e.g.,* depreciation, return on equity, taxes, cost allocation and rate design, prudence issues, and other policy matters). OPUC further noted that some rate cases involve novel issues that necessitate propounding more discovery, while some involve highly controversial matters like the approval of the Turk plant in SWEPCO's Docket No. 40443. OPUC pointed out that some rate cases are supported with the testimony of more than thirty witnesses, thousands of pages of testimony, and voluminous workpapers, but that looking at the amount of discovery, the issues at play, the number of witnesses or the quality of the rate filing package submitted by the utility does not tell the whole story. OPUC argued that the same amount of discovery may be reasonable in one case and wildly out of line in another. OPUC suggested that if the commission wishes to include subsection (c)(4) in the adopted rule, the language should be amended to consider the amount of discovery in context with the issues in controversy, the number of witnesses, and other contributing factors.

The Alliance agreed with Houston and OPUC that a municipality should not be penalized for conducting the amount of discovery needed to meaningfully review a utility's case and that in the vast majority of instances, the utility initiates the case and controls the number of issues in dispute. The Alliance noted that if a municipality has to "pull its punches" for fear of not receiving

reimbursement for legitimate discovery efforts, ratepayers will suffer by paying higher rates. The Alliance disagreed with Joint Utilities' proposal to restrict discovery in a manner that would impede Staff and intervenors' abilities to meaningfully review the utility's case.

Houston reiterated in reply comments that the amount of discovery should not be one of the permissible criteria for reviewing the reasonableness of a rate-case expense request and that the amount of discovery varies from case to case, depending on the issues, facts, and circumstances of the case, largely within the utility's control. Houston pointed out that because PURA §33.021 already provides the commission with the criterion for judging the reasonableness of the amount of discovery by providing that the information requested from utilities must be necessary, subsection (c)(4) in its proposed form or any suggested amendments thereto are not needed.

Mr. Baron proposed retaining subsection (c)(4) as published and moving it to subsection (b) in order to more clearly indicate that this is an issue on which the commission requires the presentation of evidence.

Commission response

The commission declines to adopt State Agencies' suggested insertion in subsection (c)(4) as published to specify that the presiding officer shall consider the amount of opposition to discovery as well as the amount of discovery in a proceeding. The commission notes that this consideration is already implied and declines to enumerate all of the considerations implicit in subsection (c)(4) as published lest a party infer that those factors not included are intentionally excluded. Rather, the commission reiterates that the factors listed therein are non-exhaustive and nothing in the rule should be interpreted to prevent a party from presenting evidence on any relevant factor in order to establish the reasonableness or unreasonableness of a particular rate-case expense request.

The commission acknowledges Joint Utilities' concern that consideration of the amount of opposition to discovery requests may somehow penalize a utility or municipality for challenging discovery. However, subsection (c)(4) as published lists one of several factors that the presiding officer will consider, and nothing in the rule should be interpreted to require the disallowance of rate-case expenses related to challenging discovery requests. Instead, the commission retains the flexibility to consider all relevant factors when evaluating the reasonableness of rate-case expenses.

The commission declines to adopt Houston's proposal to delete subsection (c)(4) as published. Houston states that subsection (c)(4) may provide an incentive for a utility to provide less information in its application, so that parties would be required to file additional discovery. The commission also disagrees with the Alliance, which states that subsection (c)(4) could be interpreted to penalize a municipality for conducting robust discovery. The commission finds that the total amount of discovery is an important factor to consider when evaluating rate-case expenses. However, nothing in the rule shall be interpreted to prevent a party from challenging a utility's rate-case expenses attributable to discovery on the basis that they are unreasonable. Additionally, nothing in the rule shall be interpreted to impose limitations on the number of discovery requests a party may promulgate.

Houston also stated that subsection (c)(4) as published is unnecessary because PURA §33.021 already provides the commission with the criterion for judging the reasonableness of discovery by providing that the information requested from utilities must be necessary. The commission disagrees with Houston's argument. The commission notes that PURA §33.021 applies to rate cases conducted by a municipality. The commission adopts the proposed rule to cover all requests for recovery of or reimbursement for rate-case expenses incurred in proceedings before the commission, including proceedings in which PURA §33.021 does not apply.

The commission agrees with OPUC, which stated that the amount of discovery, if considered without context, would not present the presiding officer with sufficient information with which to determine the reasonableness of rate-case expenses. OPUC proposed amending subsection (c)(4) as published to instruct the presiding officer to consider the amount of discovery in context with the issues in controversy, the number of witnesses, and other contributing factors. The commission rejects OPUC's proposal and declines to enumerate all of the considerations implicit in subsection (c)(4) lest a party infer that those factors not included are intentionally excluded. The commission notes that the rule instructs the presiding officer to consider all relevant factors. Accordingly, OPUC's proposal is not necessary.

The commission agrees with Mr. Baron. The amount of discovery is an issue regarding which the commission will require the presentation of evidence by an applicant. Accordingly, this requirement is better listed in subsection (b) instead of in subsection (c). As discussed regarding subsection (b), the commission has incorporated this concept into subsection (b)(5)(D).

Section (c)

(5) the occurrence of a hearing; and

Mr. Baron proposed retaining subsection (c)(5) as published and moving it to subsection (b) in order to more clearly indicate that this is an issue on which the commission requires the presentation of evidence.

Commission response

The commission agrees with Mr. Baron. The occurrence of and details regarding the underlying rate case is an issue regarding which the commission will require the presentation of evidence by an applicant. Accordingly, this requirement is better listed in subsection (b) instead of in subsection (c). As discussed regarding subsection (b), the commission has incorporated this concept into subsection (b)(5)(E).

Section (c)

(6) the size of the utility and number of customers served.

Houston commented that it is not certain how size and number of customers served would significantly impact the reasonableness and necessity of the rate-case expenses. Houston expressed concern with this proposal due to the transfer of the economic regulation of water utilities from the TCEQ to the commission because Houston regulates approximately four water/wastewater investor-owned utilities operating within its jurisdiction. Houston noted that each of these systems serves less than approximately 2,000 Houston customers and that the rate-setting process is potentially less contentious and involved as a result of the smaller revenue requirement and the level of rate change requested. Houston commented that while often the number and complexity of the issues may remain the same in these cases, focus on any particular issue is dependent on the overall monetary impact. Houston commented that with a revenue requirement of approximately $250,000, the number of potentially contentious issues

pursued is significantly fewer compared to a request involving a $20 million revenue requirement that would more than likely provide a more comprehensive rate filing package and include of a larger number of witnesses. Houston expressed concern on this issue related to precedent in that cost may necessarily be incurred on a small dollar issue in a small case, but the precedent established on the issue would be applied to larger rate cases. Houston commented that more appropriate measures might include the number and complexity of issues pursued, whether or not the utility provided sufficient proof supporting its rate request, and the total amount of the revenue requirement or rate change requested. Houston noted that based on its own experience, the overall rate-case expenses incurred in a rate proceeding involving a small water utility is significantly less than that for the review of a large gas or electric utility and that perhaps another metric to be examined is a threshold based on the proportion of rate-case expenses to the revenue requirement.

Oncor Cities commented that this subsection should be deleted because it does not reflect the reality of the issues presented in nearly every rate case and that the scope of issues posed by a rate filing generally does not vary with the size of the utility or the number of customers served. Oncor Cities acknowledged that there may be scope differences in an application filed by a vertically integrated utility as opposed to a TDU, but within the broad categories, having fewer customers does not equate to a smaller rate filing. Oncor Cities argued that certain issues such as depreciation, return, and self-insurance reserve must be addressed in every rate case and do not vary in complexity with the size of the utility. Oncor Cities pointed out that municipal intervenors do not determine the scope and complexity of a rate filing--the utility does, and that intervenors must respond to the breadth of issues presented by the utility. Oncor Cities commented that to penalize those intervenors because the utility may have fewer customers than others is inequitable and that proposed subsection (c)(6) should not become part of any rule adopted in this proceeding.

Joint Utilities commented that subsection (c)(6), which directs the presiding officer to consider the size of the utility and the number of customers served, should not be adopted because a utility's size and customer count have no bearing on the amount of rate-case expenses a utility reasonably and necessarily incurs to prosecute a rate case. Joint Utilities argued that this subsection would therefore unnecessarily impose a higher standard on smaller utilities and the municipalities that intervene in their rate proceedings. Joint Utilities pointed out that, generally speaking, a utility bears the same burden of proof, must address the same issues, and must assemble and file the same commission-mandated rate-filing package regardless of whether it has 10,000 or 100,000 customers. Joint Utilities noted that putting on a direct case on a utility's return on equity (ROE) requires the same amount of analysis and supporting testimony regardless of the size of the utility and that a depreciation study requires the same type of analysis and supporting testimony to determine service lives and net salvage value regardless of whether the study addresses $500,000,000 in plant or $1,000,000,000 in plant. Joint Utilities pointed out that the burden of proof applicable under the affiliate cost recovery standard in PURA §36.058 applies regardless of the size of the utility or the number of its customers and that the amount of discovery and other litigation costs is not necessarily affected by the size of the utility involved but, rather, by the parties involved and the number and nature of the issues they decide to contest. Joint Utilities urged that neither the utility nor the municipalities should be penalized for litigating these issues simply because the utility has relatively fewer customers.

Water IOUs commented that utility rate cases before TCEQ, regardless of size, have required varying amounts of rate-case expenses depending on the level of opposition encountered. Water IOUs stated that in past TCEQ water/wastewater rate cases involving smaller investor-owned utilities, there has been unjust use or attempted use of the size or number of customers served in efforts to cut rate-case expense surcharges even when total rate-case expenses were otherwise reasonable and necessary. Water IOUs argued that under Senate Bill 567, adopted by the 83rd Texas Legislature, and the commission's current transfer rule proposal for water utilities, rate cases for acquired small size/connection systems by affiliates of Class A utilities will receive the same Class A rate case treatment with the accompanying unlimited discovery and extensive filing requirements. Water IOUs noted that much of the same work is required for smaller-sized rate cases, particularly with respect to discovery and RFI responses, as has been experienced with larger past rate cases and that this shows that utility size or customer figures are not valid considerations for rate-case expense recovery. Water IOUs argued that using such criteria creates the potential for arbitrary rate-case expense disallowance and discriminatory treatment, particularly if the commission plans to continue forcing Class A utilities to litigate smaller size/connection rate cases using the same procedures as larger size/connection rate cases.

OPUC replied that the utility's size and number of customers can be relevant in determining whether the magnitude of rate-case expenses is reasonable since the utility largely controls the amount of rate-case expenses incurred and must act as the prudent gatekeeper of expenses on behalf of ratepayers. OPUC argued that if costs are completely out of proportion to the benefits (which may be apparent when comparing the costs incurred with the number of customers benefitted) the commission should be able to take this factor into consideration. OPUC noted that the commission has the discretion to determine which factors are relevant to the particular case before it, as well as how much weight to give each factor and should therefore maintain its flexibility to consider the utility's size and number of customers.

Mr. Baron proposed retaining subsection (c)(6) as published and moving it to subsection (b) in order to more clearly indicate that this is an issue on which the commission requires the presentation of evidence.

Commission response

Houston, Oncor Cities, Joint Utilities, and Water IOUs commented that it is not certain that size and number of customers served significantly impact the reasonableness and necessity of the rate-case expenses. These parties expressed concern that parties may be penalized for participating in the review of applications filed by smaller utilities, even if they are no less complex than the applications filed by larger utilities. Houston proposed that more appropriate measures might include the number and complexity of issues pursued, whether or not the utility provided sufficient proof supporting its rate request, and the total amount of the revenue requirement or rate change requested. The commission rejects Houston's proposed changes. The commission agrees with OPUC, which stated that the utility's size and number of customers can be relevant in determining whether the magnitude of rate-case expenses is reasonable. The commission finds that the size of a utility is frequently correlated with the amount of rate-case expenses it incurs. Accordingly, the commission determines that evidence regarding the size of the utility and the number and type of customers served shall be considered by the presiding officer, along with all relevant

factors, when determining the reasonableness of rate-case expenses. However, nothing in the rule shall be interpreted to prevent a party from presenting evidence with regard to the issues listed by Houston. The presiding officer and the commission will then have the discretion to weigh this factor on a case-by-case basis as appropriate in light of this or any other evidence presented by a party.

The commission agrees with Mr. Baron. The size of the utility and number and type of customers served is an issue regarding which the commission will require the presentation of evidence by an applicant. Accordingly, this requirement is better listed in subsection (b) instead of in subsection (c). As discussed regarding subsection (b), the commission has incorporated this concept into subsection (b)(5)(A).

Additional suggestions related to subsection (c):

State Agencies proposed that consideration be given to a comparison of the requested amount of rate relief with the amount actually granted consistent with the Railroad Commission rule regarding rate-case expenses. State Agencies pointed out that the State Bar of Texas' standard for assessing the reasonableness of attorney's fees takes this into consideration as does the TCEQ's rate-case expenses rule, which disallows all rate-case expenses unless the amount of the rate increase granted is at least 51% of the requested amount. OPUC supported State Agencies' suggestions.

OPUC commented that, although as currently written this rule could possibly be read to cover the complexity and expense of the work being commensurate with the complexity of the issues in the proceeding, it does not explicitly state this, nor does it consider the amount of the rate increase sought versus the amount granted unless subsection (d) comes into play. OPUC pointed out that, while part of this concept is found in paragraph (d)(2) of the published proposed rule, that subsection deals solely with how to calculate the expenses, not the reasonableness of them. OPUC argued that these are important considerations when determining the reasonableness of the rate-case expenses, not merely factors for calculating the amount of rate-case expenses to be recovered. OPUC noted that the last sentence of the Railroad Commission's rate-case expense rule includes these considerations when determining reasonableness. OPUC recommended that a new paragraph (c)(7) be added to the proposed rule that reads as follows: *"(c)(7) whether the complexity and expense of the work was commensurate with both the complexity of the issues in the proceeding and the amount of increase sought as well as the amount of any increase granted."*

Mr. Baron commented that the rule should provide for a disallowance when the amount of a utility's or municipality's rate-case expenses as a whole are found to be clearly disproportionate, excessive, and unwarranted, after taking into consideration the full nature and scope of the rate case. Mr. Baron urged that this standard should replace or substitute for the other global standards for disallowance implicit in subsections (d)(1), (2), and (4) of the proposed rule by laying the necessary predicate for a proportionate disallowance using a "Results Oriented" calculation or other method. Mr. Baron proposed incorporating this suggestion by creating a new paragraph in subsection (c) that would read: "the amount of rate-case expenses as a whole was clearly disproportionate, excessive, and unwarranted in relation to the nature and scope of the rate case addressed by the evidence pursuant to subsection (b)(5) of this section."

Mr. Baron also suggested the creation of a new paragraph in subsection (c) that would instruct the presiding officer to consider the recommendation of a disallowance when a utility or municipality fails to present sufficient evidence as required by subsection (b). Mr. Baron's proposed paragraph would read: "the utility or municipality failed to comply with the requirements of presenting a prima facie case pursuant to subsection (b) of this section."

State Agencies commented that it is readily apparent from information provided previously in this project that the experts and attorneys employed by the utilities are considerably more expensive than those of the municipalities and other intervenors. State Agencies argued that there should be a comparison of the costs for experts and attorneys for work of the same or similar nature, consistent with the Railroad Commission rule. Joint Utilities replied that the reasonableness of these rates and fees is already addressed in proposed subsection (c)(1), so the proposal is duplicative of the existing rule language.

State Agencies commented that some utilities file rate cases more frequently than others and that this may indicate a lack of efficiency in presentation, cost control, or prosecuting incremental rate measures like the TCRF, DCRF, and PCRF. State Agencies proposed additional language that takes into consideration the amount of time that has passed since a final order in the utility's previous base rate case. OPUC was supportive of State Agencies' suggestion.

Commission response

The commission declines to adopt the several new criteria for review proposed by State Agencies and OPUC. State Agencies and OPUC proposed that consideration be given to a comparison of the requested amount of rate recovery ultimately granted in the rate proceeding with the amount of requested rate-case expenses. OPUC also proposed that the rule explicitly state that the presiding officer will consider whether the issues in a proceeding, the amount of increase sought, and the amount of any increase granted are commensurate with the expense of litigating the proceeding. Additionally, State Agencies proposed that the rule provide for a comparison of the costs of experts and attorneys employed by utilities with the costs of experts and attorneys employed by other parties. Finally, State Agencies and OPUC proposed additional language that takes into consideration the amount of time that has passed since a final order in the utility's previous base rate case, on the basis that the frequent filing of rate cases indicates a lack of efficiency in presentation, cost control, or prosecution of rate cases.

The commission declines to adopt State Agencies' and OPUC's proposals. The commission declines to attempt to draft an exhaustive list of all potentially relevant factors that underpin the commission's inquiry into the reasonableness of particular rate-case expenses. Rather, the commission finds that the published rule, as amended, provides the flexibility necessary for a robust review of a party's rate-case expenses while at the same time providing notice to parties appearing before the commission regarding the factors that the presiding officer must consider as part of that analysis.

However, the commission finds that the two new paragraphs proposed by Mr. Baron should be included among the factors that the presiding officer is instructed to consider. While the commission disagrees that adoption of this provision obviates the need for the adoption of any of the proportional methodologies found in subsection (d), the commission adopts as a new subsection (c)(5) the requirement for the presiding officer to con-

sider whether the "rate-case expenses as a whole were disproportionate, excessive, or unwarranted in relation to the nature and scope of the rate case addressed by the evidence pursuant to subsection (b)(5) of this section." The commission adopts this criterion as one that the presiding officer must explicitly consider because of its close relationship to the question of whether a party's rate-case expenses are reasonable. Additionally, the commission inserts this paragraph because, as discussed below, a disallowance recommended pursuant to subsection (c)(5) as adopted is one of the two circumstances in which the commission finds it is reasonable to permit the calculation of the disallowance using the methodologies found in subsection (d) as adopted.

The commission also finds that Mr. Baron's proposal to instruct the presiding officer to consider as a basis for a disallowance whether the utility or municipality has failed to comply with the requirements of subsection (b). This provision is directly related to the question of whether a party has satisfied its burden of proof to show the reasonableness of its rate-case expenses. Accordingly, the commission requires consideration of this issue in each rate-case expense proceeding. As discussed above, because the commission has declined to adopt any reference to the establishment of a prima facie case from subsection (b), the commission declines to adopt the new paragraph as drafted by Mr. Baron. Instead the commission adopts the following language as a new subsection (c)(6): "the utility failed to comply with the requirements for providing sufficient information pursuant to subsection (b) of this section."

Section (d) Methodologies for calculating rate-case expenses.

When considering a utility's or municipality's request for recovery of its rate-case expenses pursuant to PURA §33.023 or §36.061(b)(2), if the evidence presented pursuant to subsection (b) of this section does not enable the presiding officer to determine the amount of expenses to be disallowed with reasonable certainty and specificity then the presiding officer may deny recovery of a proportion of a utility's or municipality's requested rate-case expenses equal to any or a combination of the following:

OPUC, TIEC, and State Agencies commented that subsection (d) should not be limited to cases in which the evidence presented does not allow the amount to be disallowed to be determined with reasonable certainty and specificity. OPUC stated that the proposed language would significantly constrain the commission from evaluating and acting upon policy issues rather than merely engaging in dollar-for-dollar recovery and disallowances. OPUC expressed concern that, under the proposed rule as worded, if an issue costs very little to raise but is contrary to clearly established commission precedent, then utilities would not be discouraged from pursuing that issue. TIEC stated that the commission should not be precluded from allocating a portion of rate-case expenses to a utility's shareholders as a policy matter to encourage the utility to act like a private litigant, regardless of whether the utility has proven up these expenses.

In response, the Joint Utilities stated that, if subsection (d) is adopted, none of the methodologies listed in subsection (d) would comply with PURA without the proposed limitation that those methodologies may only be used in situations where the presiding officer is not able to quantify a disallowance. Accordingly, Joint Utilities recommended that, if subsection (d) is to be adopted, the commission must retain that limiting language.

TIEC commented that the methodologies listed in subsection (d) should not be interpreted to limit the commission's discretion. TIEC further commented that the commission should continue to explicitly reserve its discretion to make decisions that may be outside the bounds of subsection (d) based on evidentiary factors and other policy directives. Additionally, TIEC proposed revisions to subsection (d) to clarify that the commission is not prohibited from considering evidence other than the evidence provided by a utility or municipality pursuant to subsection (b).

Mr. Baron proposed revising the first sentence of subsection (d) to state affirmatively that the calculation of any allowance or disallowance must be based on the amount of expenses actually incurred and shown to be reasonable or unreasonable by the evidence as applied to the factors and criteria detailed above. Mr. Baron proposed three new sentences to replace the first sentence in subsection (d) as published, which would read: "Based on the factors and criteria in subsections (b) and (c) of this section, the presiding officer shall allow or recommend allowance of recovery of rate-case expenses equal to the amount shown in the evidentiary record to have been actually and reasonably incurred by the requesting utility or municipality. The presiding officer shall disallow or recommend disallowance of recovery of rate-case expenses equal to the amount shown to have been not reasonably incurred under the criteria in subsection (c). A disallowance may be based on cost estimates in lieu of actual costs only if reasonably accurate and supported by the evidence." Mr. Baron also proposed an additional sentence that would state that the commission retains the authority to use a proportional disallowance methodology, but only when necessary to calculate a disallowance imposed based on the criteria found in what is numbered subsection (c)(5) of adopted version of the rule. Mr. Baron's comments indicated that it would be reasonable to limit the application of subsection (d) of the published rule if the commission were to adopt the requirement that rate-case expenses be segregated by litigated issue.

State Agencies stated that Mr. Baron's proposed revisions to subsection (d) of the published rule effectively eliminate the commission's discretion and ability to use the alternative approaches set out in the proposed rule and fail to incorporate the essential criterion of "necessity" that must be determined before rate-case expenses may be recovered. Joint Utilities commented that the commission should reject the language labeled subsections (d)(5) and (e) in Mr. Baron's comments (which correspond to subsections (c)(5) and (d) in the commission's adopted rule) because they impose a "results-oriented" analysis on the reasonableness inquiry that is inconsistent with PURA. OPUC stated that the alternative to subsection (d) of the published rule proposed by Mr. Baron is flawed because it ignores the commission's broad discretion in ordering recovery of rate-case expenses. OPUC stated that Mr. Baron's proposed language would tie the commission's hands by requiring that the commission "shall allow" recovery of rate-case expenses based on the amount actually and reasonably incurred by the utility or municipality. OPUC also stated that Mr. Baron's proposed language permitting disallowance of expenses based on cost estimates only if reasonably accurate and supported by the evidence is a narrower interpretation of the purpose of the proposed subsection (d).

Commission response

The commission finds that Mr. Baron's proposed changes better clarify the commission's intent in adopting the proposed rule. Accordingly, the commission adopts the first three sentences that

Mr. Baron proposes should be included in subsection (d). The commission also adopts Mr. Baron's proposal that the commission retain a proportional reduction methodology but limit its application to the calculation of a disallowance imposed based on the criteria found in what is numbered subsection (c)(5) of the adopted version of the rule. However, as discussed below, the commission has modified Mr. Baron's proposed language regarding the proportional reduction methodology to better clarify how the Results Oriented Method is to be applied. In adopting this revision, the commission restates that it intends to use a "reasonableness" review when considering requests for recovery of or reimbursement for rate-case expenses. Accordingly, the commission intends that recovery or reimbursement will be granted with respect to reasonably incurred rate-case expenses.

The commission disagrees with State Agencies and OPUC who expressed opposition to Mr. Baron's proposed revisions to subsection (d) of the published rule. OPUC stated that Mr. Baron's proposed language would tie the commission's hands by requiring that the commission "shall allow" recovery of rate-case expenses that are reasonably incurred, which may be more restrictive than the language provided by PURA §36.061(b). However, the commission finds that it does not unduly limit its discretion by adopting a provision stating that the presiding officer shall allow or recommend recovery of rate-case expenses equal to the amount shown in the evidentiary record to have been actually and reasonably incurred. The commission notes that rate-case expenses that are not in the public interest or, as discussed above, are not necessary will likely be disallowed on the basis that they were not reasonably incurred. However, the commission finds that the rule as adopted comports with PURA while maintaining reasonableness as the essential standard for reviewing rate-case expenses.

OPUC also stated that Mr. Baron's proposed language permitting disallowance of expenses based on cost estimates only if reasonably accurate and supported by the evidence is based on a narrow interpretation of the purpose of the proposed subsection (d). However, as stated above, two of the methodologies found in subsection (d) as published have been deleted, while the applicability of other two have been narrowed. As such, the commission finds that subsection (d) as adopted clearly states the commission's intention that disallowances will be based on quantifications of unreasonably incurred rate-case expenses to the extent that it is possible. For the reasons discussed below, the commission finds that the narrowed scope of the methodologies in subsection (d) provide for the efficient processing of rate-case expense proceedings while retaining the necessary flexibility to use another means of determining the value of disallowances when necessary.

The commission declines to adopt the proposals by OPUC, TIEC, and State Agencies, all of which proposed that the commission modify subsection (d) so that its methodologies are not limited to only proceedings in which the presiding officer has determined that some disallowance is appropriate but is not able to quantify the amount of the disallowance based on the evidence provided by the parties in the proceeding.

While the commission agrees that it retains substantial discretion under PURA §36.061(b) to disallow a utility's rate-case expenses, including by using the methodologies in subsection (d) as published, the commission nevertheless finds that in proceedings where it is possible to quantify the disallowance attributable to unreasonably incurred rate-case expenses, it is preferable to disallow that amount of rate-case expenses rather than use a proxy amount. As discussed below, the commission adopts the changes proposed by Mr. Baron into subsection (d)(1) as adopted, which states affirmatively that the calculation of any allowance or disallowance should be based on the amount of expenses actually incurred and shown to be reasonable or unreasonable by the evidence as applied to the factors and criteria set forth in subsection (c) of the adopted rule, in part because these changes emphasize that it is preferable to disallow a quantified amount of rate-case expenses when possible rather than use a proxy amount.

TIEC requested that the methodologies listed in subsection (d) should not be interpreted to limit the commission's discretion and that the commission should explicitly reserve its discretion to make decisions that are not prescribed by subsection (d) and to consider evidence other than the evidence provided by a utility or municipality pursuant to subsection (b). The commission notes that subsection (c) requires that the presiding officer consider all relevant factors. Accordingly, nothing in the rule as adopted should be interpreted to prevent the consideration of relevant evidence presented by any party in a proceeding. Accordingly, the commission declines to adopt TIEC's requested change because it is unnecessary.

Section (d)

(1) The 50/50 Method. For utilities, 50% of the utility's total requested expenses, in recognition that the utility's shareholders, who reap benefits from a rate increase, should also share in the cost of obtaining that rate increase.

LCRA, Joint Utilities, and Mr. Baron commented that the proposed subsection (d)(1) was inadvisable because it would disallow rate-case expenses regardless of whether the expenses were reasonably incurred and because it is not clear that shareholders reap benefits from a rate increase. LCRA further commented that subsection (d)(1) appears to violate PURA because it appears to automatically disallow recovery of legitimate expenses. Commenting parties relied on various cases, including the *Oncor* case, to support the contention that a utility is entitled under PURA to recover all of its actual, necessary, and reasonable rate-case expenses. These parties commented that, therefore, subsection (d)(1) should not be adopted because it would appear to disallow recovery of rate-case expenses without a finding that those expenses are unreasonable or unnecessary. These parties also stated that they viewed any application of subsection (d)(1) as inappropriately punitive.

OPUC, TML, TIEC, the Alliance, State Agencies commented in support of the adoption of subsection (d)(1). OPUC also stated that Joint Utilities advance a far too narrow interpretation of the *Oncor* case as requiring that all of a utility's reasonable and necessary rate-case expenses be recoverable because the *Oncor* case mainly focused on notice issues and whether the commission's jurisdiction extended to certain rate-case expenses. OPUC stated that the assignment of certain rate-case expenses to a utility's shareholders does not serve as a punishment of utility and its shareholders and, instead, recognizes the reality that the utility's shareholders reap benefits from implementing rate increases and that the utility's board of directors owes a fiduciary duty to the utility's shareholders to maximize profits. OPUC stated that it agreed with TIEC, which stated that subsection (d)(1) creates an incentive for a utility to better manage its rate-case expenses and act more like private litigants. TML stated that utilities initiate the majority of ratemaking proceedings and that it is therefore fair that utilities' shareholders pay some of the associated costs. The Alliance commented that util-

ities' shareholders should bear some of the costs for seeking increases in the utility's rates because rate cases are filed, in part, to improve the utility's return on its shareholders' investment. OPUC stated that the commission has broad discretion to determine recovery of expenses in a ratemaking proceeding. OPUC cited PURA §36.061, which states that the commission *may* allow as a cost or expense the reasonable costs of a utility's participation in a ratemaking proceeding. OPUC also stated that the commission is not limited to line-item disallowances or charges relating to underlying unreasonable costs. OPUC contended that, in *City of Amarillo v. Railroad Commission of Texas,* 894 S.W.2d 491 (Tex. App.--Austin 1995, writ denied), the court upheld the Railroad Commission's decision to reduce the uncontested expenses related to one analyst's charges by 20% due to insufficiency of support. OPUC also stated that it is within the commission's discretion to find rate-case expenses to be unreasonable even if the underlying cost item in the rate case is found to be reasonable. State Agencies commented that Mr. Baron and Joint Utilities mischaracterized the *Oncor* precedent because the reasonableness and necessity of the rate-case expenses at issue in that proceeding had been stipulated by the parties. State Agencies stated that, in the *Oncor* precedent, the commission had held that it had no jurisdiction in a 2009 proceeding to order recovery of certain rate-case expenses incurred in 2004 and 2005 because Oncor had failed to obtain approval to seek recovery of them in the later proceeding. State Agencies stated that the "prior authorization" issue was central to the holding in the *Oncor* precedent and that the holding does not limit the commission's discretion under PURA §36.061(b)(2) to approve or deny recovery of rate-case expenses. State Agencies commented that the adoption of a rule that sets out guidelines that the commission will consider in its analysis of the reasonableness and necessity of rate-case expenses, sets out objective caps on travel-related expenses, and that sets out alternative methods for analyzing the full impact of unnecessary and unreasonable rate-case expenses will give parties notice that was arguably lacking in the *Oncor* precedent and would fall well within the commission's broad rulemaking authority.

Commission response

LCRA, Joint Utilities, and Mr. Baron commented that subsection (d)(1) should not be adopted based on concerns that it would be used to disallow rate-case expenses regardless of whether the expenses were reasonably incurred. While the commission finds that adoption of subsection (d)(1) as published is within the commission's authority, the commission has determined that it is not necessary to adopt the 50/50 Method at this time. The commission has adopted revisions to the evidentiary requirements in the adopted rule that will incentivize utilities and municipalities to act more like self-funded litigants. As indicated by Mr. Baron, because the commission has adopted subsection (b)(6) of the adopted rule, the commission is persuaded that sufficient evidence will be presented in most circumstances to permit the quantification of disallowances for unreasonably incurred rate-case expenses. As such, the commission only retains the use of a methodology to quantify a disallowance in two particular circumstances: (1) when rate-case expenses are disallowed because, as a whole, they are disproportionate, excessive, or unwarranted in relation to the nature and scope of the rate case, or (2) if the evidence presented pursuant to subsection (b)(6) of the adopted rule does not enable the presiding officer to determine the appropriate disallowance of rate-case expenses associated with a particular issue. Accordingly, the rule as adopted only retains those methodologies that are best tailored to each scenario while permitting the presiding officer the discretion to use any other appropriate methodology. The commission finds that explicitly retaining the 50/50 Methodology adds unnecessarily to the complexity of the rule without furthering the commission's aim to provide for the efficient processing of rate-case expense proceedings.

Section (d)

(2) The Results Oriented Method.

LCRA, Joint Utilities, and Mr. Baron expressed opposition to the adoption of subsection (d)(2) based on objections to the Results Oriented Method of calculating disallowances. LCRA further commented that application of subsection (d)(2) would not recognize all costs attributable to concluding a rate case and is not comprehensive. Joint Utilities commented that subsections (d)(2) applies a "prevailing theory" of cost recovery that is inconsistent with PURA, under the *Oncor* precedent, and could perpetuate litigation and actually increase litigation costs. Joint Utilities stated that whether a utility prevails on a particular issue in a rate case does not necessarily reflect the reasonableness of the underlying rate-case expenses. Joint Utilities also noted that a utility receiving a rate of return 100 basis points below its request would result in a reduced revenue requirement, increasing a disallowance calculated using subsection (d)(2), even though it would not be clear that the utility's position was unreasonable or that it "won" or "lost" that issue. Joint Utilities also stated that a company's requested revenue requirement may be reduced by amortizing certain expenses, such as rate-case expenses over a longer period of time, even though these decisions may not represent a clear "loss" for the utility. Mr. Baron commented that adoption of subsection (d)(2) is not advisable because there is no necessary correspondence between the amount of a commission-authorized revenue requirement increase and the reasonable of rate-case expenses incurred in a ratemaking proceeding. Mr. Baron indicated, however, that, if the commission wishes to retain a proportional disallowance methodology, it should only be applied with respect to a disallowance imposed based on the criteria found in what is numbered subsection (c)(5) of adopted version of the rule. Mr. Baron proposed rewording the language providing for proportional disallowances so as to avoid specifically listing the Results Oriented Method or other possible formulae. Mr. Baron's proposed language states generally that the presiding officer may take into consideration the amount of relief requested that was denied. Mr. Baron noted that, if the commission agrees that proportionate disallowances are problematic and should not be used, then these revisions would not be necessary and the Results Oriented Method could be deleted entirely.

TIEC stated that the commission should reject Joint Utilities' arguments that it is inappropriate to apply subsections (d)(2) and (d)(3) to the context of a ratemaking proceeding on the basis that a "prevailing party" theory is not appropriate with respect to issues, like rate of return, that do not produce clear "winners" and "losers." TIEC stated that these arguments are not compelling because subsections (d)(2) and (d)(3) are not mandatory or prescriptive but are guidelines to be referenced when the commission exercises its discretion in reviewing rate-case expenses. TIEC stated that, with respect to issues for which subsections (d)(2) and (d)(3) cannot be reasonably applied, the commission will not apply those provisions. TIEC stated that adoption of subsections (d)(2) and (d)(3) is appropriate because those provisions may be applied to issues which do tend to produce "winners" and "losers."

Commission response

The commission agrees with TIEC that the commission should retain the Results Oriented Method. Accordingly, the commission disagrees with LCRA, Joint Utilities, and Mr. Baron, which stated that the Results Oriented Method relies on a "prevailing party" theory of cost recovery that is inconsistent with PURA and that may not provide for a comprehensive evaluation of a party's rate-case expenses. Mr. Baron notes that there is no necessary correspondence between the amount of a commission-authorized revenue requirement increase and the reasonableness of the rate-case expenses incurred in the ratemaking proceeding. Because it is not mandatory that the Results Oriented Method be applied to each proceeding, it is not the case that the Results Oriented Method requires the disallowance of reasonable rate-case expenses. The Results Oriented Method does not imply that rate-case expenses are unreasonably incurred merely because a utility does not prevail on all issues in a proceeding.

However, the commission finds there is merit in Mr. Baron's recommendation that, if the commission wishes to retain this proportional disallowance methodology, it should be applied with respect to a disallowance imposed based on the criteria found in what is numbered subsection (c)(5) of adopted version of the rule. The commission declines to adopt Mr. Baron's proposed language that generally permits the presiding officer to compare the relief requested by a party with the relief that was granted or denied but does not specify what methodology should be used when conducting this comparison. Instead, the commission retains more specific language that more clearly lays out the components of the ratio used in the Results Oriented Method. Specifically, if a disallowance is imposed pursuant to subsection (c)(5), the disallowance may be calculated, for a utility, by calculating the ratio of the increase in revenue requirement requested by the utility that was denied to the total amount of the increase in revenue requirement requested in a proceeding by the utility or, for a municipality, the ratio of the amount of the increase in revenue requirement requested by the utility unsuccessfully challenged by the municipality to the total amount of the increase in revenue requirement challenged by the municipality. The commission notes that the adopted language also retains the commission's broad flexibility to use any other appropriate methodology. The commission finds that limiting the scope of the Results Oriented Method in this manner while providing explicit instructions for its application provides for the efficient processing of rate-case expense proceedings by reducing the likelihood that the commission will be required to weigh the benefits of each of the published methodologies in relation to each proceeding. Instead, the commission expects that the evidence presented pursuant to subsection (b) as adopted will limit the circumstances in which it will be necessary to resort to some proportional methodology. Accordingly, the commission need only retain the Results Oriented Method with respect to those proceedings in which a disallowance is imposed pursuant to subsection (c)(5).

Additionally, Joint Utilities commented that the Results Oriented Method should not be adopted because some issues, such as rate of return, do not tend to produce clear "prevailing parties." Although some ratemaking issues do not lend themselves to the application of the Results Oriented Method, the commission notes the methodologies listed in subsection (d) of the adopted rule are not exclusive or exhaustive and may only be applied where appropriate. The commission retains the discretion of the presiding officer to determine in which proceedings the application of the Results Oriented Method is appropriate based on the facts of each proceeding.

Additionally, because subsections (d)(2) and (d)(3) of the adopted rule have been restated to permit the application of any other appropriate methodology, subsection (d)(5) of the published rule is duplicative and has been deleted.

Section (d)

(2)(A) For utilities, the ratio of the amount of the increase in revenue requirement requested by the utility that was denied to the total amount of the increase in revenue requirement requested in a proceeding by the utility.

(2)(B) For municipalities, the ratio of the amount of the increase in revenue requirement requested by the utility unsuccessfully challenged by the municipality to the total amount of the increase in revenue requirement challenged by the municipality.

As indicated above, OPUC, the Alliance, El Paso, State Agencies, the TML, and Houston commented that subsection (d)(2)(B) should not be applied to municipalities. OPUC also stated that subsections (d)(2)(B) and (d)(3)(B) as proposed result in a disproportionate disallowance to a municipality when compared with the commensurate provisions for utilities in subsections (d)(2)(A) and (d)(3)(A) due to the larger size of a utility's requested revenue requirement compared to the relatively small size of a municipality's requested disallowances. The Alliance stated that municipalities do not control the issues raised by the utility initiating the ratemaking proceeding and must respond to the utility's proposals or else municipalities' citizens and businesses will be forced to pay higher rates. The Alliance further noted that it is unfair to penalize the ratepayers in those municipalities for trying to minimize the utility's proposed rate increases. The Alliance stated that it would be more equitable to maintain the status-quo than to adopt subsections (d)(2)(B) and (d)(3)(B). El Paso asserted that it is inappropriate to tie a municipality's recovery of its rate-case expenses to the results obtained in a proceeding because municipalities review the entire rate filing package and not simply opposing a rate increase. Houston maintained that it is concerned that subjecting municipalities to the proposed new rule would potentially interfere with a municipality's ability to continue to properly fulfill its legislatively mandated regulatory obligations. Houston noted that the cost of a municipality's rate-case expenses is typically minimal compared to the benefits achieved through a municipality's intervention. Houston stated that the reimbursement of a municipality's rate-case expenses allows a municipality to present a more complete case than many intervenors do, providing valuable information to the commission in each case. State Agencies agreed with OPUC, stating that subsections (d)(2) and (d)(3) might impose disproportionate penalties on municipalities compared with utilities.

TIEC stated that the positions taken by a municipality in a ratemaking proceeding are not influenced by and may be adverse to out-of-city customers and that it would be inequitable to require out-of-city customers to bear part of the cost of the municipality's rate-case expenses. TIEC stated that, if municipalities' rate-case expenses are collected only from customers within the municipal limits, then it is not necessary to apply subsections (d)(2) and (d)(3) to municipalities. TIEC also stated that there is some merit in OPUC's argument that applying subsections (d)(2) and (d)(3) to municipalities can result in disproportionate disallowances, could create an incentive for municipalities to challenge more issues in order to avoid disproportionate disallowances, or could create a disincentive for a municipality to challenge a particularly high-dollar issue. TIEC states that, because of these issues, it would be preferable not

to adopt subsections (d)(2) and (d)(3) and, instead, to mandate that a municipality's rate-case expenses shall only be recovered from in-city customers.

Commission response

The commission disagrees with those parties, such as OPUC, the Alliance, El Paso, State Agencies, TML, and Houston, who stated, variously, that the Results Oriented Method should not be applied to municipalities because its application would result in disproportionate disallowances for municipalities. Specifically, these parties objected to the application of the Results Oriented Method to municipalities because, among other things, it penalizes the citizens of municipalities for challenging the utility's requested revenue requirement or interferes with a municipality's ability to continue to properly fulfill its legislatively mandated regulatory obligations, including its statutory right to intervene in ratemaking proceedings before the commission. The commission disagrees that application of the Results Oriented Method to municipalities would necessarily result in disproportionately large disallowances for municipalities. First, the commission notes that the Results Oriented Method is not mandatory, but may only be applied in situations where some disallowance is appropriate but in which the municipality has not presented sufficient evidence to quantify the appropriate disallowance. Furthermore, in proceedings in which the application of the Results Oriented Method would result in a disproportionate disallowance, the commission notes that the presiding officer retains the discretion to apply any other appropriate methodology. Second, the commission disagrees that the application of the Results Oriented Method would penalize the citizens of municipal intervenors or impair the municipality's legislatively mandated regulatory obligations. To the extent that a municipality's rate-case expenses are reasonably incurred and are not disproportionate, excessive, or unwarranted in relation to the nature and scope of the rate case, the Results Oriented Method will not be applied to the municipality. The commission disagrees that the disallowance of unreasonably incurred rate-case expenses unfairly penalizes the citizens of a municipality or impairs the municipality's ability to conduct or participate in ratemaking proceedings. Accordingly, the commission includes in the adopted rule a provision explicitly permitting the application of the Results Oriented Method to municipalities. This provision is found in subsection (d)(2)(B) of the adopted rule.

TIEC recommended that it would be preferable to decline to adopt subsections (d)(2)(B) and (d)(3)(B) of the published rule and, instead, to require that a municipality's rate-case expenses be collected only from ratepayers inside the municipality's territory. The commission disagrees with TIEC's proposal because the commission wishes to retain the flexibility to address the recovery and allocation of a municipality's rate-case expenses among a utility's customer groups based on the facts of each proceeding. Accordingly, the commission declines to adopt TIEC's recommendation.

Section (d)

(3) The Issue Specific Method.

LCRA, Joint Utilities, and Mr. Baron expressed opposition to the adoption of subsection (d)(3) based on objections to the Issue Specific Method of calculating disallowances. LCRA further commented that application of subsection (d)(3) may become very complicated depending on whether issues are successfully appealed, noting that a successful appeal means that the utility did not in fact unsuccessfully litigate that issue. LCRA asked specifically how to determine the specific point in time at which the commission determines the appropriate measurement of total rate-case expenses on which to base any disallowance. Joint Utilities stated that their concerns regarding the propriety and applicability of a "prevailing party" theory with respect to the Results Oriented Method also apply to the Issue Specific Method. Mr. Baron commented that adoption of subsection (d)(3) is not advisable because it will not be necessary if the commission requires utilities and municipalities to present sufficient evidence to determine the actual value of incurred rate-case expenses.

For the same reasons as those stated above, TIEC stated that the commission should also reject Joint Utilities' arguments that it is inappropriate to apply subsections (d)(2) and (d)(3) to the context of a ratemaking proceeding on the basis that a "prevailing party" theory is not appropriate with respect to issues, like rate of return, that do not produce clear "winners" and "losers."

Commission response

Mr. Baron commented that adoption of the Issue Specific Method is not advisable because it will not be necessary if the commission requires utilities and municipalities to present sufficient evidence to determine the actual value of incurred rate-case expenses associated with each litigated issue. Although the commission agrees with Mr. Baron that it is advisable to adopt subsection (b)(6), which requires a party to reasonably associate its rate-case expenses with each litigated issue, the commission has determined that it is still advisable to retain the Issue Specific Method. In recognition of several parties' concerns, instead of adopting Mr. Baron's recommendation to reject the Issue Specific Method entirely, the commission decides instead to limit its application to only those cases in which the evidence presented pursuant to subsection (b)(6) does not enable the presiding officer to determine the appropriate disallowance of rate-case expenses reasonably associated with an issue with certainty and specificity. The commission notes that Mr. Baron's comments regarding the Results Oriented Method indicated that the commission may wish to retain a proportional reduction methodology but restrict its application to disallowances imposed pursuant to a limited number of criteria. As the commission discussed above regarding the Results Oriented Method, the commission finds that it is preferable to retain some of the methodologies found in subsection (d) as published but limit their application to a narrower range of circumstances. Accordingly, although the adoption of subsection (b)(6) increases efficiency in the processing of rate-case expense proceedings and decreases the likelihood that the evidence presented pursuant to subsection (b) would not enable the presiding officer to determine the appropriate disallowance of rate-case expenses reasonably associated with an issue with certainty and specificity, the commission also retains the necessary discretion to address such a situation when necessary.

The commission notes that subsection (d)(3) as adopted is permissive but does not require the application of the Issue Specific Method. The commission finds that it is reasonable to retain flexibility when considering rate-case expense proceedings and retains the presiding officer's discretion to find that an application is insufficient for further processing when an applicant has not presented the necessary information pursuant to subsection (b) of the adopted rule. The commission wishes to provide a range of reasonable options for situations in which it is determined that it is not possible to determine the rate-case expenses associated with each issue with certainty and specificity.

The commission disagrees with LCRA, Joint Utilities, and Mr. Baron, which expressed objections to the Issue Specific Method. LCRA stated that the application of the Issue Specific Method may become very complicated because a successful appeal means that the utility did not in fact unsuccessfully litigate that issue. LCRA states that it is not clear at which point in time a utility can be said to have definitively "lost" an issue in order for the application of the Issue Specific Method to apply. However, the commission concludes that the successful appeal of a commission decision with respect to a litigated issue does not necessarily prove that all of the costs associated with litigating that issue before the commission were reasonably incurred. The commission notes that the Issue Specific Method represents a methodology for quantifying a disallowance after it is determined that some rate-case expenses were unreasonably incurred. Accordingly, even if an issue is successfully appealed, it is not necessarily the case that it was inappropriate to have applied the Issue Specific Method with respect to the requested revenue associated with that issue. Accordingly, the commission retains the presiding officer's discretion to assess the propriety of applying the Issue Specific Method on a case-by-case basis.

Additionally, for reasons stated above, the commission disagrees with Joint Utilities' concerns that the Issue Specific Method inappropriately relies on a "prevailing party" theory of cost recovery. As stated above, the commission notes that the Issue Specific Method may only be used in proceedings in which some disallowance of unreasonably incurred rate-case expenses is appropriate but in which the utility or municipality has not presented sufficient evidence to quantify the disallowance. Because this methodology is not used to determine the reasonableness of expenses, it is not the case that the Issue Specific Method requires the disallowance of rate-case expenses or implies that rate-case expenses are unreasonably incurred merely because a utility does not prevail on all issues in a proceeding.

The commission retains broad discretion to use an appropriate methodology after considering the specific facts of each proceeding. The commission also notes that successful appeal of a commission decision with respect to a litigated issue does not necessarily prove that all of the costs associated with litigating that issue before the commission were reasonably incurred. Accordingly, the commission declines to adopt any other proposed changes to this subsection.

Additionally, because subsections (d)(2) and (d)(3) of the adopted rule have been restated to permit the application of any other appropriate methodology, subsection (d)(5) of the published rule has been deleted.

Section (d)

(3)(A) For utilities, the ratio of the amount of the increase in revenue requirement requested by a utility related to any unsuccessfully litigated issue(s) to the total revenue requirement increase requested by the utility.

(3)(B) For municipalities, the ratio of the amount of the increase in revenue requirement requested by the utility unsuccessfully challenged by the municipality relating to any unsuccessfully litigated issue(s) by the municipality to the total amount of the increase in revenue requirement challenged by the municipality.

OPUC, the Alliance, El Paso, State Agencies, TML, and Houston expressed similar objections to the adoption of subsection (d)(3)(B) as indicated by those parties in opposition to subsection (d)(2)(B). El Paso also commented that subsection (d)(3)(B) should not be adopted because it will not always be clear whether an issue is in fact successfully litigated.

For the same reasons as those stated above, TIEC asserted that it would be preferable not to adopt subsections (d)(2) and (d)(3) and, instead, to mandate that a municipality's rate-case expenses shall only be recovered from in-city customers.

Commission response

OPUC, the Alliance, El Paso, State Agencies, TML, and Houston expressed the same concerns regarding the application of the Issue Specific Method to municipalities as these parties expressed regarding the application of the Results Oriented Method. These parties stated, variously, that the Results Oriented Method should not be applied to municipalities because its application would result in disproportionate disallowances for municipalities, it penalizes the citizens of municipalities for challenging the utility's requested revenue requirement, and/or it interferes with a municipality's ability to continue to properly fulfill its legislatively mandated regulatory obligations, including its statutory right to intervene in ratemaking proceedings before the commission. The commission notes that these methodologies are not mandatory, but rather the presiding officer retains the flexibility to determine in which proceedings each methodology may be appropriately applied. Second, the commission disagrees that the application of the Issue Specific Method would penalize the citizens of municipal intervenors or otherwise impair the municipality's legislatively mandated regulatory obligations. To the extent that a municipality's rate-case expenses are reasonably incurred and to the extent that a municipality presents sufficient evidence pursuant to subsection (b) of the adopted rule, the Issue Specific Method will not be applied to the municipality. The commission disagrees with any contention that the disallowance of rate-case expenses for which the municipality has not met its burden of proof unfairly penalizes the citizens of a municipality or impairs the municipality's ability to conduct or participate in ratemaking proceedings. Accordingly, the commission includes in the adopted rule a provision explicitly permitting the application of the Issue Specific Method to municipalities. This provision is found in subsection (d)(3)(B) of the adopted rule.

For the same reasons as stated above, the commission declines to adopt TIEC's proposal to mandate that a municipality's rate-case expenses shall only be recovered from in-city customers instead of adopting the Issue Specific Method as applied to municipalities. However, as stated above, the commission retains the discretion to evaluate the allocation of the recovery of rate-case expenses among a utility's customer groups in individual ratemaking proceedings.

Section (d)

(4) The 51% Allowance Method. For utilities, all of a utility's requested rate-case expenses incurred in a proceeding in which the increase in the utility's approved revenue requirement after a contested hearing is less than 51% of the total amount of the increase in revenue requirement requested by the utility.

Water IOUs, Mr. Baron, LCRA, and Joint Utilities expressed opposition to the 51% Allowance Method. Water IOUs stated that subsection (d)(4) of the published rule should not be adopted because, in every rate case, assuming there is any merit to the application at all, there is some amount of reasonable and necessary cost associated with the application that would be unfairly disallowed. Water IOUs stated that a recent application of a similar provision by the TCEQ is being challenged on appeal in the

case styled *Canyon Lake Water Service Company's Application for a Rate/Tariff Change;* SOAH Docket No. 582-11-1468; TCEQ Docket No. 2010-1841-UCR. Mr. Baron commented that adoption of the 51% Allowance Method would be unnecessary if his proposal to require that rate-case expenses be associated with the rate case's litigated issues. LCRA commented that application of the 51% Allowance Method would violate PURA and recent case precedents because it appears to over-reach while sacrificing a utility's ability to recover its reasonable costs authorized by PURA. Joint Utilities commented that the 51% Allowance Method is inconsistent with PURA because it systematically and arbitrarily disallows rate-case expenses without any review of the reasonableness of the individual costs.

In response, TIEC agreed that subsection (d)(4) is based on a TCEQ rule. TIEC stated that the Texas Water Code contains provisions similar to PURA §36.051 and that, therefore, it is permissible for the commission to adopt subsection (d)(4). TIEC stated that because these provisions would be listed explicitly in the rule, utilities would have clear notice of the risk that one of these disallowance provisions could be applied, which allows the utilities to factor that risk into their spending decisions and further preserves their opportunity to earn a reasonable return pursuant to PURA §36.051.

Commission response

The commission agrees with Mr. Baron that adoption of the requirement that rate-case expenses be associated with the rate case's issues decreases the need to adopt the 51% Allowance Method. Accordingly, the commission finds at this time that it is not necessary to adopt subsection (d)(4) of the published rule. The commission therefore deletes subsection (d)(4) of the published rule. As indicated by Mr. Baron, because the commission has adopted subsection (b)(6) of the adopted rule, the commission is persuaded that sufficient evidence will be presented in most circumstances to permit the quantification of disallowances for unreasonably incurred rate-case expenses. The commission only retains the use of a methodology to quantify a disallowance in two particular circumstances: (1) when rate-case expenses are disallowed because, as a whole, they are disproportionate, excessive, or unwarranted in relation to the nature and scope of the rate case, or (2) if the evidence presented pursuant to subsection (b)(6) of the adopted rule does not enable the presiding officer to determine the appropriate disallowance of rate-case expenses associated with a particular issue. Accordingly, the rule as adopted only retains those methodologies that are best tailored to each scenario while permitting the presiding officer the discretion to use any other appropriate methodology. The commission finds that explicitly retaining the 51% Allowance Method adds unnecessarily to the complexity of the rule without furthering the commission's aim to provide for the efficient processing of rate-case expense proceedings.

The commission disagrees with Water IOUs, Mr. Baron, LCRA, and Joint Utilities, which state that, assuming there is any merit to the application at all, there is some amount of reasonable and necessary cost associated with the application that would be unfairly disallowed if all rate-case expenses are disallowed. LCRA similarly commented that application of the 51% Allowance Method would violate PURA because it systematically and arbitrarily disallows rate-case expenses without a review of the reasonableness of the individual costs. The commission agrees that it is possible that some rate-case expenses are reasonably incurred, even if more than 51% of a request is disallowed. However, the published version of the rule provides the presiding officer's discretion to determine on a case-by-case basis whether the facts of each proceeding support using the 51% Allowance Method to quantify a disallowance to be associated with unreasonably incurred rate-case expenses.

The commission acknowledges Water IOUs' statement that the 51% Allowance Method should not be adopted because a similar provision in TCEQ's rules is being challenged on appeal by Canyon Lake Water Service Company. However, this provision has not been overturned on appeal at this time. Additionally, even if TCEQ's application of the provision is overturned on appeal, the commission retains the flexibility to assess at that time whether the adoption of the 51% Allowance Method may be appropriately applied in other proceedings with different factual and policy issues than the TCEQ proceeding that is currently subject to appeal.

Section (d)

(5) The result of the use of any other appropriate methodology.

Other comments related to subsection (d)

LCRA, Joint Utilities, Water IOUs, and Oncor Cities commented that subsection (d) should be deleted from the proposed rule. LCRA and Joint Utilities commented that, in any given case, the commission has the prerogative to disallow any unreasonable expenses as long as the basis for denial is explained. LCRA clarified that it believes that the commission already has the ability to evaluate a utility's rate-case expenses on the merits and determine if they are unreasonable or imprudent. LCRA further commented that subsection (d) is unnecessary because it does not see a need for any mechanical methods to calculate the value of disallowances. Joint Utilities further commented that the adoption of subsection (d) could make reaching settlements more difficult because a party that is confident of "winning" an issue will have less incentive to settle and can instead use the issue to drive up other parties' rate-case expenses. Joint Utilities stated that, if a case that would otherwise have settled is fully litigated, customers may be forced to bear the additional litigation costs of a hearing as well as higher rates related to cost-of-service issues a utility may "win" but that it otherwise would have settled. Water IOUs commented that the application of subsection (d) may result in confiscatory decisions because it may allow for arbitrary disallowances of reasonable and necessary expenditures. Water IOUs stated, generally, that all of the proposed methodologies for calculating disallowances must be rejected because any proposals to systematically disallow rate-case expenses for "policy" reasons without regard to their reasonableness may violate PURA. The Oncor Cities also proposed deletion of subsection (d), stating that subsection (d) implies that it is *per se* unreasonable to incur costs to litigate issues that are ultimately lost. Oncor Cities stated that this connection is not always clear because losing parties do not necessarily unreasonably litigate a novel issue. Oncor Cities stated that disallowances calculated pursuant to subsection (d) could result in arbitrary and capricious reductions that would necessarily sweep broadly enough to capture expenses associated with not just the problematic issue but also other expenses that are not unreasonable.

In response to these concerns, OPUC and State Agencies stated that deletion of subsection (d) is not warranted. OPUC stated that subsection (d) as proposed does not require the commission to use any of these particular methods but, appropriately, puts the parties on notice that the commission may use these methods in a particular case where it is justified. OPUC stated that the proposed rule, with OPUC's suggested changes stated above,

strikes a balance in maintaining the broad discretion granted to the commission while also providing guidance to the parties who come before the commission. OPUC agreed with TIEC's comments that the commission should delete the restrictive language in subsection (d) limiting the use of the enumerated methodologies to cases where the evidence presented does not enable the presiding officer to determine the amount of expenses to be disallowed. TIEC also replied, stating that the methodologies listed in subsection (d) are within the commission's authority to adopt. TIEC stated that it disagrees with Joint Utilities' justification for seeking to remove these methodologies from the rule. TIEC stated that PURA §36.061 permits the commission to allow recovery of a utility's rate-case expenses but does not guarantee recovery of rate-case expenses. TIEC disagreed that the *Oncor* precedent created a requirement that a utility be permitted to recover all rate-case expenses that it shows to be reasonable and necessary. TIEC stated that, pursuant to PURA §36.051, a utility is entitled to just and reasonable rates so that it may be afforded an opportunity to earn a reasonable return but that it is difficult to imagine a disallowance of rate-case expenses that would deprive a utility of this opportunity. TIEC stated that, as a matter of law, the commission is not precluded from applying the types of disallowances listed in proposed subsection (d). State Agencies commented that Joint Utilities are incorrect in asserting that subsection (d) would violate PURA because subsection (d) is not required to be employed in every case but allows the commission flexibility to apply appropriate disallowances where facts warrant them. State Agencies pointed out that similar methodologies had been adopted by other administrative agencies in Texas.

Commission response

The commission disagrees with LCRA, Joint Utilities, Water IOUs, and Oncor Cities, who commented that subsection (d) should be deleted from the proposed rule. LCRA and Joint Utilities commented that, in any given case, the commission has the authority to disallow unreasonable expenses as long as the basis is explained and that, therefore, the mechanical methods to calculate disallowances are unnecessary. The commission disagrees and notes that, in some proceedings, the utility or municipality does not present sufficient evidence to quantify disallowances associated with unreasonably incurred rate-case expenses. The commission retains the discretion to use a methodology for calculating an appropriate disallowance in these proceedings, consistent with its prior practice. As discussed above, the commission notes that the adopted rule should be interpreted to provide the presiding officer all necessary flexibility when determining whether a failure to provide sufficient evidence pursuant to subsection (b)(6) of the adopted rule should result in a finding that the application is not sufficient for further processing or instead whether it would be appropriate to recommend a disallowance calculated pursuant to subsection (d)(3) of the adopted rule.

The commission disagrees with Joint Utilities' concern that adoption of subsection (d) may make reaching settlements difficult because it will encourage a party to drive up other parties' rate-case expenses if it is confident of "winning" an issue. Especially in light of the narrowed scope of subsection (d)(3) in the adopted version of the rule, the commission disagrees that parties will be motivated to incur additional unnecessary litigation costs in the hopes that the presiding officer may find that some of the utility's rate-case expenses should be disallowed and then resort to a discretionary methodology for the calculation of a disallowance. In fact, as discussed above, the commission finds that adopting clear evidentiary standards and specific criteria for reviewing rate-case expense proceedings will provide incentive for utilities and municipalities to act more like self-funded litigants. The commission retains the discretion to address these concerns on a case-by-case basis.

The commission also disagrees with Water IOUs, which stated that application of subsection (d) may result in confiscatory decisions by allowing for arbitrary disallowances of reasonable and necessary expenditures. The commission also disagrees with Oncor Cities, which proposed deletion of subsection (d) because it implies it is *per se* unreasonable to incur costs to litigate issues that are ultimately lost. As stated above, the methodologies in subsection (d) are not used to determine whether rate-case expenses are reasonably incurred. These methodologies are only used to quantify disallowances that are associated with disallowed and unreasonably incurred rate-case expenses. The commission agrees with OPUC and State Agencies which stated that deletion of subsection (d) is not warranted and that subsection (d) does not require the commission to use any of these particular methods. Accordingly, it is not the case that application of these methodologies may result in confiscatory decisions or in the disallowance of reasonable and necessary expenditures.

Finally, the commission disagrees with OPUC's and TIEC's suggestion that the commission should permit the application of the methodologies in subsection (d) of the proposed rule in any proceeding, even in a proceeding in which the presiding officer is able to quantify the appropriate disallowance to be associated with unreasonably incurred rate-case expenses. Although this modification is within the commission's discretion, the commission prefers at this time that, if it is possible to quantify the appropriate disallowance, then that quantity will be disallowed. The commission retains this provision as an incentive for utilities and municipalities to present sufficient evidence to quantify their rate-case expenses in as much detail as possible and as a disincentive for parties to request approval of excessive rate-case expenses. The commission also prefers to limit disagreements regarding which methodologies to apply to only those proceedings in which it is necessary to apply some methodology.

Other Comments Regarding the Proposed Rule

Oncor Cities proposed adding a new subsection stating that rate-case expenses incurred by municipalities will be quantified as late in the ratemaking proceeding as is practical and that municipalities may establish an estimate of rate-case expenses to complete the ratemaking proceeding after the quantification date and to participate in appeals of the proceeding. Oncor Cities proposed that the reasonableness of the costs comprising the estimate should be subject to commission approval in the order resolving the ratemaking proceeding. TML, the Alliance, and El Paso supported the proposal that municipalities be able to recover estimated rate-case expenses.

OPUC proposed a new subsection (e) that would limit a utility's recovery of rate-case expenses if the litigated outcome of a rate case is equal to or less than a written settlement offer. OPUC stated that a similar requirement has been adopted by the TCEQ and that the provision would encourage parties to settle ratemaking proceedings.

LCRA and the Joint Utilities opposed OPUC's proposal. LCRA stated that it objects because settlement offers are confidential but that OPUC's proposal would appear to require public disclosure of a group of parties' written settlement offer before the commission could begin to gauge whether to deny recovery of

rate-case expenses after the date of the offer. LCRA stated that OPUC did not state which parties would trigger its proposed provision. LCRA stated that OPUC's proposed provision would prevent a utility from recovering its rate-case expenses in a proceeding if the commission awarded a result worse than a group's settlement offer, even if the commission's order is overturned on appeal. LCRA further stated that it opposes OPUC's proposal because it limits the commission's ability and responsibility to perform a reasoned analysis of the facts in a given proceeding. Joint Utilities stated that the proposal is contrary to PURA and impractical in the context of a ratemaking proceeding because there exist many components to a settlement proposal other than revenue requirement, which is the criterion that OPUC's proposal focuses on. These parties stated that it would be overly complex to try to analyze the non-revenue requirement elements of a settlement proposal to determine whether the final outcome as a whole was better or worse than a settlement proposal. These parties also commented that OPUC's proposal would necessarily require the admission of confidential settlement offers into evidence in violation of Texas Rule of Evidence 408. These parties commented that this would create a chilling effect because utilities may have a greater reluctance to make settlement offers if such offers could be used against them in the manner suggested by OPUC.

Mr. Baron recommended that the commission should include a new subsection relating to procedures and specify that applications to recover rate-case expenses should be filed and separately docketed after the conclusion of a rate case. Mr. Baron recommended, in order to encourage settlement, utilities and municipalities should, before filing a request to recover rate-case expenses, offer to provide relevant documents for informal review by Staff and other parties.

Joint Utilities commented that the commission may allow rate-case expenses to be examined in a separate proceeding, but it should also allow parties to address those expenses when practicable in the proceeding in which they are incurred. State Agencies commented that, even when rate-case expenses are considered in a severed proceeding, parties should retain the ability to settle rate-case expenses as part of a total rate case settlement.

State Agencies commented that the proposed rule lacks an essential standard for evaluating costs incurred for travel, lodging, and meals. State Agencies proposed the use of an objective standard based on the guidelines for state employees' travel expenses that are published by Texas Comptroller of Public Accounts that would be used to determine whether travel, lodging, and meal expenses are reasonable.

Joint Utilities stated that any attempt to establish maximum travel expenses will be complicated and in need of ample justified exceptions. Joint Utilities further commented that it is not clear that the commission's existing policy of reviewing travel-related rate-case expenses on a case-by-case basis is ineffective. Joint Utilities stated that they are not opposed to adopting language proposed by Mr. Baron relating to travel expenses as part of the criteria the commission would consider in determining the reasonableness of rate-case expenses.

The REP Group recommended that the commission adopt an additional subsection relating to the method of recovery of rate-case expenses. The REP Group proposed that the commission specify that rate-case expenses will be recovered in a rider. The REP Group further proposed that the commission may authorize a separate rider for each eligible rate class. The REP Group also recommended that the commission suspend the effective date of any approved rider so that the rate-case expenses charges will take effect on March 1 or September 1, as applicable. The REP Group further stated that, if the final decision on a request to recover rate-case expenses has not been issued at least 46 days before March 1, the effective date of an approved rider will be suspended until September 1, and if the final decision on a request to recover rate-case expenses has not been issued at least 46 days before September 1, the effective date of an approved rider will be suspended until the following March 1. The REP Group also recommended that, unless otherwise ordered, a utility should be required to serve notice of the approved rates and the effective date of the approved rates by the first working day after the presiding officer's final decision to retail electric providers that are authorized by the registration agent to provide service in the utility's service area.

At the public hearing, OPUC commented that it generally did not oppose the REP Group's recommendation but proposed two modifications. First, OPUC suggested that ratepayers should not be required to pay interest during the delay between a commission order approving a rider and the effective date of the rider. Second, OPUC suggested that the commission use April 1 and October 1 as the effective date of the rider instead of March 1 and September 1 because March and September are particularly high-use months.

Commission response

The commission declines to adopt the proposed changes and opts to retain its broad discretion to consider many factors when determining the reasonableness and necessity of rate-case expenses, including how such expenses should be recovered.

The commission declines to adopt Oncor Cities' proposal relating to the reimbursement of a municipality's expected future rate-case expenses. Recent commission precedents, including Docket No. 40295, expressly state that approving estimated future rate-case expenses for municipal parties is not in the public interest. Accordingly, the commission declines to adopt any provision that would permit the approval of estimated future expenses. Accordingly, subsection (d) of the adopted rule states that the presiding officer shall allow or recommend recovery of rate-case expenses that have been shown to have been actually incurred.

The commission declines to adopt Mr. Baron's and Oncor Cities' proposals relating to the timing and docketing of rate-case expenses. Mr. Baron recommended that the commission should include a new subsection relating to procedures and specify that applications to recover rate-case expenses should be filed and separately docketed after the conclusion of a rate case and that utilities and municipalities should, before filing a request to recover rate-case expenses, offer to provide relevant documents for informal review by Staff and other parties. Oncor Cities proposed that the rule specify that rate-case expenses incurred by municipalities will be quantified as late in the ratemaking proceeding as is practical and that municipalities may establish an estimate of rate-case expenses to complete the ratemaking proceeding and to participate in appeals after the quantification date. The commission agrees with Joint Utilities which stated that the commission should allow parties to address rate-case expenses, when practicable, in the proceeding in which they are incurred. The commission also agrees with State Agencies, which commented that the commission should retain the flexibility to allow parties to settle rate-case expense issues as part of a ratemaking proceeding provided those issues have

already been severed into a separate proceeding. Presently, the presiding officer is granted discretion to determine the procedure for processing requests for recovery of or reimbursement for rate-case expenses based on the facts particular to each proceeding, including whether to sever the review of rate-case expenses into a separate proceeding and how best to determine an appropriate cut-off date for the counting of rate-case expenses. The commission declines to adopt particular criteria for determining a set cut-off date for rate-case expenses, as the commission prefers to retain the presiding officer's flexibility to address these issues on a case-by-case basis.

The commission declines to adopt OPUC's proposed new subsection (e) that would limit a utility's recovery of rate-case expenses if the litigated outcome of a rate case is equal to or less than a written settlement offer. The commission agrees with Joint Utilities that this proposal is not practical to implement because there exist many components to a settlement proposal other than revenue requirement, which is the criterion that OPUC's proposal focuses on. Joint Utilities commented that it would be overly complex to try to analyze the elements of the settlement proposal that do not relate to the revenue requirement in order to determine whether the final outcome was better or worse than the settlement proposal. Accordingly, the commission declines to adopt OPUC's proposal.

The commission declines to adopt State Agencies' proposal to include in the rule an objective standard for evaluating costs incurred for travel, lodging, and meals. The commission notes that subsections (b)(4) and (c) of the adopted rule require the presentation and evaluation of evidence relating to the expenses incurred for lodging, meals and beverages, transportation, or other services or materials. The commission agrees with Joint Utilities who commented that establishing maximum travel expenses is complicated and that it is not clear that the commission's existing policy of reviewing travel-related expenses on a case-by-case basis is ineffective. The commission finds that these issues depend too much on the facts of each proceeding and that it is not appropriate to adopt prescriptive criteria that would limit a party's recoverable rate-case expenses, such as using the reimbursement schedule for state employees' travel costs. The commission finds that it is preferable to retain the presiding officer's discretion to address these issues based on the facts of each particular proceeding.

The commission declines to adopt the REP Group's proposal regarding the timing of riders to recover rate-case expenses. The commission has determined that the presiding officer should retain the flexibility to address these issues based on the facts of each proceeding, including the preferences of the particular retail electric providers that participate in a given proceeding.

OPUC stated that it did not object conceptually to the REP Group's proposal but proposed two modifications relating to the timing of the proposed riders and relating to carrying costs on the balance of the amount included in the rider. Because the commission declines to adopt the REP Group's proposal, the commission declines to adopt OPUC's proposed modifications to the REP Group's proposal.

All comments, including any not specifically referenced herein, were fully considered by the commission.

This new section is adopted under the Public Utility Regulatory Act, Texas Utilities Code Annotated §14.002 (West 2007 and Supp. 2014) (PURA) which provides the commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction; and, specifically, §33.023(b), which requires that a municipality be reimbursed by an electric utility for the reasonable costs of a municipality's participation in a ratemaking proceeding, and §36.061(b)(2), which permits the commission to allow as a cost or expense the reasonable cost of a utility's participation in a proceeding initiated pursuant to PURA.

Cross Reference to Statutes: Public Utility Regulatory Act §§14.002, 33.023(b), and 36.061(b)(2).

§25.245. Rate-Case Expenses.

(a) Application. This section applies to utilities requesting recovery of expenses for ratemaking proceedings (rate-case expenses) pursuant to Public Utility Regulatory Act (PURA) §36.061(b)(2) and to municipalities requesting reimbursement for rate-case expenses pursuant to PURA §33.023(b).

(b) Requirements for claiming recovery of or reimbursement for rate-case expenses. A utility or municipality requesting recovery of or reimbursement for its rate-case expenses shall have the burden to prove the reasonableness of such rate-case expenses by a preponderance of the evidence. A utility or municipality seeking recovery of or reimbursement for rate-case expenses shall file sufficient information that details and itemizes all rate-case expenses, including, but not limited to, evidence verified by testimony or affidavit, showing:

(1) the nature, extent, and difficulty of the work done by the attorney or other professional in the rate case;

(2) the time and labor required and expended by the attorney or other professional;

(3) the fees or other consideration paid to the attorney or other professional for the services rendered;

(4) the expenses incurred for lodging, meals and beverages, transportation, or other services or materials;

(5) the nature and scope of the rate case, including:

(A) the size of the utility and number and type of consumers served;

(B) the amount of money or value of property or interest at stake;

(C) the novelty or complexity of the issues addressed;

(D) the amount and complexity of discovery;

(E) the occurrence and length of a hearing; and

(6) the specific issue or issues in the rate case and the amount of rate-case expenses reasonably associated with each issue.

(c) Criteria for review and determination of reasonableness. In determining the reasonableness of the rate-case expenses, the presiding officer shall consider the relevant factors listed in subsection (b) of this section and any other factor shown to be relevant to the specific case. The presiding officer shall decide whether and the extent to which the evidence shows that:

(1) the fees paid to, tasks performed by, or time spent on a task by an attorney or other professional were extreme or excessive;

(2) the expenses incurred for lodging, meals and beverages, transportation, or other services or materials were extreme or excessive;

(3) there was duplication of services or testimony;

(4) the utility's or municipality's proposal on an issue in the rate case had no reasonable basis in law, policy, or fact and was not

warranted by any reasonable argument for the extension, modification, or reversal of commission precedent;

(5) rate-case expenses as a whole were disproportionate, excessive, or unwarranted in relation to the nature and scope of the rate case addressed by the evidence pursuant to subsection (b)(5) of this section; or

(6) the utility or municipality failed to comply with the requirements for providing sufficient information pursuant to subsection (b) of this section.

(d) Calculation of allowed or disallowed rate-case expenses.

(1) Based on the factors and criteria in subsections (b) and (c) of this section, the presiding officer shall allow or recommend allowance of recovery of rate-case expenses equal to the amount shown in the evidentiary record to have been actually and reasonably incurred by the requesting utility or municipality. The presiding officer shall disallow or recommend disallowance of recovery of rate-case expenses equal to the amount shown to have been not reasonably incurred under the criteria in subsection (c) of this section. A disallowance may be based on cost estimates in lieu of actual costs if reasonably accurate and supported by the evidence.

(2) A disallowance pursuant to subsection (c)(5) of this section may be calculated as a proportion of a utility's or municipality's requested rate-case expenses using the following methodology or any other appropriate methodology:

(A) For utilities, the ratio of:

(i) the amount of the increase in revenue requirement requested by the utility that was denied, to

(ii) the total amount of the increase in revenue requirement requested in a proceeding by the utility.

(B) For municipalities, the ratio of:

(i) the amount of the increase in revenue requirement requested by the utility unsuccessfully challenged by the municipality, to

(ii) the total amount of the increase in revenue requirement challenged by the municipality.

(3) If the evidence presented pursuant to subsection (b)(6) of this section does not enable the presiding officer to determine the appropriate disallowance of rate-case expenses reasonably associated with an issue with certainty and specificity, then the presiding officer may disallow or deny recovery of a proportion of a utility's or municipality's requested rate-case expenses using the following methodology or any other appropriate methodology:

(A) For utilities, the ratio of:

(i) the amount of the increase in revenue requirement requested by the utility in the rate case related to the issue(s) not reasonably supported by evidence of certainty and specificity, to

(ii) the total amount of the increase in revenue requirement requested in a proceeding by the utility.

(B) For municipalities, the ratio of:

(i) the amount of the increase in revenue requirement requested by the utility in the rate case challenged by the municipality relating to the issue(s) not reasonably supported by evidence of certainty and specificity, to

(ii) the total amount of the increase in revenue requirement challenged by the municipality.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
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TITLE 22. EXAMINING BOARDS

PART 32. STATE BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

CHAPTER 741. SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

The State Board of Examiners for Speech-Language Pathology and Audiology (board) adopts amendments to §§741.1, 741.13, 741.61, 741.62, 741.64, 741.81, 741.84, 741.141, 741.161, 741.162, 741.164, and 741.211 - 741.215; the repeal of §741.66 and §741.86; and new §§741.66, 741.86, and 741.216, concerning the regulation and licensure of speech-language pathologists and audiologists. Sections §§741.66, 741.86, 741.162, 741.213, 741.214, and 741.216 are adopted with changes to the proposed text as published in the June 6, 2014, issue of the *Texas Register* (39 TexReg 4387). The amendments to §§741.1, 741.13, 741.61, 741.62, 741.64, 741.81, 741.84, 741.141, 741.161, 741.164, 741.211, 741.212, and 741.215 and the repeals of §741.66 and §741.86 are adopted without changes, and, therefore, the sections will not be republished. The board is withdrawing proposed new Subchapter P, §§741.231 - 741.233, concerning Joint Rules for Fitting and Dispensing of Hearing Instruments by Telepractice, to be subsequently republished for proposal in coordination with publication of a corresponding proposal for a new joint rule under 22 TAC Chapter 141, by the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments.

BACKGROUND AND PURPOSE

In accordance with Texas Occupations Code, Chapter 401, the adopted amendments update the board's rules to reflect current operational procedures in processing and approving licensure applications and provide clarification of the rules' intent for license holders and the public. The amendments and addition to Subchapter O, amendments to §§741.61, 741.66 and 741.86, and the adopted new §741.81(f) are necessary to comply with Senate Bill (SB) 312, 83rd Legislature, Regular Session, 2013, an Act which amended and added new provisions to Texas Occupations Code, Chapter 401, regarding the practice of speech-language pathology and audiology.

SB 312 authorizes the board to adopt rules for the practice of speech-language pathology and audiology using telecommunications technology. In implementing this provision, the board has modified existing Subchapter O so that the defini-

tions in §741.211 apply to both audiologists and speech-language pathologists; §§741.212 through 741.215 apply only to speech-language pathologists; and §741.216 sets forth the requirements applicable only to audiologists engaging in telepractice.

The repeal of, and adoption of new, §§741.66 and 741.86, are necessary to implement legislation concerning the licensing of military service members, military veterans, and military spouses from SB 312, SB 162 (83rd Legislature, Regular Session, 2013), and HB 2254 (83rd Legislature, Regular Session, 2013), and incorporate existing requirements concerning licensing while on military duty and for military spouses from Texas Occupations Code Chapter 55. SB 312 also removes a six-hour course requirement for licensure, which an amendment to §741.61 was made to implement, and provides for the renewal of certain lapsed audiology licenses issued between September 1, 2007 and 2011, to audiologists holding master's degrees, which the amendment to §741.81(f) implement.

The adopted rule changes to the following sections of Chapter 741 clarify, correct, or update various rules to improve understanding and better reflect the licensing processes and procedures currently in place: §§741.1, 741.13, 741.62, 741.64, 741.84, 741.141, 741.161, 741.162, and 741.164.

SECTION-BY-SECTION SUMMARY

The amendments to §741.1 clarify certain existing definitions and to define new terms used in new rule sections.

The amendment to §741.13 deletes obsolete language.

The amendment to §741.61 identifies the specific time frame for applications to which one of the educational requirements for licensure applies.

The amendment to §741.62 corrects a grammatical error.

The amendments to §741.64 correct an exception to a paragraph and clarify the requirements for signatures that are needed on formal documentation relating to the reimbursement of services rendered.

The amendment to §741.81 adds a new subsection (f), to comply with SB 312, to set forth the conditions under which a lapsed license of an audiologist who was licensed between September 1, 2007 and September 1, 2011, may renew his or her audiology license, including the requirement that an application for such renewal must be filed before September 1, 2014.

The amendment to §741.84 corrects a grammatical error.

The amendments to §741.141 clarify the types and expiration periods of licenses issued by the board.

The amendments to §741.161 clarify how renewal documentation can be submitted to the board.

The amendments to §741.162 clarify the areas in which continuing education credits may be earned; the number of continuing education hours that can be used for university and/or college course work; that continuing education hours can rollover to the next consecutive renewal period; that the board will accept continuing education registries as proof of completion of continuing education credits; and deletes obsolete language regarding American Medical Association Category I continuing education events.

The amendments to §741.164 correct grammatical errors.

The amendments to §741.211 add new terms and clarify existing definitions relating to telehealth.

The amendment to §741.212, which enumerates examples of different models of service delivery by telehealth, revises the title of the rule to particularize its applicability to speech-language pathologists.

The amendments to §741.213 provide that this particular telehealth rule applies only to speech-language pathologists and clarifies the requirements of the rule.

The amendment to §741.214 provides that this particular telehealth rule applies only to speech-language pathologists and clarifies the limitations on the use of telecommunications technology by speech-language pathologists.

The amendment to §741.215 provides that this particular telehealth rule applies only to speech-language pathologists.

New §741.216 creates a new rule applicable to audiologists, which sets forth all of the requirements particular to providing audiology services by telepractice. The first reference to the "State of Texas" was capitalized for grammatical consistency in adoption.

The repeal of and new §741.66 implement SB 312, 83rd Legislature, Regular Session, 2013, SB 162 (83rd Legislature, Regular Session, 2013), and HB 2254 (83rd Legislature, Regular Session, 2013), and incorporate existing requirements from Texas Occupations Code, Chapter 55, regarding licensing in speech-language pathology of military service members, military veterans, and military spouses. Revisions were made to the §741.66 title, subsection (f), and subsection (i), to provide for clearer and more thorough implementation of 2013 legislative requirements and incorporation of existing provisions in Texas Occupations Code, Chapter 55.

The repeal of and new §741.86 implement SB 312, 83rd Legislature, Regular Session, 2013, SB 162 (83rd Legislature, Regular Session, 2013), and HB 2254 (83rd Legislature, Regular Session, 2013), and incorporate existing requirements from Texas Occupations Code Chapter 55, regarding licensing in audiology of military service members, military veterans, and military spouses. Revisions were made to the §741.86 title, subsection (f), and subsection (i), to provide for clearer and more thorough implementation of 2013 legislative requirements and incorporation of existing provisions in Texas Occupations Code, Chapter 55.

COMMENTS

The board, and its Rules, Audiology Scope of Practice, and Speech-Language Pathology Scope of Practice committees, have reviewed comments received during the public comment period regarding the proposed amendments, repeal, and new rules, and each received public comments on the proposed rules during their respective committee meetings, held on July 17, 2014, and at the meeting of the full board, held on July 18, 2014. The board's responses to comments are based upon recommendations from the committees and additional consideration of comments and recommended amendments by the full board. Comments were received from multiple licensed Speech-Language Pathologists and from individuals on behalf of, or associated with, the following groups and associations: National Alliance for Medicaid In Education, PresenceLearning, Texas Charter Schools Association, Texas Council of Administrators of Special Education, Inc. (TCASE), Texas Hearing Aid Association (THAA), Texas Speech-Language-Hearing

Association (TSHA), Texas Speech-Language-Hearing Association/Texas Council of Administrators of Special Education Joint Committee, Texas Tech University Health Sciences Center, Big Spring Independent School District. The commenters were not against the rules in their entirety, and some commenters expressed support for particular rules. However, the commenters made recommendations for changes as discussed in the summary of comments.

Comment: Regarding §741.162(g), a commenter requested clarification of the amended rule language proposed.

Response: The board agrees that the reference to "semester year" in the proposed rule amendment is unclear, and revised §741.162(g) to provide that the referenced university or college course work "shall be approved for 10 continuing education hours per semester hour, with a maximum of 20 continuing education hours per course."

Comment: Regarding §741.211(5), a commenter questioned the rationale for permitting an audiology intern, but not a speech-pathology intern, to be a telehealth provider, and expressed opposition to either being allowed.

Response: The board disagrees that the rule needs to be changed to prohibit both speech-pathology and audiology interns from acting as telehealth providers. The nature of telehealth services provided by audiology interns would be primarily in the nature of assessment and evaluation in most cases, and would be permissible only to the extent that supervisors themselves have the requisite competence to supervise an intern's telepractice, and have verified that an intern has the requisite qualifications to perform the service provided. While speech-language pathology interns and supervisors would be subject to the same limitations, the nature of a speech-language pathology intern's telehealth services would be providing therapy primarily. Given that telepractice is a relatively new method of service delivery, with industry standards and education for it still evolving, and more variability in skill, training, and experience levels among supervisors, the board considers requiring interns in speech-language pathology to develop their initial therapy skills and experience using a less fluid method of service delivery to best serve the health and welfare of clients at this time. The board, therefore, adopts §741.211(5) as proposed, but will continue to monitor developments in the field in an effort to ensure that its rules continue to serve those interests.

Comment: Regarding §741.211(6), a commenter pointed out a grammatical error in number agreement.

Response: The board agrees that the first "are" in §741.211(6) should be changed to "is," and has revised the rule accordingly.

Comment: Regarding §741.213(h), formerly §741.213(g), commenters for or associated with TCASE, TSHA, TSHA/Texas Council of Administrators of Special Education Joint Committee, and Texas Tech University Health Sciences Center proposed that the language in §741.213(h) referring to "[t]he initial contact between the speech-language pathologist and the client" be amended to refer to "[t]he initial contact between a speech-language pathologist and the client" (italics added), in order to allow a licensed speech-language pathologist who is not the telehealth provider to fulfill the "initial contact" requirement.

Commenters for or associated with the Texas Charter Schools Association, PresenceLearning, and Big Spring Independent School District requested amendments to the requirement that the initial contact with a client to assess the client's candidacy for telehealth must be in person, at the same physical location as the client, prior to providing telehealth services. There was some variation in the specific suggestions for amendment, but all sought some form of exception in school settings, where the commenters contended that the Admission, Review and Dismissal (ARD) process and participants could collect the information necessary to adequately determine, or to allow a remote speech-language pathologist to determine, a client's candidacy for telehealth. The commenters' contentions included that the "initial in-person contact" requirement was cost-prohibitive, reduced client choice and access, especially in remote areas, to speech-language pathology and bilingual services, and erected an unnecessary barrier to the use of telepractice in schools to address shortages in, and uneven geographic distribution of, speech-language pathologists.

A commenter for or associated with National Alliance for Medicaid In Education expressed support for telehealth, without making a specific suggestion for changes.

Response: The board agrees with the suggested change from "the" to "a" in §741.213(h), but has added the term "licensed" after "a," so that the rule now refers to the initial contact between "a licensed speech-language pathologist" and the client, which had been the language the board had originally intended to publish for proposal, but "the" was published in error. This wording change clarifies that the initial in-person contact with a licensed speech-language pathologist does not have to be with the same licensed speech-language pathologist who would provide telehealth services for any client determined to be an appropriate candidate for telehealth, and could help to guard against unconscious bias toward overidentification of suitable candidates for telehealth by speech-language pathologists who would also be the telehealth provider if a client were determined to be a suitable candidate for telehealth.

The board recognizes the valuable and effective role that the availability of telehealth can play in the field of speech-language pathology for appropriate candidates, improving client access to services, including bilingual services, and reducing speech-language pathologists' caseloads in areas of the state most affected by a shortage of licensed speech-language pathologists. The board disagrees, however, with the commenters opposing the initial in-person contact requirement. Determining the services and method of service delivery that are best-suited to a client's capacities and potential, and which will be most effective to meet a client's needs, will often require tactile interaction with the client and/or close examination of a client, including, for example, trained examination of the inside of a client's mouth. Moreover, although all of the commenters were licensed professionals or individuals associated with organizations involved in the profession, there was no consensus that initial in-person contact to determine a student's candidacy for telepractice was not needed to ensure an appropriate determination of suitable candidacy, and one commenter noted during public comment before the Rules Committee that a survey conducted by TCASE reflected that most school districts could presently meet this requirement with staff or contracted Speech-Language Pathologists licensed in Texas.

Studies cited by the commenters or otherwise reviewed by members of the board primarily addressed the efficacy of telehealth, without addressing the methods for determining the client's candidacy for services by telepractice. Moreover, commenters requesting some form of exception to the initial in-person con-

tact requirement in school settings generally supported maintaining that requirement in other settings, implicitly recognizing that there presently is not sufficient evidence that a remote evaluation of a client through telepractice for suitable candidacy is as reliable and effective as an in-person evaluation. Other participants in the ARD process do not have the training or license to make this determination, or to ensure identification and consideration of all facts relevant to a licensed speech-language pathologist's determination concerning suitable candidacy. Without a clear evidence-based rationale for making exceptions for the initial in-person contact in the school context, the board considers clients to be best protected by maintaining the rule requirement for an in-person contact to assess a client's telehealth candidacy.

Although commenters seeking a school-based exception argued that the rule, as proposed, with its initial in-person contact requirement to determine a client's candidacy for telepractice, created a rule that was cost-prohibitive, the substance of that requirement is not new. It has existed in rule in §741.213(g), which will now become §741.213(h) under the adopted rules, since 2011, so would impose no new costs. In fact, explicitly permitting a licensed speech-language pathologist other than the licensee who would provide any telehealth services to a suitable candidate could actually reduce costs for schools by not requiring a remote provider to travel to where the client is for the initial in-person contact, and will thus increase the flexibility schools have under existing rule. Moreover, a school district with a shortage of licensed speech-language pathologists would be required to contract with licensed providers at additional cost to the district, whether the service were in person or remote and would still have to service students in person who were not good candidates for telepractice.

One commenter from the Big Spring Independent School District made reference to out-of-state providers of telehealth without indicating whether the out-of-state providers also hold a Texas license as speech-language pathologists. The existing requirement in §741.215(a) that a provider of telehealth services who practices in the State must be licensed by the board was not proposed for amendment and remains unchanged in the adopted rule.

After consideration of the comments submitted, therefore, the board adopts §741.213(h), formerly §741.213(g), as revised, which maintains the initial in-person contact required under existing rule, while adding the flexibility for the in-person contact to be by a licensed speech-language pathologist who is not the provider of telehealth services. The board will continue to monitor studies relating to telepractice and the selection of clients for telepractice in an effort to keep its rules consistent with evidence-based standards and findings.

Comment: One commenter pointed out a grammatical or typographical error in §741.214(a), which was proposed to be corrected by changing "speech-language pathologist" to the plural form.

Response: The board agrees, and revises §741.214(a) to read, "The limitations of this section apply to the use of telecommunications technology by speech-language pathologists."

SUBCHAPTER A. DEFINITIONS

22 TAC §741.1

STATUTORY AUTHORITY

The amendment is authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Vickie Dionne, Au.D.

Presiding Officer

State Board of Examiners for Speech-Language Pathology and Audiology

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For further information, please call: (512) 776-6972

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SUBCHAPTER B. THE BOARD

22 TAC §741.13

STATUTORY AUTHORITY

The amendment is authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. REQUIREMENTS FOR LICENSURE OF SPEECH-LANGUAGE PATHOLOGISTS

22 TAC §§741.61, 741.62, 741.64, 741.66

STATUTORY AUTHORITY

The amendments and new rule are authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

§741.66. Licensing in Speech-Language Pathology for Military Service Members, Military Veterans, and Military Spouses.

(a) This section sets out the speech-language pathology licensing process and procedures for military service members, military veterans, and military spouses required under Texas Occupations Code, Chapter 55 (relating to Licensing of Military Service Members, Military Veterans, and Military Spouses) and Texas Occupations Code, §401.315 (relating to Licensing for Military Spouses as speech-language pathologists or audiologists). For purposes of this section:

(1) Military service member means a person who is currently serving in the armed forces of the United States, in a reserve component of the armed forces of the United States, including the National Guard, or in the state military service of any state.

(2) Military spouse means a person who is married to a military service member who is currently on active duty.

(3) Military veteran means a person who has served in the army, navy, air force, marine corps, or coast guard of the United States, or in an auxiliary service of one of those branches of the armed forces.

(b) An applicant shall provide to the board documentation of the applicant's status as a military service member, military veteran, or military spouse. Acceptable documentation includes, but is not limited to, copies of official documents such as military service orders, marriage licenses, and military discharge records. The application of a person who fails to provide documentation of his or her status shall not be processed under the requirements of this section.

(c) An applicant shall provide to the board acceptable proof of current licensure issued by another jurisdiction. Upon request, the applicant shall provide proof that the licensure requirements of that jurisdiction are substantially equivalent to the licensure requirements of this state.

(d) The board's authority to require an applicant to undergo a criminal history background check, and the timeframes associated with that process, are not affected by the requirements of this section.

(e) For an application for a license submitted by a verified military service member or military veteran, the applicant shall receive credit towards any licensing requirements, except an examination requirement, for verified military service, training, or education that is relevant to the occupation, unless he or she holds a restricted license issued by another jurisdiction or if he or she has an unacceptable criminal history as described by Texas Occupations Code, Chapter 53.

(f) The board shall issue, as soon as practicable, a license to a verified military spouse who has completed and submitted the application and required fee(s) to the board and meets the following requirements:

(1) for a military spouse applying for a license as a speech-language pathologist:

(A) was licensed in good standing as a speech-language pathologist in another state as of the date of the application; and

(B) holds a master's degree in at least one of the areas of communicative sciences or disorders from a program accredited by a national accrediting organization that is:

(i) approved by the board; and

(ii) recognized by the United States Secretary of Education under the Higher Education Act of 1965 (20 U.S.C. §1001, *et seq.);*

(2) for a military spouse applying for any other category of speech-language pathology license, holds a current license in good standing issued by another state that has licensing requirements that are substantially equivalent to the requirements for the license for which the military spouse is applying; and

(3) for any applicant under paragraph (1) or (2) of this subsection:

(A) has not been the subject of a disciplinary action in any jurisdiction in which the applicant is or has been licensed; and

(B) has no criminal history that would preclude issuance of the license pursuant to Texas Occupations Code, Chapter 53.

(g) If the board issues an initial license to an applicant who is a verified military spouse in accordance with subsection (f) of this section, the board shall assess whether the applicant has met all licensing requirements of this state by virtue of the current license issued by another jurisdiction. The board shall provide this assessment in writing to the applicant at the time the license is issued. If the applicant has not met all licensing requirements of this state, the applicant must provide to the board proof of completion of those requirements at the time of the first renewal of the license. A license shall not be renewed, shall be allowed to expire, and shall become ineffective if the applicant does not provide proof of completion at the time of the first renewal of the license.

(h) A military spouse who within the five years preceding the application date held the license in this state that expired while the applicant lived in another state for at least six months is qualified for licensure based on the previously held license, if there are no unresolved complaints against the applicant and if there is no other bar to licensure, such as a criminal background or non-compliance with a board order.

(i) In accordance with Texas Occupations Code, §55.004(c), the executive director may waive any prerequisite for a military spouse to obtain a license under subsection (f) of this section after reviewing the applicant's credentials and determining that the applicant holds a license issued by another jurisdiction that has licensing requirements substantially equivalent to those of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Vickie Dionne, Au.D.
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State Board of Examiners for Speech-Language Pathology and Audiology
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For further information, please call: (512) 776-6972

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22 TAC §741.66

STATUTORY AUTHORITY

The repeal is authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER F. REQUIREMENTS FOR LICENSURE OF AUDIOLOGISTS

22 TAC §§741.81, 741.84, 741.86

STATUTORY AUTHORITY

The amendments and new rule are authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

§741.86. Licensing in Audiology for Military Service Members, Military Veterans, and Military Spouses.

(a) This section sets out the audiology licensing process and procedures for military service members, military veterans, and military spouses required under Texas Occupations Code, Chapter 55 (relating to Licensing of Military Service Members, Military Veterans, and Military Spouses) and Texas Occupations Code, §401.315 (relating to Licensing for Military Spouses as speech-language pathologists or audiologists). For purposes of this section.

(1) Military service member means a person who is currently serving in the armed forces of the United States, in a reserve component of the armed forces of the United States, including the National Guard, or in the state military service of any state.

(2) Military spouse means a person who is married to a military service member who is currently on active duty.

(3) Military veteran means a person who has served in the army, navy, air force, marine corps, or coast guard of the United States, or in an auxiliary service of one of those branches of the armed forces.

(b) An applicant shall provide to the board documentation of the applicant's status as a military service member, military veteran, or military spouse. Acceptable documentation includes, but is not limited to, copies of official documents such as military service orders, marriage licenses, and military discharge records. The application of a person who fails to provide documentation of his or her status shall not be processed under the requirements of this section.

(c) An applicant shall provide to the board acceptable proof of current licensure issued by another jurisdiction. Upon request, the applicant shall provide proof that the licensure requirements of that jurisdiction are substantially equivalent to the licensure requirements of this state.

(d) The board's authority to require an applicant to undergo a criminal history background check, and the timeframes associated with that process, are not affected by the requirements of this section.

(e) For an application for a license submitted by a verified military service member or military veteran, the applicant shall receive credit towards any licensing requirements, except an examination requirement, for verified military service, training, or education that is relevant to the occupation, unless he or she holds a restricted license issued by another jurisdiction or if he or she has an unacceptable criminal history as described by Texas Occupations Code, Chapter 53.

(f) The board shall issue, as soon as practicable, a license to a verified military spouse who has completed and submitted the application and required fee(s) to the board and meets the following requirements:

(1) for a military spouse applying for a license as an audiologist:

(A) was licensed in good standing as an audiologist in another state as of the date of the application; and

(B) holds a master's degree in at least one of the areas of communicative sciences or disorders from a program accredited by a national accrediting organization that is:

(i) approved by the board; and

(ii) recognized by the United States Secretary of Education under the Higher Education Act of 1965 (20 U.S.C. §1001 *et seq.);*

(2) for a military spouse applying for any other category of audiology license, holds a current license in good standing issued by another state that has licensing requirements that are substantially equivalent to the requirements for the license for which the military spouse is applying; and

(3) for any applicant under paragraph (1) or (2) of this subsection:

(A) has not been the subject of a disciplinary action in any jurisdiction in which the applicant is or has been licensed; and

(B) has no criminal history that would preclude issuance of the license pursuant to Texas Occupations Code, Chapter 53.

(g) If the board issues an initial license to an applicant who is a verified military spouse in accordance with subsection (f) of this section, the board shall assess whether the applicant has met all licensing requirements of this state by virtue of the current license issued by another jurisdiction. The board shall provide this assessment in writing to the applicant at the time the license is issued. If the applicant has not met all licensing requirements of this state, the applicant must provide to the board proof of completion of those requirements at the time of the first renewal of the license. A license shall not be renewed, shall be allowed to expire, and shall become ineffective if the applicant does not provide proof of completion at the time of the first renewal of the license.

(h) A military spouse who within the five years preceding the application date held the license in this state that expired while the applicant lived in another state for at least six months is qualified for licensure based on the previously held license, if there are no unresolved complaints against the applicant and if there is no other bar to licensure, such as criminal background or non-compliance with a board order.

(i) In accordance with Texas Occupations Code, §55.004(c), the executive director may waive any prerequisite for a military spouse to obtain a license under subsection (f) of this section after reviewing the applicant's credentials and determining that the applicant holds a license issued by another jurisdiction that has licensing requirements substantially equivalent to those of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Vickie Dionne, Au.D.

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For further information, please call: (512) 776-6972

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22 TAC §741.86

STATUTORY AUTHORITY

The repeal is authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

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SUBCHAPTER K. ISSUANCE OF LICENSE

22 TAC §741.141

The amendment is authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who

meet certain eligibility requirements and submit an application prior to September 1, 2014.

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SUBCHAPTER L. LICENSE RENEWAL AND CONTINUING PROFESSIONAL EDUCATION

22 TAC §§741.161, 741.162, 741.164

STATUTORY AUTHORITY

The amendments are authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

§741.162. Requirements for Continuing Professional Education.

(a) Continuing professional education in speech-language pathology and audiology as required by the Act consists of a series of planned individual learning experiences beyond the basic educational program which has led to a degree or qualifies one for licensure.

(b) A continuing education unit (CEU) is the basic unit of measurement used to credit individuals with continuing education activities for licensure. One CEU is defined as 10 contact hours of participation in an approved continuing education experience.

(c) A minimum of twenty clock hours (two CEUs) shall be required to renew a license issued for a two-year term. The holder of dual licenses, meaning both a speech-language pathology license and an audiology license, shall be required to earn 30 clock hours (three CEUs) to renew a license issued for a two-year term. Effective April 30, 2009, a license holder must complete a minimum of 2.0 clock hours (0.2 CEUs) in ethics as part of the continuing education requirement each renewal term.

(d) When renewing an initial license, the licensee shall submit 10 continuing education hours if the initial license was issued for less than 12 months and 20 continuing education hours if the initial license was issued for more than 12 months. Continuing education hours earned before the original effective date of a license are not acceptable.

(e) Continuing professional education shall be earned in one of the following areas:

(1) basic communication processes;

(2) speech-language pathology;

(3) audiology;

(4) ethics; or

(5) an area of study related to the areas listed in paragraphs (1) - (4) of this subsection.

(f) Any continuing education activity shall be provided by a board approved sponsor with the exception of activities referenced in subsections (g) - (i) of this section. A list of approved sponsors designated by the board shall be made available to all licensees on the board's website.

(g) University or college course work completed with a grade of at least a "C" or for credit from an accredited college or university in the areas listed in subsection (e)(1) - (4) of this section shall be approved for 10 continuing education hours per semester hour, with a maximum of 20 continuing education hours per course.

(h) For any coursework that is offered by a sponsor that is not board approved, the licensee shall submit by email the course brochure or syllabus 30 days prior to the event for consideration for approval. Partial credit may be awarded.

(i) Earned continuing education hours exceeding the minimum requirement in a previous renewal period shall first be applied to the continuing education requirement for the current renewal period.

(1) A maximum of 10 additional clock hours may be accrued during a license period to be applied to the next consecutive renewal period. Two of the 10 additional clock hours of the rollover hours may be in ethics.

(2) A maximum of 15 additional clock hours may be accrued by dual speech-language pathology and audiology licensees during a license period to be applied to the next consecutive renewal period.

(j) The licensee shall be responsible for maintaining a record of his or her continuing education experiences for a period of at least three years.

(k) Proof of completion of a valid continuing education experience shall include the name of the licensee, the sponsor of the event, the title and date of the event, and the number of continuing education hours earned. Acceptable verification shall be:

(1) a letter, Continuing Education (CE) registry, or form bearing a valid signature or verification as designated by the board approved sponsor;

(2) in the event verification referenced in paragraph (1) of this subsection cannot be obtained, the board may accept verification from the presenter of an approved event if the presenter can also provide proof that the event was acceptable to an approved sponsor; or

(3) an original or certified copy of the university or college transcript if earned under subsection (g) of this section.

(l) The documentation, certificates, diplomas, or other documentation verifying earning of continuing education hours shall not be forwarded to the board at the time of renewal unless the board selected the licensee for audit.

(m) The audit process shall be as follows.

(1) The board shall select for audit a random sample of licensees for each renewal month. The renewal form shall indicate whether the licensee has been selected for audit.

(2) A licensee selected for audit shall submit documentation defined in subsections (k) and (l) of this section at the time the renewal form and fee are submitted to the board.

(3) Failure to furnish this information in a timely manner or providing false information during the audit or renewal process are grounds for disciplinary action against the licensee.

(4) A licensee who is selected for continuing education audit may renew through the online renewal process. However, the license will not be considered renewed until required continuing education documents are received, accepted and approved by the board office.

(n) Completion of the jurisprudence examination shall count as one hour of the continuing education requirement for professional ethics, as referenced in subsection (c) of this section per renewal period.

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SUBCHAPTER O. TELEHEALTH

22 TAC §§741.211 - 741.216

STATUTORY AUTHORITY

The amendments and new rule are authorized under Texas Occupations Code, §401.202, which provides the State Board of Examiners for Speech-Language Pathology and Audiology with the authority to adopt rules necessary to administer and enforce Texas Occupations Code, Chapter 401; Texas Occupations Code, §401.405, which specifically authorizes the board to adopt telepractice rules for the practice of audiology and speech-language pathology by a person licensed under Texas Occupations Code Chapter 401; and Texas Occupations Code, §§55.002, 55.004, 55.005, 55.007, and SB 162, 83rd Legislature, Regular Session, 2013, which provide rulemaking authority and requirements concerning licensing of military service members, military veterans, and military spouses; and SB 312, which authorizes the board by rule to establish a procedure to license as audiologists certain individuals with lapsed licensed who meet certain eligibility requirements and submit an application prior to September 1, 2014.

§741.213. Requirements for the Use of Telehealth by Speech-Language Pathologists.

(a) The requirements of this section apply to the use of telehealth by speech-language pathologists.

(b) A provider shall comply with the board's Code of Ethics and Scope of Practice requirements when providing telehealth services.

(c) The scope, nature, and quality of services provided via telehealth are the same as that provided during in-person sessions by the provider.

(d) The quality of electronic transmissions shall be equally appropriate for the provision of telehealth services as if those services were provided in person.

(e) A provider shall only utilize technology which they are competent to use as part of their telehealth services.

(f) Equipment used for telehealth services at the clinician site shall be maintained in appropriate operational status to provide appropriate quality of services.

(g) Equipment used at the client/patient site at which the client or consultant is present shall be in appropriate working condition and deemed appropriate by the provider.

(h) The initial contact between a licensed speech-language pathologist and client shall be at the same physical location to assess the client's candidacy for telehealth, including behavioral, physical, and cognitive abilities to participate in services provided via telecommunications prior to the client receiving telehealth services.

(i) A provider shall be aware of the client or consultant level of comfort with the technology being used as part of the telehealth services and adjust their practice to maximize the client or consultant level of comfort.

(j) When a provider collaborates with a consultant from another state in which the telepractice services are delivered, the consultant in the state in which the client receives services shall be the primary care provider for the client.

(k) As pertaining to liability and malpractice issues, a provider shall be held to the same standards of practice as if the telehealth services were provided in person.

(l) A provider shall be sensitive to cultural and linguistic variables that affect the identification, assessment, treatment, and management of the clients.

(m) Upon request, a provider shall submit to the board data which evaluates effectiveness of services provided via telehealth including, but not limited to, outcome measures.

(n) Telehealth providers shall comply with all laws, rules, and regulations governing the maintenance of client records, including client confidentiality requirements, regardless of the state where the records of any client within this state are maintained.

(o) Notification of telehealth services shall be provided to the client, the guardian, the caregiver, and the multi-disciplinary team, if appropriate. The notification shall include, but not be limited to: the right to refuse telehealth services, options for service delivery, and instructions on filing and resolving complaints.

§741.214. Limitations on the Use of Telecommunications Technology by Speech-Language Pathologists.

(a) The limitations of this section apply to the use of telecommunications technology by speech-language pathologists.

(b) Supervision of a licensed assistant and/or intern in speech-language pathology shall not be undertaken through the use of telecommunications technology unless an exception to this prohibition is secured pursuant to the terms of this section.

(c) An exception to subsection (b) of this section shall be requested by the speech-language pathologist submitting the prescribed alternate supervision request form for review by the board's designee, within 15 working days of receipt of the request. The board's designee shall approve or not approve the plan. The plan shall be for not more than one year's duration.

(d) If the exception referenced in subsection (c) of this section is approved and the reason continues to exist, the licensed supervising speech-language pathologist shall annually resubmit a request to be evaluated by the board's designee. Within 15 working days of receipt of the request, the board's designee shall approve or not approve the plan.

(e) Telehealth services may not be provided by correspondence only, e.g., mail, email, faxes, although they may be adjuncts to telepractice.

§741.216. Requirements for Providing Telepractice Services in Audiology.

(a) Unless otherwise legally authorized to do so, an individual shall not render telepractice services in audiology from the State of Texas or to a client in the State of Texas, unless the individual qualifies as a provider as that term is defined in this subchapter and renders only those telepractice services that are within the course and scope of the provider's licensure and competence, and delivered in accordance with the requirements of that licensure and pursuant to the terms and conditions set forth in this section.

(b) The provider shall use only telecommunications technology that meets the definition of that term, as defined in this subchapter, to render telepractice services. Modes of communication that do not utilize such telecommunications technology, including telephone, facsimile, and email, may be used only as adjuncts.

(c) Subject to the requirements and limitations of this section, a provider may utilize a facilitator at the client site to assist the provider in rendering telepractice services.

(d) The provider shall be present at the provider site and shall be visible and audible to, and able to see and hear the client and the facilitator via telecommunications technology in synchronous, real-time interactions, even when receiving or sending data and other telecommunication transmissions in carrying out the telepractice services. The provider is responsible for the actions of the facilitator and shall monitor the client and oversee and direct the facilitator at all times during the telepractice session.

(e) The provider of telepractice services, prior to allowing a facilitator to assist the provider in rendering telepractice services, shall verify and document the facilitator's qualifications, training, and competence in each task the provider directs the facilitator to perform at the client site, and in the methodology and equipment the facilitator is to use at the client site.

(f) The facilitator may perform at the client site only the following tasks:

(1) Those physical, administrative, and other tasks for which the provider has trained the facilitator in connection with the rendering of audiology services for which no form of license, permit, authorization or exemption under the Texas Occupations Code is required; and

(2) a task for which the facilitator holds and acts in accordance with any license, permit, authorization or exemption required under the Texas Occupations Code to perform the task.

(g) A provider shall not render telepractice services to a client in those situations in which the presence of a facilitator is required for safe and effective service to the client and no qualified facilitator is available to the client during the telepractice session.

(h) The scope, nature, and quality of the telepractice services provided, including the assistance provided by the facilitator, shall be commensurate with the services the provider renders in person at the same physical location as the client.

(i) The provider shall not render telepractice services unless the telecommunications technology and equipment located at the client site and at the provider site are appropriate to the telepractice services to be rendered; are properly calibrated and in good working order; and are of sufficient quality to allow the provider to deliver equivalent audiology service and quality to the client as if those services were provided in person at the same physical location. The provider shall only utilize telecommunications technology and other equipment for the provider's telepractice which the provider is competent to use.

(j) Providers and facilitators involved in the provider's delivery of telepractice services shall comply with all laws, rules, and regulations governing the maintenance of client records, including client confidentiality requirements. Documentation of telepractice services shall include documentation of the date and nature of services performed by the provider by telepractice and of the assistive tasks of the facilitator.

(k) Except to the extent it imposes additional or more stringent requirements, this section does not affect the applicability of any other requirement or provision of law to which an individual is otherwise subject under this chapter or other law.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 73. LABORATORIES

25 TAC §§73.31, 73.41, 73.51, 73.54, 73.55

The Executive Commissioner of the Health and Human Services Commission (commission), on behalf of the Department of State Health Services (department), adopts amendments to §§73.31, 73.41, 73.51, 73.54, and 73.55 concerning fee schedules for clinical testing, newborn screening, and chemical analysis without changes to the proposed text as published in the May 2, 2014, issue of the *Texas Register* (39 TexReg 3541) and, therefore, the sections will not be republished.

BACKGROUND AND PURPOSE

This rule package concerns fees for laboratory services--specifically, specimen submission, sale of laboratory services, technical definitions associated with the sale of laboratory services, and fee schedules for clinical testing, newborn screening, and chemical analysis.

Adopted amendments to §73.51 remove the technical definitions from these rules and replace them with a cross reference to the department's website where the definitions will now be located. The adopted revisions provide alternative means of getting these definitions for those who do not have Internet access. Definitions for the technical terms in §73.51 change routinely as the science underlying them evolves, and so the department's Laboratory Services Section (LSS) believes that it makes more sense to move these definitions into the "Laboratory Testing Services Manual," with a rule providing a cross-reference to that document as well as providing information on how to obtain it. This change allows the technical terms to be updated as needed without going through the rulemaking process. This will help the department provide better service to its submitters because the manual--which lists the tests that the LSS offers and also outlines specimen collection and acceptance criteria-will be kept current at all times. This strategy helps reduce the chances of the department having to reject a specimen because the most up-to-date procedures for storage/shipping were not followed. Actual fee amounts remain in the rules, and are not impacted by this change in how technical definitions are handled.

Some fee amounts in the fee schedules in these rule sections changed in this rulemaking action. Senate Bill (SB) 80, 82nd Legislature, Regular Session, 2011, required that the department: (1) develop, document and implement procedures for setting fees for laboratory services, including updating and implementing a documented cost allocation methodology that determines reasonable costs for the provision of laboratory tests; and (2) analyze the department's costs and update the fee schedule as needed in accordance with Texas Health and Safety Code, §12.032(c). In a past rulemaking action (adopted October, 2012), the LSS developed and documented a cost accounting methodology and determined the costs for each test performed listed in the fee schedule. The methodology for developing cost per test included calculating the specific costs of performing a test or analysis and the administrative and overhead cost necessary to operate the state laboratories in question. It is these figures together which determined the revised fee amount for each of the tests in these fee schedules. In order to determine the specific cost for each test or analysis, LSS performed a work load unit study for every procedure or test offered by the laboratory. A work load unit was defined as a measurement of staff time, consumables and testing reagents required to perform each procedure from the time the sample enters the laboratory until the time the results are reported. More than 3,000 procedures performed by the department's LSS were included in this analysis. These procedures translated to approximately 700 different tests listed in the department fee schedule. It was understood at that time that the department will need to make periodic subsequent changes to its fee schedule in the rules in order to reflect changes in actual cost over time. Whenever such rulemaking actions are proposed, they employ the same fee calculation methodology mandates by law in 2011. In the current rulemaking adoption, this same approach was employed on a much smaller number of tests. These adopted fee changes reflect the department's current costs for providing the services at issue.

Adopted amendments to §73.54 and §73.55 are necessary because those fee schedules need to be updated to incorporate new laboratory tests, update test method references and fees, correct past errors in fee calculation, update to current actual costs using the standard formula, and to delete laboratory tests that are no longer performed by the department. For some of the tests that have been deleted, the current testing equipment or methodologies are no longer supported by the applicable manufacturers. Many of these changes to new testing methodologies will allow submitters to get faster and/or more accurate results.

Tests that are now no longer offered by the department are readily available elsewhere and only a few specific fees have increased by virtue of these rule changes. The fee increases in the clinical chemistry section of §73.54 are: cholesterol increased from $4.07 to $5.18; glucose fasting from $3.96 to $4.30; glucose post prandial (1 hour) from $3.96 to $8.60; glucose post prandial (2 hour) from $7.91 to $12.90; glucose random from $3.96 to $4.30; glucose tolerance test (1 hour) from $7.91 to $8.60; glucose tolerance test (2 hour) from $11.87 to $12.90 glucose tolerance test 3 hour from $15.82 to $17.20; and Lipid panel from $10.57 to $15.04. These increases are due to new technology and lower specimen volume.

Updated work load unit studies were conducted for the definitive identification for Campylobacter at the Austin Laboratory and PCR Ricin for the South Texas Laboratory resulting in an increased fee for both tests. In §73.54, Campylobacter increased from $165.44 to $166.88 and PCR for Ricin increased from $150.00 to $151.42.

In §73.54, the fee for Shiga toxin producing *E. coli.* PCR increased from $36.60 to $117.90. This increase was due to an error in application of the cost calculation formula for the fee adopted in October 2012. The error in the rule text must be corrected to ensure that the department recoups the department's actual costs as called for in the cost calculation formula as required by law. The costs of the consumables were accidently left out of the calculation and the price increase is the corrected price that reflects the department's actual cost to perform the test under the proper application of the standard formula.

In §73.54, the fee for Metals in urine in the Emergency Preparedness section increased from $173.25 to $176.25. This increase in price is necessary because an error was found in the previous rule text. The actual cost to perform the test is $176.25. This increase was due to a typographical error for the fee adopted in October 2012. The error in the rule text must be corrected to ensure that the LSS recoups the department's actual costs as called for in the cost calculation formula as required by law. The cost methodology used is as described in the Background and Purpose Section.

In §73.54, the Acid Fast Bacilli section, the fees for two tests were accidently reversed during the same rulemaking action referenced immediately above. Direct detection by high-performance liquid chromatography (HPLC) was $124.90 but was amended to the correct fee of $66.26; while identification of AFB isolates, HPLC was $66.26, but was amended to the correct fee of $124.90.

In §73.55, the fee for all metals drinking water group, EPA methods 200.7, 200.8 and 245.1 and SM 19th edition 2340B increased from $152.43 to $160.16. This fee increase is due to the addition of potassium as a metal to be identified in drinking water.

The adopted amendments comport with Texas Health and Safety Code, §12.031, §12.032, and §12.0122 that allow the department to charge fees to a person who receives public health services from the department, with fee amounts set to recover the department's costs for performing laboratory services.

SECTION-BY-SECTION SUMMARY

Previous §73.31(a) was amended by changing the name of the "Manual of Reference Services" to its new name "Laboratory Testing Services Manual," as well as, adding the reference to the LSS's website (currently found at http://www.dshs.state.tx.us/lab) for the manual's location.

Previous §73.31(c) was amended by updating the department's LSS phone number to (512) 776-7318 and by removing the website reference since it now appears in subsection (a) of this section.

Previous §73.41(e) was amended by changing the name of the "Manual of Reference Services" to its new name "Laboratory Testing Services Manual," as well as adding the reference to the LSS website (currently found at http://www.dshs.state.tx.us/lab) for the manual's location.

Previous §73.51 was amended by removing the technical definitions from these rules and moving them into the "Laboratory Testing Service Manual," with the rule providing a cross-reference to that manual and detailing different methods for obtaining a copy of the manual. The reason for this adopted change, as discussed previously in the Background and Purpose Section, is to provide the flexibility to update these technical definitions in a timely manner (i.e., outside of the rulemaking process) as the science underlying the applicable terms evolves.

Previous §73.54(a)(1)(B)(iii), (iv), and (x) were amended by increasing the fees to reflect both new technology being used for the tests and a decrease in testing volume experienced by department for these particular services: (iii) Cholesterol increased from $4.07 to $5.18; (iv) Glucose: (I) glucoses fasting increased from $3.96 to $4.30; (II) glucose post prandial (1 hour) increased from $3.96 to $8.60; (III) glucose post prandial (2 hour) increased from $7.91 to $12.90; (IV) glucose random increased from $3.96 to $4.30; (V) glucose tolerance test (1 hour) increased from $7.91 to $8.60; (VI) glucose tolerance test (2 hour) increased from $11.87 to $12.90; (VII) glucose tolerance test (3 hour) increased from $15.82 to $17.20; and (x) Lipid panel increased from $10.57 to $15.04.

Previous §73.54(a)(1)(B)(viii) was amended by decreasing the fee from $7.14 to $6.02 to reflect new technology.

The low volume tests in previous §73.54(a)(1)(B)(xi) and (x) were deleted to make more efficient use of LSS staff and to lower operational costs.

Previous §73.54(a)(2)(A)(vi)(I) was amended by decreasing the fee from $175.88 to 165.25. The fee reduction is due to decrease in identification time due to technician training.

Previous §73.54(a)(2)(A)(vi)(V) was amended by increasing the fee from $165.44 to $166.88. The increase is due to changes in testing methodology. The new test method is slightly more expensive for the department to perform.

Previous §73.54(a)(2)(A)(vi)(VI) was amended by deleting this subclause. This is a duplicate test and is more accurately placed in existing §73.54(a)(2)(A)(v). The remaining clauses were renumbered accordingly.

Previous §73.54(a)(2)(A)(vi)(X), which was renumbered as subclause (XI), was amended by reducing the fee from $242.23 to $107.64 to reflect new technology.

Previous §73.54(a)(2)(A) was amended by adding three new tests. These tests were added by inserting 3 new clauses: (vii) Diphtheria screen priced at $62.65, (xi) Group B streptococcus screen priced at $48.32, and (xiii) Kirby Bauer priced at $9.92. The remaining clauses were renumbered accordingly. The new clauses more accurately reflect the components of this particular type of laboratory service.

Previous §73.54(a)(2)(A)(ix), which was renumbered as clause (x), was amended by updating the name of the test to "*Escherichia coli (E. coli),* serotyping" to more accurately identify the test and by updating the fee from $26.64 to $25.71 due to the changes in technology used in the testing.

Previous §73.54(a)(2)(A)(x)(I), was renumbered as subclause (xii)(I), was amended by updating the name of the test to "Influenzae serotyping" to more accurately identify the test and by updating the fee from $91.58 to $79.64 due the changes in technology used in the testing.

Previous §73.54(a)(2)(A)(xii), which was renumbered as clause (xv), was amended by increasing the fee from $36.60 to $117.90. This increase in price is necessary because an error was found in the existing rule text. The actual cost to perform the test is $117.90. This increase was due to an error in application of the cost calculation formula for the fee adopted in October 2012. The error in the rule text must be corrected to ensure that the LSS recoups the department's actual costs as called for in the cost calculation formula. The cost methodology used is as described in the Background and Purpose section in this preamble. The costs of the consumables were accidently left out of the calculation and the price increase is the corrected price that reflects the department's actual cost to perform the test.

Previous §73.54(a)(2)(B)(ii)(II) and (VII) were amended by updating the name of the test to more accurately reflect the test as currently performed. The name changes to "Arsenic in urine, ICP-DRC (Dynamic reaction cell)-MS" and "Metals in urine (barium, beryllium, cadmium, lead, thallium, uranium), ICP/MS", respectively. Furthermore the fee for Metals in urine was corrected from $173.25 to $176.25. In a previous rule amendment (adopted in October 2012) the fee was accidently typed as $173.25. The correct fee should be $176.25.

Previous §73.54(a)(2)(C)(i)(I)(-c-) and (-d-)(-1-) were amended by correcting the fee associated with each test. In a previous rules amendment (adopted in October 2012) the fees were accidently reversed. Direct detection by high-performance liquid chromatography (HPLC) was $124.90, but is now amended to the correct fee of $66.26; while identification of AFB isolates, HPLC was $66.26 but is now amended to the correct fee of $124.90. Billing was not affected by this error. The correct fees were loaded in the billing system and the error only occurred in the rule text. Each of these fee amounts was reached using the standard calculation formula.

Previous §73.54(a)(2)(C)(v)(I)(-d-) was amended by updating the name of the test to "Isoniazid, .02 mcg/ml" to more accurately identify the test. A new item (a)(2)(C)(v)(I)(-e-) Isoniazid, 1.0mcg/ml, priced at $30.41, was added to further clarify the different concentrations of Isoniazid used in agar proportion drugs testing. The remaining items were renumbered accordingly.

Previous §73.54(a)(2)(C)(v)(I)(-f-) was amended by correcting the spelling of "Ofloxacin."

Previous §73.54(a)(2)(C)(v) was amended by deleting clauses (II) and (III), as the technology for these tests is no longer available. The remaining clauses were renumbered accordingly.

Previous §73.54(a)(2)(C)(v)(IV), was renumbered as subclause (II), was amended by reorganization of how the test is described in the rule, including adding new subitems to clarify the associated tests available. Previous §73.54(a)(2)(C)(v)(IV), was renamed" MGIT drugs susceptibility test:" and two items (-a-) Primary Panel (includes Isoniazid 0.1mg/ml, 0.4 mcg/ml, Ethambutol, and Rifampin), priced at $115.05; and (-b-) Individual MIGT primary drugs: were added to specific testing. Additionally, 4 new subitems were added to (-b-) to allow submitters to order testing for individual drugs when the entire drug panel is not needed. These 4 subitems are: (-1-) Isoniazid, .01mcg/ml, priced at $28.76; (-2-) Isoniazid, .04mcg/ml priced at $28.76; (-3-) Ethambutol, priced at $28.76; (-4-) Rifampin, priced at $28.76.

Previous §73.54(a)(2)(E)(i) was amended by reorganizing existing tests and adding new tests related to arbovirus testing to improve accuracy and readability, and to achieve consistency of format. Previous §73.54(a)(2)(E)(i)(I) was renamed "Immunoglobulin G IgG (EIA)." The three viruses referenced in existing language were broken out into individual tests to more accurately reflect how the department currently handles testing for arbovirus Immunoglobulin IgG. New items: (-a-) Dengue, priced at $72.15; (-b-) St. Louis Encephalitis, priced at $77.26; and (-c-) West Nile, priced at $77.26. Previous §73.54(a)(2)(E)(i)(II) was renamed "Immunoglobulin M (IgM) EIA." The three viruses referenced in existing language were broken out into individual tests to more accurately reflect how the lab currently handles testing for arbovirus Immunoglobulin IgM. New items: (-a-) Dengue, priced at $58.11; (-b-) St. Louis Encephalitis, priced at $107.84; and (-c-) West Nile priced at $107.84. Previous §73.54(a)(2)(E)(i)(III) PCR West Nile (WNV) and its corresponding fee were deleted. This test is listed in current rule and is more accurately placed in existing §73.54(c)(8)(A). A new test was added at §73.54(a)(2)(E)(i)(III). This test is called Immunoglobulin M (IgM) MIA (which includes: St. Louis Encephalitis and West Nile Virus), and its associated fee of $158.20, using the standard formula.

Previous §73.54(a)(2)(E)(ii), (iii), (v), (xvii), (xxii) and (xxiii) were amended by updating the name of the tests, to more accurately identify them, and by updating their associated fees to reflect new technology: (ii) *Brucella* IgG, with the fee reduced from $74.52 to $44.10; (iii) Cat scratch Fever *(Bartonella)* IgG, indirect fluorescent antibody (IFA), with the fee reduced from $171.30 to $95.19; (v) *Ehrlichia* IFA, with the fee reduced from $174.20 to $131.31; (xvii) Q-fever IgG, with the fee reduced from $234.97 to $85.61; (xxii) Schistosoma EIA, with the fee reduced from $134.49 to $10.30; and (xxiii) Strongyloides EIA, with the fee reduced from $73.45 to $16.89.

Previous §73.54(a)(2)(E)(ix), (x), and (xv) were amended by deleting the following low-volume tests: (ix) Hepatitis BeAb; (x) Hepatitis BeAg; (xv) Measles, mumps, rubella-*Varicella zoster* virus (MMR-VZV) Magnetic Immunoassay (MIA). These tests were deleted to make more efficient use of LSS staff and to lower operational costs. The remaining clauses were renumbered accordingly. As stated above, these tests are readily available at other laboratories in the state.

Previous §73.54(a)(2)(E)(xvi)(I) and (II), were renumbered as clause (xv), and were amended by updating the name of the tests to "IgG" and "IgM" respectively. The fee for IgM was decreased from $251.96 to $83.93 to reflect the implementation of new technology which has lowered the cost of performing the test.

New §73.54(a)(2)(E)(xvi) includes a new test, Pertussis Toxin IgG, priced at $89.86.

Previous §73.54(a)(2)(E)(xix) was amended by reorganizing the previous test under new subclauses to improve readability, accuracy and to achieve consistency of format. Previous §73.54(a)(2)(E)(xix) was renamed to *"Rickettsia* panel:" and two new subclauses were added to this clause to outline the individual tests available and the fees associated with those items: (I) Rocky Mountain spotted Fever (RMSF) IgG, priced at $42.93, and (II) Typhus fever IgG, priced at $42.93. This change more accurately reflects current testing in the department laboratories.

Previous §73.54(a)(2)(E)(xxi) and (xxvi) were renamed and moved within the subparagraph to be alphabetically arranged to improve accuracy and organization. Previous (xxi) Rubeola was renamed "Measles" and would be moved to §73.54(a)(2)(E)(xiv) with subclauses (I) IgG priced at $21.36 and (II) IgM priced with a reduced fee of $85.60 from $210.24. Previous (xxvi) Tularemia was renamed *"Francisella tularensis"* and move to §73.54(a)(2)(E)(vi) with subclauses (I) IgG priced at $61.15, and a new test added (II) IgM priced at $122.30. The remaining clauses were renumbered accordingly.

Previous §73.54(a)(2)(E)(xxiv)(I) was deleted. LSS has implemented a new screening process for syphilis and this previous reflex test is no longer in the testing algorithm. The remaining subclauses were renumbered accordingly.

Previous §73.54(a)(2)(E)(xxvii) was amended by reorganizing the previous test under new subclauses to improve readability, accuracy, and to achieve consistency of format. Previous §73.54(a)(2)(E)(xxvii), which is currently listed as the *Varicella zoster* test, was moved to subclause (I) and renamed "IgG." Under the reorganization, the new test for Immunoglobulin M was added at subclause (II), listed as "IgM" with a fee of $147.84 which was calculated using the standard formula.

Section 73.54(a)(2)(F)(ii) and all subclauses were deleted. These tests are more appropriately placed, from an organizational perspective, in existing §73.54(c)(8)(A). The remaining clauses were renumbered accordingly.

Previous §73.54(a)(2)(F)(xi), was renumbered as clause (x), and was amended by correcting grammatical format errors by adding semicolons instead of periods to allow for consistency of format.

New §73.54(a)(2)(F)(xii) added a new test for 2012 Novel Coronavirus, priced at $78.92.

Previous §73.54(b)(1)(E) was amended by updating the name of the test to "KOH exam for skin, hair, nails" to more accurately identify the test.

Previous §73.54(b)(3)(D)(vii) and (ix) were amended by updating the fees associated with the tests. The fee for (vii) Influenza A/H5 decreased from $125.00 to $90.62, and the fee for (ix) Ricin increased from $150.00 to $151.42. Both tests recently had an updated cost calculation conducted that resulted in the price change. These adjustments are necessary for the department to recoup cost of performing the testing.

Previous §73.54(b)(6)(D) was deleted. This test is a duplication of (b)(1)(F) and is more accurately placed in paragraph (1) Bacteriology.

Previous §73.54(b)(7)(B) and (I) were amended by updating the name of the test to "Follicle stimulating hormone (FSH)" and "Thyroid stimulating hormone (TSH)," respectively, to more accurately identify the tests.

Previous §73.54(c)(1) was deleted. This low-volume test was deleted to make more efficient use of LSS staff and to lower operational costs. Subsequent paragraphs were renumbered accordingly.

Previous §73.54(c)(4)(C), was renumbered to be (3)(C), and was amended by updating the name to "Yeast and mold enumeration" to more accurately reflect the test.

Previous §73.54(c)(5)(E)(i), was renumbered to be (4)(E)(i), and was amended by updating the name to "Charm 3SL-S beta lactam test" to more accurately reflect the test.

Previous §73.54(c)(6) was moved to new (c)(8) for alphabetical consistency of text. Remaining paragraphs were renumbered accordingly.

Previous §73.54(c)(7)(C) was amended by updating the name to "Fecal Coliforms (MPN)" to more accurately describe the test.

Previous §73.55(2)(A)(i)(XV) was amended by decreasing the fee from $135.47 to $53.75. New pricing reflects increase in volume which reduces operational cost.

Previous §73.55(2)(B)(iii)(I) was amended by increasing the fee from $152.43 to $160.16. The increase is due to the addition of potassium as a new element to the testing.

Previous §73.55(2)(C)(xii) was amended by removing method 502.2 from the name of the test. This older method was discontinued. The new name of the test would be "trihalomethanes, EPA method 524.2."

COMMENTS

The department, on behalf of the commission, did not receive any comments regarding the proposed rules during the comment period.

LEGAL CERTIFICATION

The Department of State Health Services, General Counsel, Lisa Hernandez, certifies that the rules, as adopted, have been reviewed by legal counsel and found to be a valid exercise of the agencies' legal authority.

STATUTORY AUTHORITY

The amendments are adopted under Texas Health and Safety Code, §12.031 and §12.032, which allow the department to charge fees to a person who receives public health services from the department, §12.034 which requires the department to establish collection procedures, §12.035 which required the department to deposit all money collected for fees and charges under §12.032 and §12.033 in the state treasury to the credit of the department's public health service fee fund, and §12.0122 which allows the department to enter into a contract for laboratory services; and Texas Government Code, §531.0055, and Texas 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 Texas Health and Safety Code, Chapter 1001.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 11, 2014.

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Lisa Hernandez
General Counsel
Department of State Health Services
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Proposal publication date: May 2, 2014
For further information, please call: (512) 776-6972

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 17. TAX RELIEF FOR PROPERTY USED FOR ENVIRONMENTAL PROTECTION

30 TAC §§17.4, 17.12, 17.14

The Texas Commission on Environmental Quality (TCEQ, agency, commission) adopts the amendment to §17.14 *with changes* to the proposed text as published in the March 14, 2014, issue of the *Texas Register* (39 TexReg 1823). Section 17.4 and §17.12 are adopted *without changes* to the proposed text and will not be republished.

Background and Summary of the Factual Basis for the Adopted Rules

The commission adopts the amendments to Chapter 17 to implement 2013 legislation, perform a review of property on the Tier I Table and Expedited Review List, and make various editorial or administrative changes within the rules for the TCEQ's tax relief for pollution control property or *Prop 2* program.

In 1993, the Texas Legislature, 73rd Legislature, enacted House Bill (HB) 1920, which created Texas Tax Code, §11.31 and §26.045. Texas Tax Code, §11.31 established a property tax exemption program for property that is used wholly or partly for pollution control. Texas Tax Code, §26.045 created a rollback tax relief program for political subdivisions. Texas Tax Code, §11.31 required the TCEQ to adopt rules to implement the tax relief program. Texas Tax Code, §26.045 gave the commission the authority to adopt rules but did not require the adoption of rules. In response, the commission adopted 30 TAC Chapter 277, Use Determinations for Tax Exemptions for Pollution Control Equipment, on September 30, 1994, to implement Texas Tax Code, §11.31. Chapter 277 was later repealed and replaced with Chapter 17 through rulemaking adopted May 26, 1999.

In 2007, the 80th Legislature modified Texas Tax Code, §11.31 through the passage of HB 3732. The legislature modified Texas Tax Code, §11.31 by adding three new subsections, (k), (l), and (m). Texas Tax Code, §11.31(k) requires the commission to adopt by rule a list of 18 categories of property listed in Texas Tax Code, §11.31(k). Texas Tax Code, §11.31(l) requires the commission to adopt a procedure to review the list at least once every

three years. In addition, it allows the removal of items from the list when there is compelling evidence that the item does not provide pollution control. Texas Tax Code, §11.31(m) requires the executive director to review applications, containing only items on the adopted list within 30 days of receipt of the required application documents. The executive director must issue a determination without regard to the information provided in response to §11.31(c)(1). On January 16, 2008, the commission adopted Chapter 17 amendments to implement the requirements of HB 3732. Included in that rulemaking was the commission's adoption of the Expedited Review List (now in §17.17(b)), taken from Texas Tax Code, §11.31(k).

In 2009, the 81st Legislature modified Texas Tax Code, §11.31 through the passage of HB 3206 and HB 3544. The legislature modified Texas Tax Code, §11.31 by adding subsection (g-1). Texas Tax Code, §11.31(g-1) requires that the standards and methods established in the rules be uniformly applied to all applications for determinations, including applications for property listed in Texas Tax Code, §11.31(k). Additionally, HB 3544 allows the commission the use of electronic means of transmission of information. On November 18, 2010, the commission adopted Chapter 17 amendments to implement the requirements of HB 3206 and HB 3544.

In 2013, during the 83rd Legislature, HB 1897 was passed amending Texas Tax Code, §11.31 by adding §11.31(e-1) requiring the executive director and the commission to take final action, including initial appeal, within one year from the date the executive director declares an application to be administratively complete. The commission is required to adopt rules implementing Texas Tax Code, §11.31(e-1) by September 1, 2014. To implement the requirements in HB 1897, the adopted rulemaking makes changes to §17.12 to establish a maximum of a 230-day technical review period from the date an application is declared to be administratively complete.

In addition to implementing HB 1897, the commission adopted revisions to the Tier I Table as part of the triennial review required in §17.14(b). A triennial review is required for the Expedited Review List by §17.17(b), in accordance with Texas Tax Code, §11.31(l). The Expedited Review List has been reviewed and the commission determined that no updates are necessary. Therefore, no changes to §17.17 were proposed for this rulemaking.

In a corresponding rulemaking published in this issue of the *Texas Register,* the commission amends 30 TAC Chapter 18, Rollback Relief for Pollution Control Requirements.

Section by Section Discussion

In addition to the adopted amendments associated with the rulemaking for Chapter 17, various stylistic non-substantive changes are included to update rule language to current *Texas Register* style and format requirements. Such changes include appropriate and consistent use of acronyms, section references, rule structure, and certain terminology. These changes are non-substantive and generally are not specifically discussed in this preamble.

§17.4, Applicability

The adopted amendment to §17.4 removes a reference to §17.15 which was repealed during a 2010 rulemaking.

§17.12, Application Review Schedule

The commission adopts several revisions to §17.12 in order to implement Texas Tax Code, §11.31(e-1) added by HB 1897 (83rd Legislature, 2013). Texas Tax Code, §11.31(e-1) is designed to prevent open-ended application reviews by limiting the technical review process, including the processing of the first appeal if one is filed, to one year from the date the application is declared to be administratively complete.

In order to ensure timely processing of applications, the commission adopts a revision to §17.12(2)(A) to limit the number of administrative notice of deficiency letters. This revision removes *may decide to* and inserting *shall* in the second sentence and to eliminate the need to send additional correspondence if an applicant fails to respond to the first administrative notice of deficiency letter. The commission also adopts two provisions to §17.12(2)(A). The first provision requires the executive director to send a second administrative notice of deficiency letter if the revised application received in response to the first letter is determined to be deficient. The second provision limits the number of administrative deficiency letters to two by requiring the executive director to take no further action on an application if the applicant fails to provide a second revised application within 30 days or the second revised application is deficient.

In order to provide a more robust explanation of the technical review process, the commission revises §17.12(2)(B) by inserting *revised application is determined to be incomplete or the* between *the* and *applicant* and inserting *the executive director may request additional technical information or* between *days,* and *the* in the second sentence. While current practice allows for up to three technical notice of deficiency letters to be sent, these adopted changes will by rule provide that the executive director end the technical review process if it is determined that the applicant did not provide a technically complete application.

In order to implement the requirements of Texas Tax Code, §11.31(e-1), the adopted revisions re-letters existing §17.12(2)(C) to §17.12(2)(D) and add new §17.12(2)(C). Adopted §17.12(2)(C) limits the technical review process to a total of 230 days from the day the application is declared to be administratively complete. Texas Tax Code, §11.31(e-1) requires the executive director and the commission to take final action, including initial appeal, within one year from the date the executive director declares an application to be administratively complete. The appeals process can take up to 135 days leaving a maximum of 230 days for the technical review process. In addition, the adopted revisions explain that if an application is considered to be incomplete after 230 days, the executive director will issue a negative use determination based on the failure of the applicant to document the eligibility of the property for a positive use determination.

§17.14, Tier I Pollution Control Property

The commission adopts a new Tier I Table in subsection (a). The new table is reformatted for accessibility and includes non-substantive changes for punctuation and spelling corrections. The adopted revisions also include modifying property names and descriptions to better reflect the equipment eligible for a 100% positive use determination. As discussed in the Response to Comments portion of this preamble, the commission has decided not to delete items A-42: Chlorofluorocarbon (CFC) Replacement Projects; A-43: Halon Replacement Projects; A-67: Automotive Dynamometers; W-58: Water Recycling Systems; W-62: Recycled Water Cleaning System; S-27: Concrete Reclaiming Equipment; M-5: Solvent Recovery Systems; M-6: Boxes, Bins, Carts, Barrels, Storage Bunkers; and M-17: Low NOx Combus-

tion System for Drilling Rigs from the previous Tier I Table as originally proposed. Additionally, the commission is not adopting the proposed revisions to the descriptions of items A-186: Blast Cleaning System Connected to a Control Device and M-4: Compactors, Barrel Crushers, Balers, and Shredders. These 11 items appear in the new adopted Tier I Table as the items were listed in the previous version of the table. Additionally, since no items are being removed from the Tier I Table, no items in the table are renumbered. Specific adopted changes from the previous Tier I Table are discussed in the following.

Specifically, the commission adopts the following revisions to the Air Pollution Control Equipment section of the Tier I Table. The property name for item A-1 was changed from *Baghouse Dust Collectors* to *Dust Collection Systems* to clarify that not all dust collection systems include a baghouse. The description for item A-1 was clarified by adding *in order to prevent release of particulate matter to ambient air* after *streams.* The description of item A-61, Continuous and Noncontinuous Emission Monitors, was clarified by adding *used* between *instruments* and *to demonstrate* to grammatically correct the sentence. The property description of item A-110, Carbon Adsorption Systems, was clarified by replacing *VOCs or odors* with *VOC emissions and odors* to more accurately describe the use of the equipment. The property description of item A-130, Sorbent Injection Systems, was clarified by changing *reacts* to *react* in the first sentence and inserting a *","* between *nozzles* and *ductwork* in the second sentence to grammatically correct the sentences. The property description for item A-180, Hoods, Duct and Collection Systems connected to Final Control Devices, was modified by replacing *pumps* with *blowers* to clarify that the eligible equipment is used to capture and control a gas stream. The property description for item A-184, Vapor/Liquid Recovery Equipment (for venting to a control device), was clarified by adding *those* between *including* and *used* to grammatically correct the sentence.

The commission adopts the following revisions to the Water and Wastewater Pollution Control Equipment section of the Tier I Table. The description of item W-30, Activated Sludge, was replaced with *Wastewater treatment using microorganisms to metabolize biodegradable organic matter in aqueous waste streams. Can include tanks, aeration equipment, clarifiers, and equipment used to handle sludge* in order to more accurately reflect the activated sludge process. The description of item W-31, Adsorption, was clarified by removing *water* from between *organic* and *contaminants* and adding *from wastewater* after *contaminants* to reflect that the eligible equipment is used for the treatment of wastewater. The description of item W-36, Wetlands and Lagoons (artificial), was modified by adding *from wastewater or stormwater* after *pollutants* to reflect that the eligible equipment must be used to treat wastewater or stormwater. The description of item W-56, Ultra-filtration, was clarified by adding *from wastewater* after *solutes* to reflect that the eligible equipment must be used to treat wastewater.

The commission adopts the following revisions to the Miscellaneous Pollution Control Equipment section of the Tier I Table. The description for M-2, Hazardous Air Pollutant Abatement Equipment required removal material contaminated with asbestos, lead, or some other hazardous air pollutant, was be revised by adding the word *Containers* after *Disposal* to clarify that the eligible item is the disposal containers and not the cost of disposal. The Media for item M-7, Environmental Paving located at Industrial Facilities, was amended by removing *land and water.* The description for M-7, limits this item to paving of outdoor vehicular traffic areas in order to meet or exceed an adopted air quality rule, regulation, or law; therefore, the media should be air and not air/land/water. The description of item M-15, Odor Neutralization and Chemical Treatment Systems, was amended by changing *absorption* to *adsorption* in two locations to reflect the correct chemical process used to treat odors.

The adopted revised table amends the heading of the Equipment Located at Service Stations section to Equipment Located at Tank Installations including Service Stations to reflect that equipment located in this section is often used at tank farms and other facilities with tanks for the same pollution control purposes as when used at service stations. This heading precedes the property designated as T-1 through T-5.

Final Regulatory Impact Analysis Determination

The commission reviewed the adopted rules in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined the rules do not meet the definition of *a major environmental rule.* Under Texas Government Code, §2001.0225, *a major environmental rule* means 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 the state or a sector of the state. Furthermore, the rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 applies only to a major environmental rule that: 1) exceeds a standard set by federal law, unless the rule is specifically required by state law; 2) exceeds an express requirement of state law, unless the rule is specifically required by federal law; 3) exceeds a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopts a rule solely under the general powers of the agency instead of under a specific state law. The adopted rules apply to the property tax relief program. Because the adopted rules are not specifically intended to protect the environment or reduce risks to human health from environmental exposure but to implement a tax relief program, this rulemaking is not a major environmental rule and does not meet any of the four applicability requirements. These rules do not result in any new environmental requirements and should not adversely affect in a material way the economy, a sector of the economy, productivity, competition, or jobs.

The commission invited public comment regarding the draft regulatory impact analysis determination during the comment period. No comments were received on the regulatory impact analysis determination.

Takings Impact Assessment

The commission evaluated these amended rules and performed an assessment of whether Texas Government Code, Chapter 2007 is applicable. The commission's assessment indicates Texas Government Code, Chapter 2007 does not apply to these adopted amendments. Enforcement of these adopted rules will be neither a statutory nor constitutional taking of private real property. Specifically, the adopted rules do not affect a landowner's rights in private real property, because this rulemaking action does not burden, restrict, or limit the owner's rights to property or reduce its value by 25% or more beyond which would otherwise exist in the absence of the adopted regulations.

Consistency with the Coastal Management Program

The commission reviewed the rulemaking and found that it is neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §5.05.11(b)(2) or (4), nor will it affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6). Therefore, the adopted rulemaking is not subject to the Texas Coastal Management Program (CMP).

The commission invited public comment regarding consistency with the CMP during the public comment period. No comments were received on the CMP.

Public Comment

The notice of public hearing published in the March 14, 2014, issue of the *Texas Register* (39 TexReg 1984) erroneously included references to the *State Implementation Plan* in the title of the notice as well as the first paragraph on page 1985 that corrected the title and first paragraph without the reference to the *State Implementation Plan.* A correction of error was published in the March 28, 2014, issue of the *Texas Register* (39 TexReg 2363). A public hearing on this proposal was scheduled at 2:00 p.m. on April 3, 2014, at the TCEQ complex in Austin located at 12100 Park 35 Circle, Building E, Room 201S. A question and answer session was held 30 minutes prior to the meeting. The hearing was not officially opened because no party indicated a desire to provide comment. The comment period opened on March 14, 2014, and closed on April 14, 2014. Written comments were accepted via mail, fax, and through the eComments system.

There were seven written comments received. The commission received written comments from the Tax Relief for Pollution Control Property Advisory Committee (TRPCPAC), Jackson Walker L.L.P. (Jackson Walker), Association of Electric Companies of Texas (AECT), Freescale Semiconductor, Inc. (Freescale), Texas Association of Business (TAB), Texas Taxpayers and Research Association (TTRA), and one individual.

RESPONSE TO COMMENTS

Comment

Jackson Walker, AECT, Freescale, and TAB expressed support for the proposed amendments to §17.12 implementing the requirements of HB 1897.

Response

The commission appreciates the comments. No changes were made in response to these comments.

Comment

TRPCPAC commented that it recommends the retention of A-186, W-58, W-62, S-27, M-4, M-5, and M-6 on the Tier I Table. Jackson Walker and Freescale support the recommendation of the TRPCPAC. TTRA, AECT, and TAB commented that items A-186, W-58, W-62, S-27, M-4, M-5, and M-6 should not be eliminated from the Tier I Table.

Response

After careful consideration of these comments and the discussion by the TRPCPAC at its March 27, 2014, meeting, the commission has decided not to remove property from the Tier I Table as originally proposed. The commission had proposed the removal of recycling equipment from the Tier I Table because recycling has the potential to generate a marketable product and would not be eligible for a 100% positive use determination. Other items were proposed for removal either because no applications containing the items had ever been received or due to the lack of an adopted environmental rule that required the installation of the item. Property cannot qualify as 100% pollution control property if any portion of its value is attributable to its capacity to produce goods and services. Although all equipment that was proposed to be deleted will be retained on the Tier I Table, the executive director will continue to evaluate Tier I applications to determine whether a Tier III application would be more appropriate for the particular piece of equipment. As stated in the introduction to the Tier I Table, if the executive director determines that the equipment is not being used in a standard manner (e.g., use in production or recovery of a marketable product), the executive director may require that a Tier III application, using the Cost Analysis Procedure (CAP), be filed by the applicant at an additional cost to calculate the appropriate use determination.

Comment

Freescale commented that the executive director is forcing more applicants into the Tier III process, which is more expensive, takes more time, and consumes considerable more resources for both applicants and the commission.

Response

The commission does not agree that the executive director forces Tier I applicants into the Tier III process. When applications are initially reviewed and it's determined that the property cannot qualify as 100% pollution control, the applicant has the choice to then submit a Tier III application. Tier III applications require the applicant to pay more for the review because these applications require more staff time to review. The commission's current policies and practices follow the requirements of Texas Tax Code, §11.31 for providing a partial use determination. No changes were made in response to this comment.

Comment

Jackson Walker commented that the commission should clarify preamble statements that imply that Tier I can only include 100% pollution control items. Freescale and TAB commented that there is nothing in statute or rule that restricts the Tier I list to only 100% exempt items.

Response

The items listed on the Tier I Table are all listed as eligible for a 100% positive use determination as long as the property is used in the manner described in the table and the use of the property does not generate a marketable product. The Tier I Table does not list any pollution control equipment that is eligible for a pre-determined partial use determination percentage. The executive director does not have sufficient information to establish a partial use determination percentage that can be applied to all applicants for the same piece of equipment. If an item is used in a manner different from that described on the list or if the use of the property generates a marketable product, a Tier III application requesting a partial use determination is required. No changes were made in response to these comments.

Comment

Jackson Walker, AECT, and Freescale commented that the commission should clarify preamble statements that imply that no recycling system can qualify for a 100% positive use determination.

Response

The commission agrees that some recycling systems may be eligible for a 100% positive use determination. Any statements that implied that recycling systems were not eligible for a 100% use determination have been removed. As discussed elsewhere in this Response to Comments section, the commission has decided not to remove listed property from the previously adopted Tier I Table.

Comment

Jackson Walker and Freescale commented that they support other comments that the commission should instruct the executive director to immediately initiate a rulemaking to eliminate the use of the term *marketable product* from consideration in the Tax Relief for Pollution Control Property program. TTRA commented that the TCEQ should re-evaluate and remove provisions of the rules that reduce the pollution control exemption in the event the equipment's use also produces a marketable product. TTRA urged the initiation of a rule project that focuses on the consideration of a more efficient, effective, and suitable partial use determination protocol. AECT encouraged the TCEQ to remove all *marketable product* considerations from Chapter 17 in conjunction with this rulemaking or a subsequently initiated rulemaking.

Response

The commission did not propose to amend §17.2 and the definition of *marketable product* as part of this rulemaking and cannot amend the section now in response to comments. The commission is required to have rules that allow for use determinations that distinguish the proportion of property that is used to control, monitor, prevent, or reduce pollution from the portion of property that is used to produce goods or services. The inclusion of marketable product in the CAP captures the production value of a piece property. The commission agrees that the method used to calculate partial positive use determinations, including all of its variables, could be re-examined. The commission believes that these issues should be discussed first by TRPCAC and that rulemaking could occur after the committee has reached consensus. Because of the complexity of the issue and the differing viewpoints of the various stakeholders, the commission would appreciate specific advice from TRPCAC before deciding to launch a significant rulemaking project. No changes were made in response to these comments.

Comment

TAB commented that the proposed amendments to the Tier 1 list reflect an apparent belief that the commission is charged in evaluating the use of property for pollution control purposes with assessing the extent to which such pollution control function is also linked to cost avoidance opportunities on the part of an owner.

Response

The commission did not propose to amend §17.17 and cannot amend the section now in response to comments. The commission is required to have rules that allow for use determinations that distinguish the proportion of property that is used to control, monitor, prevent, or reduce pollution from the portion of property that is used to produce goods or services. The commission agrees that it is charged in evaluating the use of property for pollution control purposes. Property cannot qualify as 100% pollution control property if any portion of its value is attributable to its capacity to produce goods and services. No changes were made in response to these comments.

Comment

TTRA commented that the CAP calculation and the reduction of the net present value of a marketable product is the most problematic element of the program and can result in a use determination that does not accurately reflect how the pollution control product actually functions. AECT commented that inclusion of the *marketable product* variable in the Tier III partial use determination is not appropriate.

Response

The commission did not propose to amend the CAP in §17.17 as part of this rulemaking and cannot amend the section now in response to comments. The commission is required to have rules that allow for use determinations that distinguish the proportion of property that is used to control, monitor, prevent, or reduce pollution from the portion of property that is used to produce goods or services. While stakeholders may not agree with all components of the current CAP used for partial determinations, the current rule does allow for determinations that distinguish the proportion of the property used for pollution control and production. The appropriate method for addressing these issues is for the commenters to request a discussion during a TRPCPAC meeting. The commission believes that these issues should be discussed by TRPCPAC first, and that a rulemaking that re-examines the current CAP could occur after the committee has reached consensus. No changes were made in response to these comments.

Comment

Jackson Walker, Freescale, and TAB commented that the proposed removal of A-42 and A-43 from the Tier I Table requires discussion of how the executive director interprets the environmental citation requirement and what it means to *meet or exceed* an environmental rule. AECT commented that TCEQ is interpreting the *meet or exceed* requirement to mean that the regulatory citation provided by the applicant must require the specific pollution control property for which the use determination is sought.

Response

The requirement that the property must be installed to *meet or exceed* an adopted environmental law, rule, or regulation is located in §17.4 and was not proposed for amendment with this rulemaking. The purpose of this tax relief program is to provide tax relief for businesses required by law to use or possess pollution control devices or equipment. The commission does not interpret *meet or exceed* to mean that the cited law, rule, or regulation must specify the pollution control property to be used. The commission interprets *meet or exceed* to mean a rule citation that compels the use, construction, acquisition, or installation of pollution control equipment. No changes were made in response to these comments.

Comment

Jackson Walker and Freescale commented that the commission should interpret the phrase *wholly or partly to meet or exceed rules or regulations* to include situations: (1) where an environmental rule sets a goal, target, or general standard that the property assists in achieving; and (2) where an environmental rule has been duly adopted but does not apply to the facility because of the timing of the property's installation or the manner in which it is utilized.

Response

The purpose of this tax relief program is to provide tax relief for businesses required by law to use or possess pollution control devices or equipment. The commission does not agree that rules that establish unenforceable goals or targets or that require the development of an unenforceable plan qualify as the type of environmental rule contemplated by the Texas Tax Code and the Constitution. If a cited environmental law has a *grandfathering* provision or an effective date such that the property owner is not subject to the law, then the property is not used, constructed, acquired, or installed to meet or exceed a law, rule, or regulation adopted by any environmental protection agency of the United States, Texas, or a political subdivision of Texas for the prevention, monitoring, control, or reduction of air, water, or land pollution. No changes were made in response to these comments.

Comment

Jackson Walker and Freescale commented that the commission should affirm that rules promulgated under the TCEQ's pollution prevention, recycling, and water conservation programs qualify as the type of environmental rule contemplated by the Texas Tax Code and the Constitution.

Response

The commission agrees that rules promulgated under the TCEQ's pollution prevention, recycling, and water conservation programs qualify as the type of environmental rule contemplated by the Texas Tax Code and the Constitution as long as the pollution control property is used, constructed, acquired, or installed wholly or partly to meet or exceed the rule. The purpose of this tax relief program is to provide tax relief for businesses required by law to use or possess pollution control devices or equipment. Rules that establish unenforceable goals or targets or require the development of a plan do not qualify as the type of environmental rules contemplated by the Texas Tax Code and the Constitution because the owner of the property is not required to use, construct, acquire, or install a device or equipment. No changes were made in response to these comments.

Comment

One individual expressed opposition to a particular facility on Moss Street in Odessa, Texas.

Response

This comment does not pertain to the rulemaking. It appears this e-comment was misdirected to this rulemaking and has been forwarded to the appropriate TCEQ staff. No changes were made in response to this comment.

Statutory Authority

The amendments are adopted under Texas Water Code (TWC), §5.102, which authorizes the commission to perform any acts authorized by the TWC or other laws that are necessary and convenient to the exercise of its jurisdiction and powers; and TWC, §5.103, which authorizes the commission to adopt rules necessary to carry out its powers and duties under the TWC. The rules are also adopted under Texas Tax Code, §11.31, which authorizes the commission to adopt rules to implement the Pollution Control Property Tax Exemption.

The adopted amendments implement the legislative mandate under House Bill 1897, 83rd Legislature, 2013, by adding subsection (e-1) to Texas Tax Code, §11.31. Texas Tax Code, §11.31(e-1) imposes time frame requirements on the executive director and the commission. Within one year from the date the executive director declares the application to be administratively complete, the executive director must issue a use determination letter, and if that use determination is appealed, the commission must also take final action on the appeal before the end of the one-year time period.

§17.14. Tier I Pollution Control Property.

(a) For the property listed in the Tier I Table located in this subsection that is used wholly for pollution control purposes, a Tier I application is required. A Tier I application must not include any property that is not listed in this subsection or that is used for pollution control purposes at a use percentage that is different than what is listed in the table. If a marketable product is recovered (not including materials that are disposed) from property listed in this subsection, a Tier III application is required.
Figure: 30 TAC §17.14(a)

(b) The commission shall review and update the Tier I Table at least once every three years.

(1) The commission may add an item to the table only if there is compelling evidence to support the conclusion that the item provides pollution control benefits and a justifiable pollution control percentage is calculable.

(2) The commission may remove an item from the table only if there is compelling evidence to support the conclusion that the item does not render pollution control benefits.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

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Director, Environmental Law Division
Texas Commission on Environmental Quality
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CHAPTER 18. ROLLBACK RELIEF FOR POLLUTION CONTROL REQUIREMENTS

30 TAC §§18.2, 18.10, 18.15, 18.25, 18.26, 18.30, 18.35

The Texas Commission on Environmental Quality (TCEQ, agency, commission) adopts §§18.2, 18.10, 18.15, 18.25, 18.26, 18.30, and 18.35. New §18.25 is adopted *with changes* to the proposed text as published in the March 14, 2014, issue of the *Texas Register* (39 TexReg 1828). Amended §§18.2, 18.10, 18.15, 18.26, 18.30, and 18.35 are adopted *without changes* to the proposed text and will not be republished.

Background and Summary of the Factual Basis for the Adopted Rules

The commission adopts the amendments to Chapter 18 to implement 2007 legislation, perform the required review of property on the Tier I Table and Expedited Review List, and make various editorial or administrative changes within the chapter for the rollback tax relief program.

In 1993, the 73rd Legislature, enacted House Bill (HB) 1920, which created Texas Tax Code, §11.31 and §26.045. Texas Tax

Code, §11.31 established a property tax exemption program for property that is used wholly or partly for pollution control. Texas Tax Code, §26.045 created a rollback tax relief program for political subdivisions. Texas Tax Code, §11.31 required the TCEQ to adopt rules to implement the pollution control property program. Texas Tax Code, §26.045 gave the commission the authority to adopt rules but did not require the adoption of rules. In response, the commission adopted 30 TAC Chapter 277, Use Determinations for Tax Exemptions for Pollution Control Equipment, on September 30, 1994, to implement Texas Tax Code, §11.31. During the 1994 rulemaking, the commission chose not to adopt a separate rule to implement Texas Tax Code, §26.045. Section 277.1, Scope and Purpose, included political subdivisions in the definition of the applicability of the rule. Chapter 277 was later repealed and replaced with 30 TAC Chapter 17, Tax Relief for Property Used for Environmental Protection, through rulemaking adopted May 26, 1999.

In 2007, the 80th Legislature modified the Rollback Relief for Pollution Control Requirements program (Texas Tax Code, §26.045) through the passage of HB 3732. The legislature modified Texas Tax Code, §26.045 by adding subsections (f) - (h). Texas Tax Code, §26.045(f) requires the commission to adopt by rule a list of 18 categories of property listed in Texas Tax Code, §26.045(f). Texas Tax Code, §26.045(g) requires the commission to adopt a procedure to review the list at least once every three years. In addition, it allows the removal of items from the list when there is compelling evidence that the item does not provide pollution control. Texas Tax Code, §26.045(h) requires the executive director upon review of applications containing only items on the adopted list to issue a determination without regard to the information provided in response to Texas Tax Code, §26.045(c)(1), within 30 days of receipt of the required application documents. On January 16, 2008, the commission adopted new Chapter 18 to implement the requirements of HB 3732.

The current rulemaking adoption implements changes from the required once every three-year review of the list of property contained in Texas Tax Code, §26.045(f) and makes other changes in order to bring Chapter 18 into agreement with Chapter 17.

In a corresponding rulemaking published in this issue of the *Texas Register,* the commission adopts amendments to Chapter 17, Tax Relief for Property Used for Environmental Protection.

Section by Section Discussion

In addition to the adopted amendments and new section associated with the rulemaking for Chapter 18, various stylistic non-substantive changes are included to update rule language to current *Texas Register* style and format requirements. Such changes include appropriate and consistent use of acronyms, section references, rule structure, and certain terminology. These changes are non-substantive and generally are not specifically discussed in this preamble.

§18.2, Definitions

The amendment to §18.2 adds 30 TAC §3.2 to the list of laws with definitions pertinent to this chapter in the introductory paragraph. Section 3.2 contains general definitions that are applicable to all commission rules and the addition is only for clarity.

The adopted amendment deletes several definitions that are not necessary, amends several definitions in response to other proposed changes contained in this rulemaking, and renumbers definitions as needed. Specifically, this rulemaking deletes: the definition *ePay* because the use of the term is clear in the rules; the definition *Equipment and Categories List (ECL)* as this adoption renames Part A of the ECL as the Tier I Table and Part B of the ECL as the *Expedited Review List* and this definition is not applicable; the definition of *Installation* as the use of the term is consistent with the standard dictionary definition making the inclusion of the definition in this section unnecessary; and the definition *Use determination letter* as the meaning of the term is clear and a definition is unnecessary.

The commission amends the definition of *Tier I* to reflect the replacement of Part A of the Equipment and Categories List with the Tier I Table; and amends the definition of *Tier II* to reflect the replacement of Part B of The Equipment and Categories List with the Expedited Review List.

To reflect the removal of the definitions in existing §18.2(1) - (3), the remaining definitions are renumbered accordingly.

§18.10, Application for Use Determination

As discussed elsewhere in the Section by Section discussion of this preamble, the commission removed Part B of the Equipment and Categories List and replaced it with the Expedited Review List located in new §18.26. The adopted revisions to §18.10 changes the reference to Part B in §18.10(c)(1) to *Expedited Review List* and changes the rule reference from §18.25(a) to §18.26.

As discussed elsewhere in the Section by Section discussion of this preamble, the commission removed Part A of the Equipment and Categories List and replaced it with the Tier I Table, located in §18.25(a). The adopted revisions to §18.10(c)(5) change references from *Part A* and *Part B* of the Equipment and Categories List to the *Tier I Table* and the *Expedited Review List* respectively.

§18.15, Application Review Schedule

The adopted amendment to §18.15(1) replaces *Within three days of* with *As soon as practicable after* to allow sufficient time for the review of applications while still allowing payment processing of application fees to occur. The short time period was not practical. The commission also amends §18.15(2) by replacing the reference to *Part B of the Equipment and Categories List* with a reference to the *Expedited Review List.*

§18.25, Equipment and Categories List

The commission renames §18.25 to Tier I Eligible Equipment.

The adopted amendment to §18.25 deletes the Equipment and Categories List located in §18.25(a) and replaces it with the same Tier I Table located in §17.14(a). Chapter 18 was not amended during the previous revisions to Chapter 17 and the Tier I Table in §17.14(a) which was adopted November 18, 2010. The commission incorporates into §18.25(a) all previous edits adopted for the Tier I Table in existing §17.14(a). As such, equipment listed in the current table in §18.25(a) that is not listed in existing §17.14(a) would not be included in the new Tier I Table in §18.25(a). Additional information regarding the previous revisions to the Tier I Table in §17.14(a) adopted on November 18, 2010, may be found in the December 10, 2010, publication of the *Texas Register* (35 TexReg 10980). Additionally, the commission amends the Tier I Table by modifying property names and descriptions to better reflect the equipment eligible for a 100% positive use determination. The adopted revisions will also reformat the table to make the figure accessible as well as make non-substantive changes including punctuation and spelling corrections. The adopted

amendment to the Tier I Table in §18.25(a) will be consistent with the amendments to the Tier I Table in §17.14(a) made in corresponding rulemaking in this issue of the *Texas Register.* As discussed in the Response to Comments portion of the preamble to the corresponding Chapter 17 rulemaking in this issue of the *Texas Register,* the commission has decided not to delete items A-42: Chlorofluorocarbon (CFC) Replacement Projects; A-43: Halon Replacement Projects; A-67: Automotive Dynamometers; W-58: Water Recycling Systems; W-62: Recycled Water Cleaning System; S-27: Concrete Reclaiming Equipment; M-5: Solvent Recovery Systems; M-6: Boxes, Bins, Carts, Barrels, Storage Bunkers; and M-17: Low NOx Combustion System for Drilling Rigs from the previous Tier I Table as originally proposed. Additionally, the commission is not adopting the proposed revisions to the descriptions of items A-186: Blast Cleaning System Connected to a Control Device and M-4: Compactors, Barrel Crushers, Balers, and Shredders. These 11 items appear in the adopted Tier I Table as the items were listed in the previous version of the table in §17.14(a). Additionally, since no items are being removed from the Tier I Table, items in the adopted table are numbered identical to the previous version in §17.14(a). Specific adopted changes from the previous Tier I Table are discussed in the following.

Specifically, the commission adopts the following revisions to the Air Pollution Control Equipment section of the Tier I Table. The property name for item A-1 is changed from *Baghouse Dust Collectors* to *Dust Collection Systems* to reflect that not all dust collection systems include a baghouse. The description for item A-1 is clarified by adding *in order to prevent release of particulate matter to ambient air* after *streams.* The description of item A-61, Continuous and Noncontinuous Emission Monitors, is clarified by adding *used* between *instruments* and *to demonstrate* to grammatically correct the sentence. The property description of item A-110, Carbon Adsorption Systems, is clarified by replacing *VOCs or odors* with *VOC emissions and odors* to more accurately describe the use of the equipment. The property description of item A-130, Sorbent Injection Systems, is clarified by changing *reacts* to *react* in the first sentence and inserting a *","* between *nozzles* and *ductwork* in the second sentence to grammatically correct the sentences. The property description for item A-180, Hoods, Duct and Collection Systems connected to Final Control Devices, is modified by replacing *pumps* with *blowers* to clarify that the eligible equipment is used to capture and control a gas stream. The property description for item A-184, Vapor/Liquid Recovery Equipment (for venting to a control device), is clarified by adding *those* between *including* and *used* to grammatically correct the sentence.

The commission adopts the following revisions to the Water and Wastewater Pollution Control Equipment section of the Tier I Table. The description of item W-30, Activated Sludge, is replaced with *Wastewater treatment using microorganisms to metabolize biodegradable organic matter in aqueous waste streams. Can include tanks, aeration equipment, clarifiers, and equipment used to handle sludge* in order to more accurately reflect the activated sludge process. The description of item W-31, Adsorption, is clarified by removing *water* from between *organic* and *contaminants* and adding *from wastewater* after *contaminants* to reflect that the eligible equipment is used for the treatment of wastewater. The description of item W-36, Wetlands and Lagoons (artificial), is modified by adding *from wastewater or stormwater* after *pollutants* to reflect that the eligible equipment must be used to treat wastewater or stormwater. The description of item W-56, Ultra-filtration, is clarified by adding *from wastewater* after *solutes* to reflect that the eligible equipment must be used to treat wastewater.

The commission adopts the following revisions to the Miscellaneous Pollution Control Equipment section of the Tier I Table. The description for M-2, Hazardous Air Pollutant Abatement Equipment required removal material contaminated with asbestos, lead, or some other hazardous air pollutant, is amended by adding the word *Containers* after *Disposal* to clarify that the eligible item is the disposal containers and not the cost of disposal. The Media for item M-7, Environmental Paving located at Industrial Facilities, is amended by removing *land and water.* The description for M-7 limits this item to paving of outdoor vehicular traffic areas in order to meet or exceed an adopted air quality rule, regulation, or law; therefore, the media should be air and not air/land/water. The description of item M-15, Odor Neutralization and Chemical Treatment Systems, is amended by changing *absorption* to *adsorption* in two locations to reflect the correct chemical process used to treat odors.

The adopted revisions to the table amended the heading of the Equipment Located at Service Stations section to Equipment Located at Tank Installations including Service Stations to reflect that equipment located in this section is often used at tank farms and other facilities with tanks for the same pollution control purposes as when used at service stations. This heading precedes the property designated as T-1 through T-5.

§18.26, Expedited Review List

The commission adopts new §18.26, Expedited Review List, which is the location of the table of equipment located in Texas Tax Code, §26.045(f). Adopted new §18.26 contains a description of the Expedited Review List, a requirement that the list be reviewed at least once every three years, and an explanation that items can only be added to or removed from the list if there is compelling evidence that the item does or does not provide a pollution control benefit. The adopted new table in §18.26 contains the Expedited Review List, which consists of the categories of equipment located in Texas Tax Code, §26.045(f). The list of equipment in the adopted Expedited Review List was previously identified as Part B of the Equipment and Categories List in §18.25(a), which was deleted. The Expedited Review List in adopted §18.26 is identical to the list located in §17.17(b).

§18.30, Partial Determinations

The commission amends §18.30 by removing the reference to Part B, by changing the section number to reflect the correct location of the Expedited Review List, and changing the reference to the *Equipment and Categories List* to the *Expedited Review List* to reflect the replacement of Part B of the Equipment and Categories List with the Expedited Review List.

§18.35, Application Fees

The commission amends §18.35(a)(1) to reflect the revisions to the title of §18.25 and to the title of the table contained in §18.25(a). The adopted revisions to §18.35 amend §18.35(a)(2) to reflect the revisions to §18.25(a) and the replacement of Part B of the Equipment and Categories List with the Expedited Review List in adopted new §18.26.

Regulatory Impact Analysis Determination

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined the rules do not meet the definition of a *major environmental rule.* Under Texas Government

Code, §2001.0225, *major environmental rule* means 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 the state or a sector of the state. Furthermore, the rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 applies only to a major environmental rule which 1) exceeds a standard set by federal law, unless the rule is specifically required by state law; 2) exceeds an express requirement of state law, unless the rule is specifically required by federal law; 3) exceeds a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopts a rule solely under the general powers of the agency instead of under a specific state law. The adopted rulemaking implements a Rollback Relief for Pollution Control Requirements program as described in the background and summary of the factual basis for the adopted rules and section by section discussion sections above. Because the adopted rules are not specifically intended to protect the environment or reduce risks to human health from environmental exposure but to implement a tax exemption program, this rulemaking is not a major environmental rule and does not meet any of the four applicability requirements. This rule does not result in any new environmental requirements and should not adversely affect in a material way the economy, a sector of the economy, productivity, competition, or jobs.

The commission invited public comment on the proposed regulatory impact analysis determination during the public comment period. No comments were received on the regulatory impact analysis determination.

Takings Impact Assessment

The commission evaluated these adopted rules and performed an assessment of whether Texas Government Code, Chapter 2007 is applicable. The commission's assessment indicates Texas Government Code, Chapter 2007 does not apply to these adopted rules because this action creates a program which is available only to political subdivisions as described in the Background and Summary of the Factual Basis for the Adopted Rules and the Section by Section discussion sections of this preamble.

Promulgation and enforcement of these adopted rules will be neither a statutory or constitutional taking of private real property. Specifically, the adopted rules do not affect a landowner's rights in private real property, because this rulemaking action does not burden, restrict, nor limit the owner's rights to property or reduce its value by 25% or more beyond which would otherwise exist in the absence of the adopted regulations.

Consistency with the Coastal Management Program

The commission reviewed the adopted rulemaking and found the amendments are not a rulemaking identified in the Coastal Coordination Act Implementation Rules, 31 TAC §505, concerning rules subject to the Texas Coastal Management Program (CMP), and will, therefore, not require that goals and policies of the CMP be considered during the rulemaking process.

The commission invited public comment regarding the consistency with the CMP during the public comment period. No comments were received on the CMP.

Public Comment

The notice of public hearing published in the March 14, 2014, issue of the *Texas Register* (39 TexReg 1984) erroneously included references to the *State Implementation Plan* in the title of the notice as well as the first paragraph on page 1985 that corrected the title and first paragraph without the reference to the *State Implementation Plan.* A correction of error was published in the March 28, 2014, issue of the *Texas Register* (39 TexReg 2363). A public hearing on this proposal was scheduled at 2:00 p.m. on April 3, 2014, at the TCEQ complex in Austin located at 12100 Park 35 Circle, Building E, Room 201S. A question and answer session was held 30 minutes prior to the meeting. The hearing was not officially opened because no party indicated a desire to provide comment. The comment period opened on March 14, 2014, and closed on April 14, 2014. Written comments were accepted via mail, fax, and through the eComments system.

There were seven written comments received with regard to the concurrent rulemaking of Chapter 17. None of these comments were specifically addressed to Chapter 18. The responses to comments on the Chapter 17 rules are addressed in the corresponding rulemaking published in this issue of the *Texas Register.*

Statutory Authority

The new and amended sections are adopted under Texas Water Code (TWC), §5.102, which authorizes the commission to perform any acts authorized by the TWC or other law which are necessary and convenient to the exercise of its jurisdiction and powers; and TWC, §5.103, which authorizes the commission to adopt rules necessary to carry out its powers and duties under the TWC. The new and amended sections are also adopted under Texas Tax Code, §26.045, which authorizes that the rollback tax rate for a political subdivision of this state be increased by the rate that, if applied to the total current value, would impose an amount of taxes equal to the amount the political subdivision will spend out of its maintenance and operation funds under Texas Tax Code, §26.012(16) to pay for a facility, device, or method for the control of air, water, or land pollution that is necessary to meet the requirements of a permit issued by the commission.

The adopted new and amended sections implement Texas Tax Code, §26.045.

§18.25. Tier I Eligible Equipment.

(a) For the property listed on the Tier I Table located in this subsection that is used wholly for pollution control purposes, a Tier I application is required. A Tier I application must not include any property that is not listed in this subsection or that is used for pollution control purposes at a use percentage that is different than what is listed in the table in this subsection. If a marketable product is recovered (not including materials that are disposed) from property listed in this subsection, a Tier II application is required.

Figure: 30 TAC §18.25(a)

(b) The commission shall review and update the Tier I Table at least once every three years.

(1) An item may be added to the list only if there is compelling evidence to support the conclusion that the item provides pollution control benefits and a justifiable pollution control percentage is calculable.

(2) An item may be removed from the list only if there is compelling evidence to support the conclusion that the item does not render pollution control benefits.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

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Director, Environmental Law Division
Texas Commission on Environmental Quality
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For further information, please call: (512) 239-2141

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CHAPTER 295. WATER RIGHTS, PROCEDURAL

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts the amendments to §295.13 and §295.155 and adopts a new §295.177 *without change* to the proposed text as published in the March 14, 2014, issue of the *Texas Register* (39 TexReg 1860) and, therefore, the text will not be republished.

Background and Summary of the Factual Basis for the Adopted Rules

In 2013, the 83rd Legislature passed House Bill (HB) 3233, relating to interbasin transfers of state water. HB 3233 amended Texas Water Code (TWC), §11.085, to remove TWC, §11.085(b)(4), which requires an application for an interbasin transfer to include the projected effect on user rates and fees for each class of ratepayers. HB 3233 also added language to TWC, §11.085(e), which limits consideration of issues in an evidentiary hearing to those requirements included in TWC, §11.085. HB 3233 further amended TWC, §11.085(g), to clarify the length of notice publication. Additionally, HB 3233 amended TWC, §11.085(v)(4), which describes geographic areas exempt from the provisions of TWC, §11.085. The commission's procedural rules related to water rights are in 30 TAC Chapter 295.

In a corresponding rulemaking published in this issue of the *Texas Register,* the commission also adopts the amendments to 30 TAC Chapter 297, Water Rights, Substantive.

Section by Section Discussion

Section 295.13, Interbasin Transfers, describes the general application requirements and exemptions for transferring state water from one river basin to another basin.

The commission deleted §295.13(b)(4) which requires an application for a non-exempt interbasin transfer of state water to include the projected effect on user rates and fees for each class of ratepayers. The commission adopts this amendment to update its rules to reflect the deletion of TWC, §11.085(b)(4), by HB 3233. Paragraphs (5) - (9) of §295.13(b) are renumbered to accommodate the deleted provision. HB 3233 amended TWC, §11.085(v)(4), to clarify the geographic areas exempt from the provisions of TWC, §11.085(b) - (u). The commission adopts amendments to §295.13(c)(4) to incorporate these changes.

Section 295.155, Notice for Interbasin Transfers, describes the requirements and exemptions for public notice for an application to transfer state water from one river basin to another basin. The commission adopts the amendment to change the published notice requirement in §295.155(b)(2) from once a week for two consecutive weeks to two different weeks within a 30-day period. The commission adopts this amendment to incorporate the changes made to TWC, §11.085(g), by HB 3233. The commission also adopts the amendment to §295.155(d)(4) to incorporate the revisions to the description of exempt geographic areas as described in TWC, §11.085(v)(4).

New §295.177, Evidentiary Hearing on Interbasin Transfer Amendments, is adopted to limit the issues to be considered during a hearing to those requirements under TWC, §11.085. This new section implements TWC, §11.085(e), as amended by HB 3233.

Final Regulatory Impact Determination

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to Texas Government Code, §2001.0225. "Major environmental rule" means 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 the state or a sector of the state.

First, the adopted rulemaking does not meet the statutory definition of a "major environmental rule" because its specific intent is not to protect the environment or reduce risks to human health from environmental exposure. The specific intent of the adopted rulemaking is implementing legislation to clarify and streamline requirements for the issuance of interbasin transfer authorizations upon application by a current or prospective water right owner.

Second, the adopted rulemaking does not meet the statutory definition of a "major environmental rule" because the adopted rulemaking would not 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 the state or a sector of the state. It is not anticipated that the cost of complying with the adopted rulemaking would be significant with respect to the economy as a whole or with respect to a sector of the economy; therefore, the adopted rulemaking will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, or jobs.

The commission invited public comment regarding the draft regulatory impact analysis determination during the public comment period. The commission received no comments regarding the draft regulatory impact analysis determination.

Takings Impact Assessment

The commission evaluated this adopted rulemaking and performed an assessment of whether the adopted rules constitute a taking under Texas Government Code, Chapter 2007. The commission adopted the rules for the specific purpose of implementing legislation to clarify and streamline requirements for the issuance of interbasin transfer authorizations. The commission would not act under the adopted rule unless an application from a current or prospective water right owner is received requesting an authorization for an interbasin transfer. Further, the rulemaking clarifying exemptions to the requirement that an interbasin transfer be authorized by the commission expands the ability of a retail public utility to transfer water owned under surface water rights within the utility's service area.

A "taking" under Texas Government Code, Chapter 2007 means a governmental action that affects private real property in a manner that requires compensation to the owner under the United States or Texas Constitution, or a governmental action that affects real private property in a manner that restricts or limits the owner's right to the property and reduces the market value of affected real property by at least 25%.

Because no taking of private real property will occur by amending the definitions as adopted, the commission has determined that promulgation and enforcement of the adopted rules would be neither a statutory nor a constitutional taking of private real property. Specifically, there are no burdens imposed on private real property under the rule because the adopted rules neither relates to, nor has any impact on, the use or enjoyment of private real property, and there would be no reduction in real property value as a result of the rules. Therefore, the adopted rules would not constitute a taking under Texas Government Code, Chapter 2007.

Consistency with the Coastal Management Program

The commission reviewed the adopted rulemaking and found the adoption is a rulemaking identified in the Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(4), relating to rules subject to the Coastal Management Program, and will, therefore, require that goals and policies of the Texas Coastal Management Program (CMP) be considered during the rulemaking process.

The commission reviewed this rulemaking for consistency with the CMP goals and policies in accordance with the regulations of the Coastal Coordination Advisory Committee and determined that the rulemaking is administrative and procedural in nature and will have no substantive effect on commission actions subject to the CMP and is, therefore, consistent with CMP goals and policies.

The commission invited public comment regarding the Consistency with the Coastal Management Program section during the public comment period. The commission received no comments regarding the Consistency with the Coastal Management Program section.

Public Comment

The commission held a public hearing on April 10, 2014. The comment period closed on April 14, 2013. The commission received one comment from an individual.

The commenter asked a question outside the scope of this rulemaking as discussed in the Response to Comments section of this preamble.

Response to Comments

One individual requested information regarding the limit of water that can be drilled or produced per well per year in Atascosa and McMullen counties.

The purpose of this rulemaking is to implement HB 3233, relating to interbasin transfers of state water. The commenter's question is outside the scope of this rulemaking. The rules were not changed in response to this comment.

SUBCHAPTER A. REQUIREMENTS OF WATER RIGHTS APPLICATIONS GENERAL PROVISIONS

DIVISION 1. GENERAL REQUIREMENTS

30 TAC §295.13

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; TWC, §5.103, which establishes the commission's general authority to adopt rules; and TWC, §5.105, which establishes the commission's authority to set policy by rule.

The adopted amendment implements TWC, §§5.102, 5.103, 5.105 and 11.085(v)(4).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Robert Martinez
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SUBCHAPTER C. NOTICE REQUIREMENTS FOR WATER RIGHT APPLICATIONS

30 TAC §295.155

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; TWC, §5.103, which establishes the commission's general authority to adopt rules; and TWC, §5.105, which establishes the commission's authority to set policy by rule.

The adopted amendment implements TWC, §§5.102, 5.103, 5.105, and 11.085(g) and (v)(4).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. CONTESTED CASE HEARING

30 TAC §295.177

Statutory Authority

The new section is adopted under Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; TWC, §5.103, which establishes the commission's general authority to adopt rules; and TWC, §5.105, which establishes the commission's authority to set policy by rule.

The adopted new section implements TWC, §§5.102, 5.103, 5.105 and 11.085(e).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 297. WATER RIGHTS, SUBSTANTIVE

SUBCHAPTER B. CLASSES OF WATER RIGHTS

30 TAC §297.18

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts the amendment to §297.18 *without change* to the proposed text as published in the March 14, 2014, issue of the *Texas Register* (39 TexReg 1864) and, therefore, it will not be republished.

Background and Summary of the Factual Basis for the Adopted Rule

In 2013, the 83rd Legislature passed House Bill (HB) 3233, relating to interbasin transfers of state water. HB 3233 amended Texas Water Code (TWC), §11.085, to add language to TWC, §11.085(l)(1), to specify that the commission's analysis of whether the benefits to the receiving basin are greater than the detriments to the basin of origin in an application for an interbasin transfer be based on the factors described in TWC, §11.085(k). HB 3233 also amended TWC, §11.085, to add language to TWC, §11.085(n), to clarify that interbasin transfers based on contracts can be extended as contracts are renewed or extended. Additionally, HB 3233 also amended TWC, §11.085(v)(4), which describes geographic areas exempt from the provisions of TWC, §11.085. The commission's substantive rules related to water rights are in 30 TAC Chapter 297.

In a corresponding rulemaking published in this issue of the *Texas Register,* the commission adopts amendments to 30 TAC Chapter 295, Water Rights, Procedural.

Section Discussion

Section 297.18, Interbasin Transfers, Texas Water Code, §11.085 describes the substantive requirements and exemptions for transferring state water from one river basin to another basin.

The commission adopts the amendment to §297.18(d)(1), to clarify the scope of the factors considered as benefits to the receiving basin and detriments to the basin of origin are only those in TWC, §11.085(k). The commission excluded §297.18(c)(5) from the factors considered by the commission in §297.18(d)(1), because the requirement in §297.18(c)(5) is not included in the requirements listed in TWC, §11.085(k). The commission adopts this change to implement TWC, §11.085(l)(1). Additionally, the commission adopts the amendment to §297.18(f) to incorporate the change from TWC, §11.085(n), which clarify that interbasin transfers based on contracts can be extended as contracts are renewed or extended. The commission also adopts the amendment to §297.18(k)(5) to reflect the revision to the description of exempt geographic areas as described in TWC, §11.085(v)(4). The commission adopts this rulemaking to implement the changes made to the TWC by HB 3233.

Final Regulatory Impact Determination

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to Texas Government Code, §2001.0225. "Major environmental rule" means 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 the state or a sector of the state.

First, the adopted rulemaking does not meet the statutory definition of a "major environmental rule" because its specific intent is not to protect the environment or reduce risks to human health from environmental exposure. The specific intent of the adopted rulemaking is implementing legislation to clarify and streamline requirements for the issuance of interbasin transfer authorizations upon application by a current or prospective water right owner.

Second, the adopted rulemaking does not meet the statutory definition of a "major environmental rule" because the adopted rule would not 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 the state or a sector of the state. It is not anticipated that the cost of complying with the adopted rule would be significant with respect to the economy as a whole or with respect to a sector of the economy; therefore, the adopted amendment will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, or jobs.

The commission invited public comment regarding the draft regulatory impact analysis determination during the public comment period. The commission received no comments regarding the draft regulatory impact analysis determination.

Takings Impact Assessment

The commission evaluated this adopted rulemaking and performed an assessment of whether the adopted rule constitutes a taking under Texas Government Code, Chapter 2007. The commission adopted the rule for the specific purpose of implementing legislation to clarify and streamline requirements for the issuance of interbasin transfer authorizations. The commission would not act under the amended rule unless an application from a current or prospective water right owner is received requesting an authorization for an interbasin transfer. Further, the amendment clarifying exemptions to the requirement that an interbasin

transfer be authorized by the commission expands the ability of a retail public utility to transfer water owned under surface water rights within the utility's service area.

A "taking" under Texas Government Code, Chapter 2007 means a governmental action that affects private real property in a manner that requires compensation to the owner under the United States or Texas Constitution, or a governmental action that affects real private property in a manner that restricts or limits the owner's right to the property and reduces the market value of affected real property by at least 25%.

Because no taking of private real property will occur by amending the definitions as adopted, the commission has determined that promulgation and enforcement of the adopted rule would be neither a statutory nor a constitutional taking of private real property. Specifically, there are no burdens imposed on private real property under the rule because the adopted rule neither relates to, nor has any impact on, the use or enjoyment of private real property, and there would be no reduction in real property value as a result of the rule. Therefore, the adopted rule would not constitute a taking under Texas Government Code, Chapter 2007.

Consistency with the Coastal Management Program

The commission reviewed the adopted rulemaking and found the adoption is a rulemaking identified in the Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(4), relating to rules subject to the Coastal Management Program, and will, therefore, require that goals and policies of the Texas Coastal Management Program (CMP) be considered during the rulemaking process.

The commission reviewed this rulemaking for consistency with the CMP goals and policies in accordance with the regulations of the Coastal Coordination Advisory Committee and determined that the rulemaking is administrative and procedural in nature and will have no substantive effect on commission actions subject to the CMP and is, therefore, consistent with CMP goals and policies.

The commission invited public comment regarding the Consistency with the Coastal Management Program section during the public comment period. The commission received no comments regarding the Consistency with the Coastal Management Program section.

Public Comment

The commission held a public hearing on April 10, 2014. The comment period closed on April 14, 2013. The commission received one comment from an individual.

The commenter asked a question outside the scope of this rulemaking as discussed in the Response to Comments section of this preamble.

Response to Comments

One individual requested information regarding the limit of water that can be drilled or produced per well per year in Atascosa and McMullen counties.

The purpose of this rulemaking is to implement HB 3233, relating to interbasin transfers of state water. The commenter's question is outside the scope of this rulemaking. The rule was not changed in response to this comment.

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; TWC, §5.103, which establishes the commission's general authority to adopt rules; and TWC, §5.105, which establishes the commission's authority to set policy by rule.

The amendment implements TWC, §§5.102, 5.103, 5,105, and 11.085(l)(1), (n), and (v)(4).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 57. FISHERIES

SUBCHAPTER N. STATEWIDE RECREATIONAL AND COMMERCIAL FISHING PROCLAMATION

The Texas Parks and Wildlife Commission in a duly noticed meeting on March 26, 2014 adopted the repeal of §57.977, amendments to §§57.973, 57.981, and 57.992, and new §57.977 and §57.978, concerning the Statewide Recreational and Commercial Fishing Proclamations. The amendment to §57.981 is adopted with changes to the proposed text as published in the February 21, 2014, issue of the *Texas Register* (39 TexReg 1063). The repeal of §57.977, amendments to §57.973 and §57.992, and new §57.977 and §57.978 are adopted without changes and will not be republished.

The change to §57.981, concerning Bag, Possession, and Length Limits, increases the possession limit from five fish to 10 fish in all waters south of F.M. 457 to the Rio Grande, places all regulations concerning spotted seatrout in one location, and imposes a five-year limit on the effectiveness of the rule as adopted. As proposed, the amendment would have imposed a five-fish daily bag limit and five-fish possession limit between Mile Marker 21 in the lower Laguna Madre and F.M. 457 in Matagorda County. In considering public comment on the proposal, the commission determined that the goal of the proposal (to increase the number of spotted seatrout in the mid-coast area) could still be achieved with a possession limit of twice the daily bag limit from F.M. 457 southward to the Rio Grande. Therefore, the rule as adopted would impose a five-fish daily bag limit in all waters from the Rio Grande to F.M. 457 in Matagorda County, with a possession limit of ten fish (twice the daily bag limit). In adopting the modified

proposal, the commission specified that a five-year limit be placed on its effectiveness. Therefore the change also provides for a reversion to the current regulations in five years' time. In order to accommodate the possibility of a reversion to the current rule, the change also retains the rule structure of the current rule and places all bag, possession, and length limits for spotted seatrout in §57.981(c)(5). Under current rule, the statewide bag, possession, and length limits for each species of fish are established in subsection (c) and the exceptions to the statewide standard (if any) are listed in subsection (d). By placing all spotted seatrout harvest regulations in one location, the Parks and Wildlife Department ("department" or "TPWD") intends to enhance enforcement and compliance.

The repeal of §57.977, concerning Violations and Penalties, allows the department to adopt new §57.977, concerning Spawning Event Closures. The provisions of current §57.977 become new §57.978, concerning Violations and Penalties.

The amendment to §57.973, concerning Devices, Means, and Methods, adds three locations to the list of locations where persons are restricted to no more than two pole-and-line devices while angling, expands the geographical extent of special rules governing the take of rainbow trout on the Guadalupe River, and simplifies rules specifying the color of floats that must be employed with jug lines.

In 2012 the department implemented harvest and gear restrictions on Canyon Lake Project #6 in Lubbock County that are similar to those in effect for community fishing lakes (CFL). The lake is 82 acres, which is larger than the maximum size of 75 acres established by rule for CFLs; therefore, the lake was subject to statewide harvest and devices regulations. By rule, CFLs share a single regulatory structure on catfish (no minimum length limit, five fish bag) and gear usage (pole-and-line angling only, with a limit of two poles per person). The rulemaking last year addressed the restriction to pole-and-line angling only but not the pole limit and harvest limitations. The amendment corrects that oversight by imposing the statewide CFL harvest regulations for channel and blue catfish and the two-pole limit on Canyon Lake Project #6. In addition, there are two segments of the Concho River within the city limits of the City of San Angelo that have also been managed under regulations similar to those in effect for CFLs. The amendment imposes the CFL gear restriction rules on those stream segments.

Current rules require juglines used for non-commercial purposes to be marked with a white, free-floating device. The department has received requests from the public to change the rule to remove the color requirement because "noodle" floats are ideal for this purpose but are not commonly available in white. The department has determined that allowing floats to be any color does not present an enforcement issue, provided the float is not orange, which is the required color for floats used on commercial juglines.

Current harvest and gear regulations for rainbow and brown trout on the Guadalupe River from Canyon Lake Dam to the easternmost bridge crossing on Farm to Market Road (F.M.) 306 consist of the statewide limits for trout (a five-fish daily bag limit and no length limit). From the easternmost F.M. 306 crossing downstream to the second bridge crossing on River Road, current rules allow the harvest of trout 18 inches or longer, and anglers are allowed to retain one trout per day. The retention of trout harvested in this area is also restricted to trout caught on artificial lures. Downstream of the second bridge crossing on the River Road, the regulations revert back to statewide limits. The amendment imposes a 12- to 18-inch slot length limit and five-fish daily bag limit, restricts harvest to artificial lures only, and allows only one trout over 18 inches to be retained. The river segment affected by the amendment extends from 800 yards downstream from the Canyon Dam release to the easternmost F.M. 306 bridge crossing.

Rainbow trout have been stocked in the Guadalupe River below Canyon Reservoir since 1966 by TPWD through a state/federal/private partnership, and the river has been a popular fishery since its inception. The Guadalupe River Chapter of Trout Unlimited (GRTU) has also stocked the Guadalupe River since the early 1970s. Because of the release from Canyon Reservoir, water temperature in the Guadalupe River below Canyon Reservoir is suitable for oversummer survival of rainbow trout in most years. The distance below the reservoir where water temperature remains suitable (below 70° F) is determined by outflow from the reservoir. Higher flows extend the distance, while lower flows reduce it. TPWD and/or GRTU have continuously monitored water temperatures at five sites in the river since 1997. Water temperature data indicate the 4-mile segment of the river from the outflow of Canyon Dam to the easternmost bridge crossing on F.M. 306 has the most consistent, suitable water temperatures. Mortality due to above optimal water temperature (70°F or higher) in this stretch is likely the lowest. Oversummer survival of trout in this segment of the river was documented in fall 2011 despite extremely low summer (June - August) flows (less than 70 cfs) and record high ambient temperatures.

Length limits for the harvest of trout are not currently regulated in this section of the river. Trout of any length can be harvested in this stretch of the river although potential for multi-year survival in this stretch is likely the highest of anywhere on the river. A more-restrictive harvest regulation in this stream segment could be used to increase angler catch rates as well as potentially increase the size structure of the trout population. The amendment is designed to avoid interfering with the popular catch-and-keep fishery directly below the dam. The 12-inch lower end of the slot limit allows harvest of trout stocked by TPWD, as most are below this length, while protecting trout stocked by GRTU which are typically above this length.

New §57.977, concerning Spawning Event Closure, establishes a process to allow the department to temporarily prohibit the take of alligator gar in places where they are spawning or are about to spawn. Alligator gar populations are believed to be declining throughout much of their historical range in North America, which includes the Mississippi River system as well as the coastal rivers of the Gulf of Mexico from Florida to northern Mexico. Although the specific severity of these declines is unknown, habitat alteration and over-exploitation are thought to be partially responsible. Alligator gar have been extirpated in Illinois, Indiana, and Ohio and designated as a "Species of Concern" in Oklahoma and Kentucky. In addition, the Endangered Fishes Committee of the American Fisheries Society has listed the alligator gar as "Vulnerable." Observed declines in other states, vulnerability to overfishing, and increased interest in the harvest of trophy gar indicate that a conservative management approach is warranted until populations and potential threats can be fully assessed. On that basis, the Commission in 2009 adopted a daily bag limit of one alligator gar per person, which was intended to protect adult fish while allowing limited harvest, thus ensuring population stability. Since 2009, the department has conducted (and is continuing to conduct) research to determine the estimated harvest of alligator gar, quantify reproduction, understand habitat usage, and determine geographic differences

in populations. Initial analysis of the research data indicate that alligator gar in Texas have the greatest chance of spawning success if the creation of preferred spawning habitat (the seasonal inundation of low-lying areas of vegetation) occurs in late spring through early summer. Since each year does not necessarily bring seasonal inundation at the optimum time, spawning success varies greatly. For example, department data for the middle Trinity River indicate that between 1980 and 2010, strong reproductive success occurred in only five years (1980, 1989, 1990, 1991, and 2007). Furthermore, in 21 of the years between 1980 and 2010, reproductive success was nonexistent or weak, and in many of these years, rainfall was low or drought conditions occurred. Because the conditions for spawning do not exist on a regular or cyclical basis, and because spawning occurs in shallow waters where numerous gar can be concentrated in one area, alligator gar are extremely vulnerable to harvest during spawning. To protect alligator gar from excessive harvest during spawning, the new rule allows the executive director of the department to prohibit the take of alligator in an affected area, which is defined as "an area of fresh water containing environmental conditions conducive for alligator gar spawning" or "an area of fresh water where alligator gar are in the process of spawning activity." The new rule defines "environmental conditions conducive for alligator gar spawning" as "the components of a hydrological state (including but not limited to water temperatures, duration and timing of flooding events, river discharge rates, and any other factors that are known to be conducive to gar reproduction) that are predictors of the likelihood of spawning activity of alligator gar." The new rule requires the executive director to provide appropriate public notice when an affected area is declared and when lawful fishing for alligator may resume, and would limit the duration of a prohibition to no more than 30 days. The department believes it is important to provide the angling public with a specific maximum timespan for the effectiveness of an action under the new section. The new rule is necessary to manage alligator gar populations and ensure their ability to perpetuate themselves successfully.

The amendment to §57.981, concerning Bag, Possession, and Length Limits, alters regulations for blue and channel catfish on Louisiana border waters (Toledo Bend Reservoir, Caddo Lake, and lower Sabine River).

Current harvest regulations for blue and channel catfish on Louisiana border waters consist of a 50-fish daily bag limit in any combination, of which no more than five blue or channel catfish longer than or equal to 20 inches may be retained. Fish of any length may be harvested. The amendment increases the length restriction on the harvest of five catfish from 20 to 30 inches.

The current regulations were implemented on all border waters on September 1, 2011 in collaboration with Louisiana Department of Wildlife and Fisheries (LDWF). There have been numerous complaints from anglers, particularly on Toledo Bend Reservoir, that the regulation is too restrictive because it results in high proportions of undersized fish being caught on juglines and trotlines. In response to the complaints, supplemental creel, population sampling, and opinion surveys were conducted by TPWD and LDWF. Anglers interviewed during creel surveys caught 1,230 blue catfish, of which 46% were 20 inches or longer and 6% 30 inches or longer. LDWF sampled blue catfish with trotlines and results were similar to those obtained from Texas anglers, with 50% of the catch 20 inches or longer and 6% longer than 30 inches. An opinion survey of anglers indicated that 89% opposed the retention limit of five fish greater than 20 inches and only 3% supported it. Of those opposing, 91% favored a five-fish bag limit but wanted the length limit increased to 30 inches, while 9% supported the current length limit (20 inches) but preferred a bag limit increase to 10 fish.

Toledo Bend Reservoir currently supports an abundant blue catfish population with stable recruitment, and trotline and jugline anglers routinely catch fish that weigh 20 pounds or more and exceed 35 inches in length. Elimination of the minimum length limit under a 50-fish daily bag limit for blue and channel catfish (in any combination) while allowing the retention of no more than five fish of 30 inches or greater in length should provide harvest opportunities that Toledo Bend Reservoir anglers desire without resulting in detrimental effects on the blue catfish population. Blue catfish abundance is high, recruitment is stable, and annual population exploitation is likely low. Additionally, the proposed amendment should not negatively affect blue catfish populations at Caddo Lake or the lower Sabine River, since minimal blue catfish fisheries exist in those places, and no effect is anticipated on the channel catfish population in any border waters because fish longer than or equal to 20 inches are scarce.

The amendment to §57.981 also affects harvest regulations for red drum on Tradinghouse Creek Reservoir in McLennan County. The current regulations consist of a 20-inch minimum length limit, no maximum length limit, and a three-fish daily bag limit. The amendment eliminates the current requirements and implements the statewide length limits (20-inch minimum length limit, 28-inch maximum length limit, and harvest of up to two red drum 28 inches or longer per year with trophy drum tag). The daily bag limit would remain at three. Tradinghouse Creek is a 2,012-acre reservoir located in McLennan County, 10 miles east of Waco. The reservoir was impounded in 1968 and was maintained by Texas Utilities Company for the purpose of cooling a coal-fired power plant. Plant operations were downgraded to an as-needed status in 2004, and then suspended permanently in 2009. Red drum have been stocked regularly in reservoir since 1975. The change in plant operations resulted in water quality changes (lower water temperature and chloride levels) in the reservoir that almost completely eliminate the ability of red drum to survive year round. Red drum stocking was discontinued after 2010, and red drum most likely no longer exist in the reservoir. No red drum were observed during supplemental gill netting or the summer creel survey. Temperature data confirmed near-lethal water temperatures for red drum, and there were more than 40 days of temperatures low enough to stop red drum from actively feeding. Additionally, chloride levels were found to be much lower than the minimum needed to support red drum in fresh water. Consequently, special regulations are no longer needed for this freshwater population.

The amendment to §57.981 also affects Lake Kyle in Hays County. Current regulations on Lake Kyle consist of community fishing lake (CFL) regulations (five fish daily bag limit for channel and blue catfish, no minimum length limit, methods restricted to pole-and-line only and no more than two devices per person) and a 14 to 21 inch slot length limit for largemouth bass. The amendment prohibits the harvest of channel and blue catfish, largemouth bass, or any sunfish species. Lake Kyle is a 12-acre impoundment of Plum Creek and has been open to the public since spring 2012 under the management of the City of Kyle Parks and Recreation Department. A 14- to 21-inch slot length limit was implemented for largemouth bass in 2011 to protect the quality population surveyed at this lake. A high-quality sunfish population was also detected during initial fish surveys. However, after opening to the public, the quality of the sunfish fishery has been degraded. Public access is limited

to the hours and days the park is open. All park users access the park through one entrance at the main office. This unique site provides the attributes needed to expand a quality fishing experience beyond bass to include channel catfish and sunfish.

The amendment to §57.981 also affects saltwater fisheries. The amendment alters the current regulations in effect for spotted seatrout. Until 2007, the harvest regulations for spotted seatrout were statewide, consisting of a daily bag limit of 10 fish, a 15-inch minimum size limit, and no more than one fish greater than 25 inches in length allowed to be retained. The possession limit was twice the daily bag limit. In 2007, the department became concerned about spotted seatrout populations in the lower Laguna Madre and created regional regulations for seatrout (32 TexReg 4421). Those regulations (still in effect) reduced the bag and possession limits for spotted seatrout in the lower Laguna Madre south of Marker 21 to a five-fish daily bag limit and a possession limit equal to the daily bag limit. The amendment moves the boundary for the current regulation northward to F.M. 457 in Matagorda County, lowers the daily bag limit from 10 fish to five fish in that area, and makes the possession limit twice the daily bag limit in the area from F. M. 457 in Matagorda County southward to the Rio Grande. Department sampling and survey efforts since 2007 indicate an increase in the number and size of spotted seatrout in the lower Laguna Madre, and similar results are expected within the area affected by the amendment. Surveys and modeling indicate that landings will be reduced, spawning biomass will be increased, and the number of spotted seatrout greater than 25 inches in length will increase in the affected area. Modeling indicates that improvement is possible in a reasonable period of time. The amendment is necessary to improve the quality of fishing by increasing the number and size of spotted seatrout. The current rule governing the harvest of spotted seatrout in the lower Laguna Madre is referred to as a special regulation. Because the amendment enlarges the geographical extent of the special regulation to encompass most of the Texas coast, the amendment designates the harvest regulations in the area south of F.M. 457 as the statewide standard, and the harvest rules north of F.M. 457 as the special regulation.

The amendment to §57.981(c)(5) and the amendment to §57.992, concerning Bag, Possession, and Length Limits, affect provisions governing the recreational take of flounder. The last three years of fishery-independent survey data (gill nets) indicate a downward population trend in the flounder fishery. While fall gill net sampling data showed an increase in abundance between 2009 and 2011, the two most recent years (2012, 2013) show a decline by 76%, returning to the lowest abundance recorded since the department began sampling in 1982. Based on this recent downward trend the department has determined that to stabilize or reverse this trend additional measures should be implemented to protect and replenish spawning stock biomass during the flounder spawning run. Current harvest regulations for flounder consist of a 14-inch minimum size limit and a 5-fish daily bag and possession limit for recreational take and a 30-fish daily bag and possession limit for commercial take, except during November. During November, recreational and commercial take are restricted to two flounder per day and lawful means are restricted to pole-and-line only. The proposed amendment would extend the two-fish bag limit into the first two weeks of December, but during that two-week time, any legal means could be used to harvest flounder.

Summary of Public Comment

The department received 43 comments opposing adoption of the proposed amendments to §57.973 and §57.981 that implement the statewide standards for community fishing lakes (CFL) for Canyon Lake Project #6 pond in Lubbock County (pole-and-line angling only, no more than two poles per person, daily bag limit of five channel or blue catfish with no minimum length limit). Out of the 43 comments, 10 provided a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Seven commenters opposed adoption and stated an objection to the limit of two poles per person. The department disagrees with the comment and responds that the pole limit is intended to provide a quality fishing experience by maintaining a sustainable harvest of catfish, which can be accomplished in smaller water bodies by reducing the ability of individual anglers to employ large numbers of fishing devices and thereby monopolizing limited shorelines space. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that there should be a minimum length limit on catfish. The department disagrees with the comment and responds that small water bodies such as CFLs (by rule, a CFL cannot exceed 75 acres in area) and slightly larger water bodies such Canyon Lake Project #8 (82 acres) that have CFL harvest regulations are typically close to urban areas and therefore present an ideal opportunity to introduce urban populations to the enjoyment of angling. Therefore, one goal of the department's harvest strategy on such impoundments is to provide a quality fishing experience via an increased chance of successful harvest. By removing the minimum length limit, the chances that an angler is able to catch a fish are increased. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the bag limit should be ten fish. The department disagrees with the comment and responds that the five-fish bag limit is intended to distribute opportunity for more people to enjoy a quality fishing experience. No changes were made as a result of the comment.

The department received 604 comments supporting adoption of the proposed amendment.

No groups or associations commented on adoption of the proposed amendment.

Concho River

The department received 47 comments opposing adoption of the proposed amendment to §57.973 that would limit the number of poles a person may use while fishing on parts of the North and South Concho River in San Angelo. One commenter offered a reason or rational for opposing adoption, stating the limit should be four poles per person. The department disagrees with the comment and responds that the pole limit is intended to provide a quality fishing experience in smaller water bodies by reducing the ability of individual anglers to employ large numbers of fishing devices and thereby monopolize limited shorelines space. No changes were made as a result of the comment.

The department received 569 comments supporting adoption of the proposed amendment.

No groups or associations commented on adoption of the proposed amendment.

Border Waters

The department received 80 comments opposing adoption of the amendment to §57.981 that affects harvest regulations for blue

and channel catfish on waters shared by Texas and Louisiana. Of the 80 comments, 18 provided a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Ten persons stated that a 50-fish daily bag limit is too high. Five persons wanted the regulations to not be changed, and two others suggested alternate regulatory schemes. The department disagrees with those comments as population data collected by staff from Texas and Louisiana confirm that blue and channel catfish populations can be sustained with the new harvest regulations. One person did not provide a specific reason germane to the proposed changes. No changes were made as a result of the comments.

The department received 874 comments supporting adoption of the proposed amendment.

No groups or associations commented on adoption of the proposed amendment.

Tradinghouse Creek

The department received 31 comments opposing adoption of the amendment to §57.981 that affects harvest regulations for red drum on Tradinghouse Creek Reservoir in McLennan County. Of the 31 comments, three provided a reason or rationale for opposing adoption; two persons suggested alternate regulations and one person opposed the change from current regulations. The department disagrees as the current regulations are only applicable when red drum are being stocked in inland reservoirs like Tradinghouse Creek. Since red drum will no longer be stocked, red drum will no longer exist in the reservoir, and regulations designed to manage that populations are no longer necessary. No changes were made as a result of the comments.

The department received 700 comments supporting adoption of the proposed amendment.

No groups or associations commented on adoption of the proposed amendment.

Lake Kyle

The department received 93 comments opposing adoption of the amendment to §57.981 that affect harvest regulations for bass, catfish, and sunfish in Lake Kyle in Hays County. Of the 93 comments, 18 provided a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Sixteen persons opposed adoption as they did not agree with catch and release for the three species and suggested various other harvest regulations such as catch and release for individual species or reduced bag limits. Two persons opposed adoption and said the regulations should be reevaluated after implementation. The department disagrees as the fish population characteristics of the lake along with the usage patterns should be allow the fishing quality in the lake to benefit from the regulation changes. Additionally, department staff regularly assess the impact of harvest regulations on fish populations and based on these assessments will seek to modify regulations, if necessary. Four persons did not provide a specific reason germane to the proposed changes. No changes were made as a result of the comments.

The department received 521 comments supporting adoption of the proposed amendment.

No groups or associations commented on adoption of the proposed amendment.

Rainbow Trout

The department received 95 comments opposing adoption of the proposed amendments to §57.973 and §57.981 that affect rainbow trout harvest regulations on a section of the Guadalupe River below Canyon Lake dam. Of the 95 comments, 25 articulated a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that the rules are elitist and favor fly fishing over other methods. The department disagrees with the comment and responds that the rules do not provide an advantage for any single type of means or method. No changes were made as a result of the comment.

One commenter opposed adoption and stated that trout are an invasive species. The department disagrees with the comment and responds that the habitat in the Guadalupe River below Canyon Lake has been altered as a consequence of the construction of Canyon Dam. Conditions in that stretch of the river are no longer optimal for many of the fishes in the native assemblage. Rainbow trout are a desirable sport fish that can take advantage of the altered conditions. Their habitat requirements are found in very few places in Texas, which almost eliminates any impacts to native fishes in the remainder of the state. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be no slot limit since the trout cannot survive in warm water. The department disagrees with the comment and responds that water temperature in most years allows trout to survive over the summer. No changes were made as a result of the comment.

One commenter opposed adoption and stated that artificial lures should be restricted to a single hook because hooking mortality is high. The department disagrees with the comment and responds that hooking mortality is higher for trout caught on baits other than artificial lures. No changes were made as a result of the comment.

Four commenters opposed adoption and stated various preferences for bag and length limits: one commenter stated that the bag limit should be increased to three fish; one commenter stated that there should be a five-fish bag limit and only one fish over 18 inches in length; one commenter stated that the regulation should be a five-fish bag limit with a 16-inch minimum length limit and no maximum length limit, and one commenter opposed adoption and stated that the bag limit should be higher than one fish per day. The department disagrees with the comments and responds that the length and bag limits and harvest methods have been selected to optimize impacts to the existing population structure, allow satisfactory angler harvest, and achieve long-term management goals for the fishery. No changes were made as a result of the comments.

Nine commenters opposed adoption and stated that natural bait should be lawful. One of the commenters also stated that restricting bait to artificial bait penalizes young and inexperienced anglers. Another commenter stated that barbless hooks should be required if natural bait is unlawful. The department disagrees with the comments and responds that hooking mortality is higher for trout caught on baits other than artificial lures and results in unacceptable population reductions without corresponding angler benefits. This is true no matter the age of the angler. The de-

partment also responds that hooking mortality as a consequence of barbless versus barbed hooks is not significant enough to require barbless hooks to be used with artificial lures. No changes were made as a result of the comments.

One commenter opposed adoption and stated that creating different harvest regulations for different parts of the river creates confusion. The department disagrees with the comment and responds that to provide a quality fishery, equitably distribute angling opportunity, and reduce hooking mortality, the segment of the river in which angler interest for trout is highest must be placed under a separate regulatory regime. No changes were made as a result of the comment.

One commenter opposed adoption and stated that government funds and employees should not be used to enforce rules affecting non-native species. The department disagrees with the comment and responds that rainbow trout are a desirable sport fish that can take advantage of the conditions immediately below the Canyon Dam release without negative impacts to native fishes in the remainder of the state. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be no slot limit since the fish do not reproduce. The department disagrees with the comment and responds that the slot limit is not intended to protect breeding fish but to distribute the opportunity for anglers to enjoy a successful harvest. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be no more than two regulatory zones. The department disagrees with the comment and responds that to provide a quality fishery, equitably distribute angling opportunity, and reduce hooking mortality, the segment of the river in which angler interest for trout is highest must be placed under a separate regulatory regime. No changes were made as a result of the comment.

Ten persons opposed adoption and stated that the harvest restriction was too restrictive. The department responds that hooking mortality of trout caught and released on other baits, such as live bait, is higher than artificial lures and could result in unacceptable morality of trout caught and released.

Eight persons opposed adoption and proposed alternate scenarios for length or bag limits, or harvest methods, and two additional persons commented that the rules were too complex. The department responds that the habitat in the Guadalupe River below Canyon Lake was altered from pre-impoundment conditions and conditions in that stretch of the river are no longer optimal for many of the fishes in the native assemblage. Rainbow trout are a beneficial sport fish that can take advantage of the altered conditions. Their habitat requirements are found in very few places in Texas almost eliminating any impacts to native fishes in the remainder of the state. Four persons opposed did not give reasons germane to the changes. No changes were made as a result of the comments.

The department received 948 comments supporting adoption of the rule as proposed.

No groups or associations commented on adoption of the proposed amendment.

Alligator Gar

The department received 991 comments opposing adoption of new §57.977, which establishes a process to allow the department to temporarily prohibit the take of alligator gar in places where they are spawning or are about to spawn. This included a petition with 464 signatures. Of the 991 comments, 253 provided a reason or rationale for opposing adoption. Those comments, categorized for convenience and accompanied by the department's response to each, follow.

Science/Biology/Data

Thirteen commenters opposed adoption and stated that the department has inadequate data to justify the regulation. Since 2009, the department has conducted (and is continuing to conduct) research to determine the estimated harvest of alligator gar, quantify reproduction, understand habitat usage, and determine geographic differences in populations. Initial analysis of the research data indicate that alligator gar in Texas have the greatest chance of spawning success when the creation of preferred spawning habitat (the seasonal inundation of low-lying areas of vegetation) occurs in late spring through early summer. Because the conditions for spawning do not exist on a regular or cyclical basis, and because spawning occurs in shallow waters where numerous gar can be concentrated in one area, alligator gar are extremely vulnerable to harvest during spawning. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that the department has no data to support the claim that alligator gar have low reproduction rates. The department disagrees with the comments and responds that numerous studies and investigations have affirmed that alligator gar have comparatively low reproductive rates. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that spawning gar are not vulnerable to harvest because the daily bag limit of one fish is more than adequate protection. The department disagrees with the comment and responds that although the one-fish daily bag limit is believed to offer a substantial safeguard against overharvest, intense harvest pressure during a spawning event, when alligator gar are extremely vulnerable to harvest, could result in negative population effects. No changes were made as a result of the comment.

One commenter opposed adoption and stated that since the department doesn't stock alligator gar in every lake there is no way to tell when the spawn is taking place. The department disagrees with the comment and responds that the spawning behavior of alligator gar is not correlated to stocking activities. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule doesn't adequately define "spawning," which will cause game wardens to "cite everyone." The department disagrees and responds that it is not necessary to define "spawning," because the rule does not require anglers to determine whether is spawning is occurring or not, only to refrain from harvesting alligator gar in an affected area declared by the department. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the current rule was sufficient to protect the population. The department disagrees with the comment and responds that although the one-fish daily bag limit is believed to offer a substantial safeguard against overharvest, intense harvest pressure during a spawning event, when alligator gar are extremely vulnerable to harvest could result in negative population effects. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that because the bag limit is one fish per day, it shouldn't matter when or where

harvest occurs. The department disagrees with the comment and responds that although the one-fish daily bag limit is believed to offer a substantial safeguard against overharvest, intense harvest pressure during a spawning event, when alligator gar are extremely vulnerable to harvest, could result in negative population effects. No changes were made as a result of the comments.

One commenter opposed adoption and stated that there should be no bag limits. The department disagrees with the comment and responds that a return to unregulated harvest of alligator gar would result in unacceptable population declines and consequent ecological imbalances resulting from the loss of an apex predator species. No changes were made as a result of the comment.

One commenter opposed adoption and stated that gar declines in other states are not due to harvest pressure but to human-created infrastructure that alters river hydrology; therefore, the regulation is unnecessary. The department disagrees with the comment and responds that although stream disruption results in habitat alteration and undoubtedly contributes to factors affecting alligator gar populations elsewhere, overharvest is believed to be the primary causative factor in population declines, including in Texas. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that because spawning occurs infrequently and the bag limit is one per day, there shouldn't be a danger to populations compared to the years before the one fish per day limit was imposed. The department disagrees with the comment and responds that although the one-fish daily bag limit is believed to offer a substantial safeguard against overharvest, intense harvest pressure during a spawning event, when alligator gar are extremely vulnerable to harvest, could result in negative population effects. No changes were made as a result of the comments.

One commenter opposed adoption and stated that alligator gar are an undesirable species and should be eradicated. Similarly, six commenters opposed adoption and stated that alligator gar are trash or nuisance fish and should not be protected. The department disagrees with the comment and responds that alligator gar are an important part of riverine foodwebs and ecosystems, functioning as apex predators to keep populations of other aquatic species balanced. The department also responds that as a management strategy, eradication of an indigenous component of an ecosystem is likely to result in ecological responses that are undesirable. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that fish that affect desirable species, such as bass, should not be protected. The department disagrees with the comment and responds that studies in the U.S. have uniformly concluded that the most common prey of alligator gar is carp, shad, buffalo, or freshwater drum, and that sportfish are a small proportion of the prey consumed. Since 1970, the department has examined alligator gar food habits in six Texas reservoirs and the results are similar to other studies that demonstrate no noticeable negative impacts to bass populations. No changes were made as a result of the comment.

Five commenters opposed adoption and stated that there should be no limit on alligator gar because they destroy bass fisheries or threaten other species. The department disagrees with the comment and responds that studies in the U.S. have uniformly concluded that the most common prey is of alligator gar is carp, shad, buffalo, or freshwater drum, and that sportfish are a small proportion of the prey consumed. Since 1970, the department has examined alligator gar food habits in six Texas reservoirs and the results are similar to other studies that demonstrate no noticeable negative impacts to bass populations. Because alligator gar are a native fish that are important to riverine ecosystems, the department believes that adequate and necessary management is prudent. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the fewer alligator gar, the better. The department disagrees with the comment and responds that alligator gar are an important component of riverine ecosystems and were they to experience significant declines (as they have in other states) there could be undesirable ecological consequences. No changes were made as a result of the comment.

One commenter opposed adoption and stated that alligator gar spawn everywhere during the spring. The department disagrees with the comment and responds that although alligator gar typically spawn during the spring, hydrological conditions must be conducive for the spawn to occur. No changes were made as a result of the comment.

One commenter opposed adoption and stated that angling pressure is not intense enough to endanger alligator gar populations. The department disagrees with the comment and responds because alligator gar reach sexual maturity late in a very long lifespan, significant damage to the population can be inflicted even when numbers apparently seem high. The loss of reproductive potential can result in severe population declines in a short period of time. For these reasons the department imposed a one-fish daily bag limit and now imposes additional measures to enhance reproductive success. No changes were made as a result of the comment.

One commenter opposed adoption and stated that recreational harvest of alligator gar is less than 3% of the adult population, which is below the 5% harvest that TPWD regards as sustainable, so there is no reason to prohibit the recreational harvest. The department disagrees with the comment and responds that the 5% harvest represents a best-case estimate of the point at which severe population could be expected and assumes that environmental and harvest parameters remain stable. Additional protection for alligator gar during spawning activities will function to buffer the impacts of harvest and infrequent optimal spawning conditions. No changes were made as a result of the comment.

One commenter opposed adoption and stated that because so few anglers are interested in alligator gar there is no reason to make harvest more difficult than it already is. The department disagrees with the comment and responds that alligator gar are very popular with anglers because of their size and vigorous fighting ability. Because of the increase in popularity of this fish, additional protections are necessary. No changes were made as a result of the comment.

One commenter opposed adoption and stated that because people don't bowfish for more than 3-5 years, which means the harvest of alligator gar won't change. The department disagrees with the comment and responds that the most helpful value with respect to estimating the effects of angling pressure is overall fishing pressure and not the frequency or duration of individual choices of means or methods. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the population doesn't seem to be decreasing and that the state is just looking for additional revenue from tourists catching large alligator gar. The department disagrees with the comment and responds that observed declines in alligator gar in other states, vulnerability to overfishing, and increased interest in the harvest of trophy gar indicate that a conservative management approach is warranted until populations and potential threats can be fully assessed. Since 2009, the department has conducted (and is continuing to conduct) research to determine the estimated harvest of alligator gar, quantify reproduction, understand habitat usage, and determine geographic differences in populations. The rule is based on protection of the species rather than revenue enhancement. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that the alligator gar population is increasing. Similarly, fourteen commenters opposed adoption and stated that alligator gar populations are abundant or overabundant. In addition, two commenters opposed adoption and stated that alligator gar are not being overfished. The department disagrees with the comments and responds that while in some parts of the state, a casual observer may notice what appear to be healthy populations of alligator gar, given the unique life history of alligator gar, and the potential for intense harvest pressure during a spawning event, when alligator gar are extremely vulnerable to harvest, could result in negative population effects. In addition, the one-fish daily bag limit enacted in 2009 was intended to help stabilize the population of alligator gar. However, the department disagrees that the amended rule is unnecessary and responds that the potential for intense harvest pressure during a spawning event, when alligator gar are extremely vulnerable to harvest, could result in negative population effects. Thus the rule is believed to offer a substantial safeguard against overharvest. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that the regulation would be difficult or impossible to enforce. The department disagrees with the comment and responds that it is confident that the rule as adopted can be enforced by department law enforcement personnel. No changes were made as a result of the comments.

One commenter opposed adoption and stated that instead of designating closed areas, the department should "make it illegal to harvest." The department agrees with the comment and responds that it a matter of semantics; a closed area is by definition an area where harvest is illegal. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that harvest regulations for alligator gar should be based on the biological realities in each river system. The department both agrees and disagrees with the comment and responds that until the department is able to complete the research necessary to determine management options in various riversheds, a conservative management approach is prudent. No changes were made as a result of the comments.

Twelve commenters opposed adoption and stated that more research is needed before the regulations are promulgated. The department both agrees and disagrees with the comment and responds that until the department is able to complete the research necessary to characterize populations status and dynamics, a conservative management approach is prudent. No changes were made as a result of the comments.

One commenter opposed adoption and stated that there should be a slot limit for alligator gar. The department disagrees with the comment and responds that additional population data is needed if the department were to pursue a slot limit to protect older fish and that the one-fish daily bag limit coupled with the ability to temporarily halt harvest during spawning events offers sufficient protection to the species. No changes were made as a result of the comment.

One commenter opposed adoption and stated that if Texas alligator populations were in danger of decline they would have already declined as they have in other states. The department disagrees with the comment and responds that due to the long life span and late reproductive maturity of alligator gar, population declines can occur rapidly as a result of overharvest. Rather than gamble that the current harvest is sustainable, the department advocates a conservative management approach until the dimensions of the situation are definitively known. No changes were made as a result of the comment.

One commenter opposed adoption and stated that because he doesn't take more than one alligator gar per year and in some years harvests no alligator gar at all "it's the same odds of them spawning." If the commenter intends to posit that the infrequent harvest effort of one angler in years when spawning does not occur tends to function to offset or compensate for harvest when spawning does occur, the department disagrees with the comment and responds that because alligator gar reach reproductive maturity very late and are extremely vulnerable during spawning and pre-spawning activity, harvest during spawning represents an increased potential for negative population effects. No changes were made as a result of the comment.

Authority/Regulatory Scope

One commenter opposed adoption and stated that the department should not have the authority to specify the places and times when angling is legal. The department disagrees with the comment and responds that such authority is expressly granted to the Parks and Wildlife Commission by statute. No changes were made as a result of the comment.

One commenter opposed adoption and stated the government should not make decisions because taxpayers pay for the lakes and rivers. The department disagrees with the comment and responds that the Parks and Wildlife Department is the primary agency charged with protecting and conserving fish and wildlife resources in public waters. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the regulation violates fishermen's rights. The department disagrees with the comment and responds that the harvest of a public resource is a privilege granted as a consequence of purchasing a fishing license and is otherwise illegal in public water. No changes were made as a result of the comment.

Eleven commenters opposed adoption and stated that the regulation was too vague. The department disagrees with the comment and responds that the rule as adopted specifically states the conditions for temporary closure of an affected area, stipulates the actions to be taken by the department, and limits the effectiveness of such a closure to no more than 30 days. No changes were made as a result of the comments.

Four commenters opposed adoption and stated that the rule is so broadly worded that it will be used to shut down fishing any time the department desires and even when spawning isn't occurring.

The department disagrees with the comment and responds that the rule as adopted specifically states the conditions for temporary closure of an affected area, stipulates the actions to be taken by the department, and limits the effectiveness of such a closure to no more than 30 days. The department also notes that it would be of no conservation value to protect spawning if no spawning was or was expected to occur. No changes were made as a result of the comments.

One commenter opposed adoption and stated that prohibiting access to public waters because gar might be spawning is ridiculous. The department disagrees with the comment and responds that the rule does not in any way prohibit access to public water; it prohibits the take of alligator gar in an affected area during a declared spawning event. No changes were made as a result of the rule.

One commenter opposed adoption and stated that the rule was a rash political decision. The department disagrees with the comment and responds that the motivation for promulgation of the rule is the discharge of the agency's statutory duty to protect and conserve nongame fish under the provisions of Parks and Wildlife Code, Chapter 67, and that the rule was carefully considered prior to being promulgated. No changes were made as a result of the comment.

Ten commenters opposed adoption and stated that the decision to close an area should not be left up to one person (i.e., the executive director of the department). The department disagrees with the comments and responds that the rule as adopted does not allow any person to unilaterally close an area to harvest of alligator gar, but requires a definitive biological assessment ("including but not limited to water temperatures, timing and duration of flood events, river discharge rates, and any other factors that are known to be conducive to alligator gar reproduction") as a precursor to any designation by the executive director. No changes were made as a result of the comments.

Notification/Compliance

Seven commenters opposed adoption and stated that it will be difficult or impossible to notify fishermen when closures are initiated. The department disagrees with the comment and responds that the rule requires the department to provide appropriate notice of closures, which will take the form of signage at nearby boat ramps and access points, press releases, email blasts, social media, internet notices, and instant updating of the department's mobile fishing regulation application. The department's Outdoor Annual will also contain detailed information to educate the angling public about the conditions that could result in temporary closure of an affected area. No changes were made as a result of the comments.

One commenter opposed adoption and stated that it is difficult for anglers to keep informed about constantly changing regulations, which makes criminals out of good citizens. The department disagrees with the comment and responds that although the department strives to avoid complicated regulations, one of the duties of a responsible angler is to familiarize themselves with applicable regulations. In addition, as noted above, the department intends to notify anglers of changes resulting from the rule by signage at nearby boat ramps and access points, press releases, email blasts, social media, internet notices, and instant updating of the department's mobile fishing regulation application. The department's Outdoor Annual will also contain detailed information to educate the angling public about the conditions that could result in temporary closure of an affected area. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule will alienate anglers and cause them to stop cooperating with the department. The department disagrees with the comment and responds that it believes most anglers will continue to participate in a mutually beneficial relationship with the department. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule was not specific as to when, why, and for how long temporary closures would be. The department disagrees with the comment and responds that the rule as adopted specifically states the conditions for temporary closure of an affected area and limits the effectiveness of such a closure to no more than 30 days. No changes were made as a result of the comment.

Alternatives to Temporary Closure

Two commenters opposed adoption and stated that the season should be closed during the months when spawning occurs. The department disagrees with the comment and responds that because spawning is dependent on many variables besides the time of year, spawning events occur too infrequently to justify annual closures. No changes were made as a result of the comments.

One commenter opposed adoption and stated that alligator gar should be transplanted from Falcon Lake to the places where the department is concerned about alligator gar populations. The department disagrees with the comment and responds that it is more cost effective and ecologically sensible to manage the natural alligator gar fishery in situ than to transplant alligator gar. No changes were made as a result of the comment.

One commenter opposed adoption and stated that if the department wants to protect alligator gar then it should stock lakes with alligator gar. The department disagrees with the comment and responds that it is more cost effective and ecologically sensible to manage the natural alligator gar fishery in situ than to stock alligator gar. No changes were made as a result of the comment.

One commenter opposed adoption and stated that a rain event could ruin a tournament. The department agrees that the unfortunate coincidence of a tournament and the hydrological conditions conducive to spawning could result in disappointment for tournament participants, but responds that the welfare of the resource is paramount and that such coincidences would be fairly unusual, if they occur at all. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the department was overreaching its power. The department disagrees with the comment and responds that under Parks and Wildlife Code, Chapter 67, the commission is required to develop management programs to insure the continued ability of nongame fish species to perpetuate themselves successfully and to establish any limits on the taking, possession, propagation, transportation, importation, exportation, sale, or offering for sale of nongame fish that the department considers necessary to manage the species; therefore, the department not only possesses the statutory authority to promulgate rules to protect alligator gar, but an affirmative duty to do so. No changes were made as a result of the comment.

Means and Methods

One commenter opposed adoption and stated that spawning harvest closures should prohibit the harvest of alligator gar by means of archery equipment and make all other means lawful. The department disagrees with the comment and responds that because spawning events are rare, they represent a very limited opportunity for recuperative advantage; therefore, to maximize the effect of spawning events, all harvest would be prohibited in an affected area. No changes were made as a result of the comment.

One commenter opposed adoption and stated that all means and methods should be prohibited during a closure. The department agrees with the comment and responds that the rule as adopted prohibits the take of alligator gar by any means or method in an affected area during a temporary closure under the rule. No changes were made as a result of the comment.

One commenter opposed adoption and stated that harvest of alligator gar should be restricted to catch-and-release. The department disagrees with the comment and responds that because alligator gar are a nongame fish, they can be taken with archery equipment, which is a very popular method of take; however, since take by archery is invariably fatal, catch-and-release would not be a successful management tool. No changes were made as a result of the comment.

Bag and Possession Limits

Thirty-two commenters opposed adoption and stated that the bag limit for gar on Falcon Lake should be increased. The department disagrees with the comment and responds that the intent of the rule is to protect alligator gar during spawning activities. The rule does not contemplate bag or possession limits during such spawning events. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that the alligator gar population in Falcon Lake is too high. The department disagrees with the comment and responds that the intent of the rule is to protect alligator gar during spawning activities, and that in any case, department data do not indicate an overabundance of alligator gar in Falcon Lake. However, department biologists have initiated work on Lake Falcon to assess potential impacts of alligator gar on largemouth bass and are continuing a food habit study at Lake Falcon to better evaluate the diet of alligator gar which will hopefully address the concerns that may be underlying this comment. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that the daily bag limit should be five fish. The department disagrees with the comments and responds that the current bag limit of one alligator gar per day is necessary to prevent overharvest of older, reproductively important individuals. Increasing the bag limit to five fish per day would deplete the resource and negatively affect the species' ability to perpetuate itself. No changes were made as a result of the comments.

One commenter opposed adoption and stated that there should minimum and maximum length limits on alligator gar in all areas. The department disagrees with the comment and responds that because alligator gar are a nongame fish, they can be taken with archery equipment, which is a very popular method of take; however, since take by archery is invariably fatal, slot limits would be of no conservation value because oversized or undersized fish could not be released. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the bag limit should be one per day no matter what. The department disagrees with the comment and responds that although the current rule is a substantial safeguard against overharvest, intense harvest pressure during a spawning event, when alligator gar are extremely vulnerable to harvest, could result in negative population effects. No changes were made as a result of the comment.

Miscellaneous Comments

Ten commenters opposed adoption and stated that the data presented by staff to the Parks and Wildlife Commission was inaccurate because it came from a taxidermist located in one area of a river and not fishermen. The department disagrees with the comments and responds that information presented by staff to the Parks and Wildlife Commission comes from a variety of internal and external sources. No changes were made as a result of the comments.

One commenter opposed adoption and stated that other states provide for the sportsman but not Texas. The department disagrees with the comment and responds that because the commenter made no reference to specific examples the department is unable to respond. However, the department does note that the department's mission includes providing fishing opportunities in Texas for the use and enjoyment of present and future generations. No changes were made as a result of the comment.

One commenter opposed adoption and stated that alligator gar are important to license sales. The department agrees with the commenter to the extent that all species are important to hunters and anglers, but disagrees that the rule as adopted will affect license sales. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule was promulgated by people who dislike the taking of trophy fish. The department disagrees with the comment and responds that the motivation for the rule is the protection of spawning alligator gar. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule would prevent the take of other species. The department disagrees with the comment and responds that rule affects only the harvest of alligator gar. No changes were made as a result of the comment.

Four commenters opposed adoption and stated that closures would hurt tourism and the economy. The department disagrees with the comments and responds that closures, if they occur, would be infrequent and affect only specific areas, leaving other areas available for alligator gar harvest. In addition, temporary closures would affect only the harvest of alligator gar and not any other species of game or nongame fish. No changes were made as a result of the comments.

Comments Not Germane to the Rulemaking

Two commenters opposed adoption but the department was unable to determine from the comments the nature of the commenters' disagreement.

The department received 1,156 comments, including a petition with 353 names, supporting adoption of the proposed new rule.

The Texas Bowfishing Association commented in opposition to the adoption of the proposed amendment.

Jugline Floats

The department received 55 comments opposing adoption of the amendment to §57.977 affecting gear requirements for juglines.

Of the 55 comments, 37 offered a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Twenty-eight commenters opposed adoption and stated that allowing colors in addition to white to mark juglines could result in damage to boats or be a safety hazard. The department disagrees with the comment and responds that the previous rule requiring floats to be white was intended only to function as a way to let law enforcement personnel know where taking devices were located. The department does not believe that people will employ float colors that are difficult to see because that would hamper the anglers' ability to locate the device and retrieve the catch. No changes were made as a result of the comments.

One commenter opposed adoption and stated that allowing "noodles" to be used instead of floats could confuse boaters, who might not know that hooks could be attached to the device. The department disagrees with the comment and responds that rule has never required anything other than "a floating device" to mark a jugline; thus, "noodles" have always been legal. No changes were made as a result of the comments.

One commenter opposed adoption and stated that allowing "noodles" to be used instead of floats would harm fish and water quality because noodle decompose readily. The department disagrees with the comment and responds that rule has never required anything other than "a floating device" to mark a jugline; thus, "noodles" have always been legal. No changes were made as a result of the comments.

One commenter opposed adoption and stated juglines should be allowed only in daylight because they are often abandoned and become safety hazards. The department disagrees with the comment and responds that juglines are required to have a gear tag attached that identifies the person who set the device out. Although the department cannot prevent people from abandoning taking devices, those that are abandoned without identification are subject to confiscation. No changes were made as a result of the comment.

One commenter opposed adoption and stated that floats should be one color because multiple multicolored floats are not attractive. The department disagrees with the comment and responds that the rule is intended only to simplify the gear requirements for jugline anglers and does not contemplate aesthetic standards. No changes were made as a result of the comment.

Four commenters opposed adoption and stated that juglines should be unlawful. The department disagrees with the comments and responds that the rule is intended only to simplify the gear requirements for jugline anglers and does not contemplate the prohibition of juglines. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the department should regulate the placement of juglines and require them to be permanently anchored. The department disagrees with the comment and responds that the rule is intended only to simplify the gear requirements for jugline anglers and does not contemplate any other aspect concerning the use, placement, or employment of juglines. No changes were made as a result of the comment.

The department received 1,093 comments supporting adoption of the proposed amendment.

No groups or associations commented on adoption of the proposed amendment.

Flounder

The department received 540 comments opposing adoption of the proposed amendment to §57.981 affecting harvest regulations for flounder. Of the 540 comments, 138 offered a reason or rationale for opposing adoption. Those comments, categorized for convenience and accompanied by the department's response to each, follow:

Thirty-six commenters opposed adoption and stated that the department should reduce or limit commercial harvest, rather than further restrict recreational anglers. The department disagrees with the comment and responds that department data indicates that commercial harvest is less than half of the recreational harvest. The rule is intended to protect the resource while equitably distributing harvest opportunity to various user groups. In addition, the rule applies equally to recreational and commercial harvest. No changes were made as a result of the comments.

Thirty-two commenters opposed adoption and stated either that department data does not justify the rule as adopted or that the current regulations are sufficient to achieve the department's management goals. The department disagrees with the comments and responds that although flounder populations rebounded following the 2009 rulemaking that established special harvest regulations for the month of November (two-fish daily bag limit, pole-and-line only), the population decreased in 2012 and was at an all-time low in 2013. Based on this downward trend, the department has determined that reducing the bag limit during the first two weeks of December is necessary to offer further protection during the flounder migration. No changes were made as a result of the comments.

Twenty-seven commenters opposed adoption and stated that the department should impose further restrictions on flounder gigging. The department disagrees with the comments and responds that although the department's routine creel surveys do not capture effort or harvest from nighttime recreational anglers who use gigs, a department study indicates that those landings are equivalent to approximately one-third of the recreational landings from daytime harvest. Thus, additional restrictions focused on night gigging alone could not be expected to provide as great a benefit in comparison to a bag limit reduction for all anglers. The department also notes that under current rule, gigging is not allowed during the month of November, which historical data show was the month when most gigging effort occurred. No changes were made as a result of the comments.

Eleven commenters opposed adoption and stated that the department should increase the daily bag limit for flounder. The department disagrees with the comments and responds that the rule as adopted represents a balance between providing optimal protection for migrating flounder and the opportunity for reasonable enjoyment of the resource by the public. The department also notes that increasing the daily bag limit would increase harvest and therefore would not provide protection to the stocks, frustrating the goal of the rule, which is to increase the overall relative abundance of flounder. No changes were made as a result of the comments.

Eight commenters opposed adoption and stated that the season should be expanded. The department disagrees with the comments and responds that flounder are most susceptible to overharvest during migrations, which are triggered by the arrival of cold fronts, typically between November and December. The timing of the special regulation is based on this chronology, which is intended to balance the desire of anglers to har-

vest flounder against the susceptibility of flounder to harvest during the migration. Expanding the season incrementally allows the department to view the results of the expansion without potentially resulting in undesired additional harvest impacts. No changes were made as a result of the comments.

Four commenters opposed adoption and stated that the department should place limitations on harvest by "flounder boats." The department disagrees with the comments and responds that harvest regulations for flounder apply to all anglers regardless of whether they are in a boat or not, or have specialized equipment or skill levels. No changes were made as a result of the comments.

Four commenters opposed adoption and stated the two-fish limit makes floundering not worth the time, expense, or effort. The department disagrees with the comment and responds that in addition to the two flounder per day, which applies to everyone and is necessary to protect flounder when they are most vulnerable to harvest, there are many other species of fish and shellfish that are legal to harvest during November and December. No changes were made as a result of the comment.

Four commenters opposed adoption and stated that the department should implement a slot limit or a minimum size limit. The department disagrees with the comments and responds that the department data indicate that over 90% of flounder landed in November currently are between 14 inches and 20 inches. Given the escapement of flounder during this time of the year, gear types used, and the life history of flounder, slot limits would not be a favorable alternative management measure. The department also responds that lowering the minimum size limit would increase the harvest of immature females and consequently reduce the number of spawning females in the future; increasing the minimum size limit would result in higher release mortality, which is also undesirable. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that the regulation is confusing. The department disagrees with the comments and responds that it is confident that anglers will be able to comply with the extension of the two-fish limit from December 1 through December 14 and the fact that during that time, all lawful means may be used to harvest flounder. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that Galveston Bay and Sabine Lake should be excluded from the applicability of the rule. The department disagrees with the comments and responds that in 2013, approximately 80% of recreational flounder landings were from these two systems, with Galveston Bay alone accounting for 47% of all recreational flounder landings. Excluding these two systems from the effectiveness of the rule would defeat the purpose of the rule which is to reduce the flounder harvest in order to increase spawning biomass and rebuild flounder stocks. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that gigging should be permitted in November. The department disagrees with these comments and responds that although the rule as proposed did not contemplate modification of the current prohibition on gigging in November, to allowing gigging in November, when migrating flounder are most susceptible to take, would result in an undesirable increase in flounder harvest and a consequent decrease in spawning biomass, which is the opposite of the department's management goal. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the department should impose limitations on fishing guides. The department disagrees with the comment and responds that the bag limits imposed by the amendment affect all anglers equally, including those fishing with guides. The department also notes that guides are prohibited from personally retaining fish caught during a guided trip. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season for flounder should be closed for the entire month of November. The department disagrees with the comment and responds that although a November closure would be the optimum management choice for restoring flounder stocks as quickly as possible, the impact on recreational and commercial angling would be unacceptable. The rule as adopted will achieve the department's management goals while still providing for enjoyment of the resource. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the department should promulgate rules to minimize flounder bycatch by shrimp boats. The department disagrees with the comment and responds that commercial bay-shrimping effort, along with the associated bycatch, has been reduced by 95% as a consequence of the department's shrimping license buyback program; thus bycatch is not a significant contributor to flounder mortality. No changes were made as a result of the comment.

One commenter opposed adoption and stated that commercial harvest should not be further restricted. The department disagrees with the comment and responds that in order to achieve the department's management goals, commercial harvest as well as recreational harvest must be reduced. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the department intends for the rule to be permanent. The department disagrees with the comment and responds that the purpose of the rule is to replenish flounder populations; if and when the management goal is achieved, the department will review the current information and consider any bag limit increase in the context of protection of the resource. No changes were made as a result of the comment.

Seven commenters opposed adoption and stated opinions or that were not germane to the substance, intent, or effect of the proposed rule. No changes were made as a result of the comments.

The department received 1,831 comments supporting adoption of the proposed amendment.

The Saltwater Fisheries Enhancement Association, Coastal Conservation Association, Lonestar Bowhunters Association. Texas Bowfishing Association, and Texas Bowhunting and Bowfishing Association commented in support of adoption of the proposed amendment.

The Coastal Bend Guides Association commented in opposition to adoption of the proposed amendment.

Spotted Seatrout

The department received 862comments opposing adoption of the proposed amendment to §57.981 affecting regulations for spotted seatrout. Of the 862 comments, 210 offered a reason or rationale for opposing adoption. Those comments, categorized

for convenience and accompanied by the department's response to each, follow:

Sixty-seven commenters opposed adoption and stated that the department should adopt a higher bag limit, a different size limit, or a different slot limit. The department disagrees with the comments and responds that the rule as adopted is believed to represent an acceptable balance between the department's management goal (to ensure the sustainability of spotted seatrout populations) and angling public's desire to harvest spotted seatrout. The current size limit allows females to spawn at least once before reaching harvestable size and ensures a strong male population. Increasing the size limit or imposing a slot limit is undesirable because either action would result in increased release mortality because anglers would have to release more fish, which would frustrate the goal of the rule. No changes were made as a result of the comments.

Forty-seven commenters opposed adoption and stated that the department's data does not support the need for the rule. The department disagrees with the comments and responds that department data indicate that imposition of a reduced bag limit increases spawning stock biomass. No changes were made as a result of the comments.

Thirty-four commenters opposed adoption and stated that the boundary of the rule's applicability should be different or that the rule should apply everywhere. The department disagrees with the comments and responds that choice of Farm to Market Road 457 in Matagorda County was chosen because it separates the ecosystems in need of more conservative management (Matagorda Bay southward) from those that the department considers to be able to sustain more liberal harvest pressure (Galveston Bay northward) and because it is convenient for purposes of compliance and enforcement.

Sixteen commenters opposed adoption and stated that the department should impose additional limitations on guides. The department disagrees with the commenters and responds that the rule as adopted applies equally to all anglers, including guides, who the department notes are prohibited from personally retaining fish caught during a guided trip. No changes were made as a result of the comments.

Thirteen commenters opposed adoption and stated that the rule would make angling for seatrout not worth the time, expense, or effort. The department disagrees with the comment and responds that in addition to the five-fish daily bag limit, which applies to everyone and is necessary to ensure the sustainability of the fishery, there are many other species of fish and shellfish that are legal to harvest. No changes were made as a result of the comments.

Eight commenters opposed adoption and stated that the department's actual goal is to create a trophy fishery. The department disagrees with the comments and responds that the motivation for the rule is to preserve the sustainability of the trout population. Moreover, department statistical modeling indicates that the number of larger fish should increase, but will constitute a very small percent of the overall population. No changes were made as a result of the comments.

Eight commenters opposed adoption and stated that the rule's "sunset" provision be modified or eliminated. The department disagrees with the comments and responds that the five-year sunset provision is intended to reassure the public that in five years the department will either recommend extending the effectiveness of the rule or modify the provision, depending on a biological assessment of the population at that time. Statistical modeling indicates that 51 percent of the anticipated results of the rule will occur within one year, 89 percent within three years, and 99 percent within six years. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that to reduce harvest associated with fishing tournaments the department should either restrict tournaments or impose a fee on tournaments. The department disagrees with the comment and responds that currently the department does not have the authority to permit or license tournaments. No changes were made as a result of the comments.

Two commenters opposed adoption and stated the rule will result in increased pressure on trout populations off the upper coast. The department disagrees with the comments and responds that while it certainly is possible that anglers may choose to fish in the waters where the bag limit for seatrout is highest, the geographical distance and inherent logistical difficulties facing anglers who usually fish the mid- and lower coast will likely discourage large numbers of anglers from fishing northern waters, particularly since there is no guarantee that where the bag limit is 10 fish an angler will actually take 10 fish. The department also notes that it will be monitoring fishing pressure along the northern coast to determine if additional changes are warranted. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that croaker sales should be prohibited or croaker be designated a game fish. The department disagrees with the comments and responds that although croaker (and other species such as pinfish and pigfish) are effective bait, more seatrout are caught on live shrimp than any other bait. Department data indicate that on average, guided trips using live croaker catch trout at about twice the rate of other baits, but private fishing trips using live croaker catch trout at the same rate as other baits. Additionally, department data do not indicate that croaker populations are being adversely affected by their harvest for use as bait. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the department should restrict trout harvest by creating a trout tag. The department disagrees with the comment and responds that at this time, the status of the seatrout fishery is not dire; thus, extreme measures, such as a tag-only fishery, are not warranted. No changes were made as a result of the comment.

One commenter opposed adoption and stated that bag limits should be reduced for anglers who do not live within 75 miles of the coast. The department disagrees with the comment and responds that the intent of the rule is to preserve the sustainability of the seatrout fishery; creating differential bag limits for various recreational users would frustrate the intent of the rule and be problematic for compliance and enforcement. No changes were made as a result of the comments.

Eleven commenters opposed adoption and stated opinions or that were not germane to the substance, intent, or effect of the proposed rule. No changes were made as a result of the comments.

The department received 1,820 comments supporting adoption of the proposed amendment.

The Saltwater Fisheries Enhancement Association and Coastal Conservation Association commented in support of adoption of the proposed amendment.

The Coastal Bend Guides Association commented in opposition to adoption of the proposed amendment.

DIVISION 1. GENERAL PROVISIONS

31 TAC §§57.973, 57.977, 57.978

The new rules and amendment are adopted under the authority of Parks and Wildlife Code, Chapter 61, which requires the commission to regulate the periods of time when it is lawful to hunt, take, or possess aquatic animal life in this state; the means, methods, and places in which it is lawful to take, or possess aquatic animal life in this state; the species, quantity, age or size, and, to the extent possible, the sex of the aquatic animal life authorized to be taken or possessed; and the region, county, area, body of water, or portion of a county where aquatic animal life may be taken or possessed; and §67.004, which requires the commission to establish any limits on the taking, possession, propagation, transportation, importation, exportation, sale, or offering for sale of nongame fish or wildlife that the department considers necessary to manage the species.

The new rules and amendment affect Parks and Wildlife Code, Chapters 66, and 67.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 7, 2014.

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Ann Bright
General Counsel
Texas Parks and Wildlife Department
Effective date: September 1, 2014
Proposal publication date: February 21, 2014
For further information, please call: (512) 389-4775

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31 TAC §57.977

The repeal is adopted under the authority of Parks and Wildlife Code, Chapter 61, which requires the commission to regulate the periods of time when it is lawful to take or possess aquatic animal life in this state; the means, methods, and places in which it is lawful to take or possess aquatic animal life in this state; the species, quantity, age or size, and, to the extent possible, the sex of the aquatic animal life authorized to be taken or possessed; and the region, county, area, body of water, or portion of a county where aquatic animal life may be taken or possessed.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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DIVISION 2. STATEWIDE RECREATIONAL FISHING PROCLAMATION

31 TAC §57.981

The amendment is adopted under the authority of Parks and Wildlife Code, Chapter 61, which requires the commission to regulate the periods of time when it is lawful to take or possess aquatic animal life in this state; the means, methods, and places in which it is lawful to take or possess aquatic animal life in this state; the species, quantity, age or size, and, to the extent possible, the sex of the aquatic animal life authorized to be taken or possessed; and the region, county, area, body of water, or portion of a county where aquatic animal life may be taken or possessed.

§57.981. Bag, Possession, and Length Limits.

(a) For all wildlife resources taken for personal consumption and for which there is a possession limit, the possession limit shall not apply after the wildlife resource has reached the possessor's residence and is finally processed.

(b) The possession limit does not apply to fish in the possession of or stored by a person who has an invoice or sales ticket showing the name and address of the seller, number of fish by species, date of the sale, and other information required on a sales ticket or invoice.

(c) There are no bag, possession, or length limits on game or non-game fish, except as provided in this subchapter.

(1) Possession limits are twice the daily bag limit on game and non-game fish except as otherwise provided in this subchapter.

(2) For flounder, the possession limit is the daily bag limit.

(3) The bag limit for a guided fishing party is equal to the total number of persons in the boat licensed to fish or otherwise exempt from holding a license minus each fishing guide and fishing guide deckhand multiplied by the bag limit for each species harvested.

(4) A person may give, leave, receive, or possess any species of legally taken wildlife resource, or a part of the resource, that is required to have a tag or permit attached or is protected by a bag or possession limit, if the wildlife resource is accompanied by a wildlife resource document (WRD) from the person who took the wildlife resource, provided the person is in compliance with all other applicable provisions of this subchapter and the Parks and Wildlife Code. The properly executed WRD document shall accompany the wildlife resource until it reaches the possessor's residence and is finally processed. The WRD must contain the following information:

(A) the name, signature, address, and fishing license number, as required of the person who killed or caught the wildlife resource;

(B) the name of the person receiving the wildlife resource;

(C) a description of the wildlife resource (number and type of species or parts); and

(D) the location where the wildlife resource was killed or caught (name of ranch; area; lake, bay or stream; and county).

(5) Except as provided in subsection (d) of this section, the statewide daily bag and length limits shall be as follows.
Figure: 31 TAC §57.981(c)(5)

(d) Exceptions to statewide daily bag, possession, and length limits shall be as follows:

(1) Freshwater species.

Figure: 31 TAC §57.981(d)(1)

(2) Saltwater species.

Figure: 31 TAC §57.981(d)(2)

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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DIVISION 3. STATEWIDE COMMERCIAL FISHING PROCLAMATION

31 TAC §57.992

The amendment is adopted under the authority of Parks and Wildlife Code, Chapter 61, which requires the commission to regulate the periods of time when it is lawful to take or possess aquatic animal life in this state; the means, methods, and places in which it is lawful to take or possess aquatic animal life in this state; the species, quantity, age or size, and, to the extent possible, the sex of the aquatic animal life authorized to be taken or possessed; and the region, county, area, body of water, or portion of a county where aquatic animal life may be taken or possessed; and §67.004, which requires the commission to establish any limits on the taking, possession, propagation, transportation, importation, exportation, sale, or offering for sale of nongame fish or wildlife that the department considers necessary to manage the species.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 58. OYSTERS, SHRIMP, AND FINFISH

SUBCHAPTER A. STATEWIDE OYSTER FISHERY PROCLAMATION

31 TAC §58.21

The Texas Parks and Wildlife Commission in a duly noticed meeting on March 27, 2014 adopted an amendment to §58.21, concerning Taking or Attempting to Take Oysters from Public Oyster Beds: General Rules, without changes to the proposed text as published in the February 21, 2014, issue of the *Texas Register* (39 TexReg 1069). The amendment closes approximately 434 acres to oyster harvesting in the East Bay Approved Area in Galveston Bay and a 54-acre area encompassing Half-Moon Reef in Matagorda Bay for two harvest seasons, which will allow for scheduled oyster cultch plantings to repopulate these areas with oysters and for those oysters to reach market size. Oyster cultch is the material to which oyster spat (juvenile oysters) attach in order to create an oyster bed. Private oyster leases in East Galveston Bay would not be affected by the closure.

Under Parks and Wildlife Code, §76.115, the department may close an area to the taking of oysters when the commission finds that the area is being overworked or damaged or the area is to be reseeded or restocked. When Hurricane Ike made landfall on the upper Texas coast on September 13, 2008, it caused extensive damage to the oyster reef habitat in Galveston Bay and especially East Bay. The damage was mainly caused by siltation on the reefs and the deposition of sediment on reef substrate. This siltation does not allow for spat to set on the reef and begin the process of oyster reef repopulation. Sidescan sonar surveys conducted by the department indicated an approximately 50-60% loss of oyster habitat in Galveston Bay due to heavy sedimentation/siltation and debris over consolidated reefs. The impact was greatest in East Bay, where over 80% of oyster habitat was lost.

The department's oyster habitat restoration efforts to date in East Bay have resulted in approximately 640 acres of sediment/silt-covered oyster habitat returned to productive habitat within the bay. Approximately $4 million in grants and other funding has been secured by the department to conduct cultch planting on approximately 170 acres of additional sediment/silt-covered oyster habitat in East Bay.

The Half-Moon reef complex lies off Palacios Point in Matagorda County between Tres Palacios Bay and the eastern arm of Matagorda Bay and was formerly a highly productive oyster reef within the Lavaca-Matagorda Estuary. The reef has been degraded due to a variety of stressors and as a result The Nature Conservancy (TNC) has secured funding to restore up to 40 acres within the historical reef footprint and within the 54-acre area proposed for temporary closure. The closure area will provide a small buffer around the restoration site.

The project will consist of the emplacement of three-dimensional structures utilizing graded limestone that will function as cultch for oyster populations and is completely funded by TNC.

The department has determined that the 434-acres encompassing the oyster restoration sites in the East Bay Approved Area in Galveston Bay and the 54-acre area encompassing Half-Moon Reef in Matagorda Bay must be closed to oyster harvest for at least two years in order to repopulate these reefs, allow for post-construction monitoring for success, and to allow oysters to reach market size.

The department received 60 comments opposing adoption of the proposed amendment. Of the 60 comments, five articulated a reason or rationale for opposition. Those comments, accompanied by the department's response to each, follow.

Two commenters opposed adoption and stated that there are too many government regulations. The department disagrees that the amendment as adopted represents excessive regu-

lation, since the only mechanism for protecting oysters while restoration efforts are underway is to close the restoration site to harvest. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that the closures would negatively impact commercial and recreational fishing. The department disagrees with the comments and responds that the rule as adopted affects only the take of oysters and that the areas affected by the closure are effectively devoid of oysters, which is why restoration efforts are being conducted. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the closure period was excessive. The department disagrees with the comment and responds that oysters grow from newly settled spat to marketable size (3 inches) in approximately 18-24 months. A two-year closure will allow the recruitment and growth of oysters on the deployed cultch.

The department received 1,402 comments supporting adoption of the proposed amendment.

The amendment is adopted under Parks and Wildlife Code, §76.115, which authorizes the commission to close an area to the taking of oysters when the area is to be reseeded or restocked.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 7, 2014.

TRD-201403580
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Effective date: September 1, 2014
Proposal publication date: February 21, 2014
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CHAPTER 65. WILDLIFE
SUBCHAPTER N. MIGRATORY GAME BIRD PROCLAMATION

31 TAC §65.315, §65.319

The Texas Parks and Wildlife Department (the department) adopts amendments to §65.315 and §65.319, concerning the Migratory Game Bird Proclamation, without changes to the proposed text as published in the May 16, 2014, issue of the *Texas Register* (39 TexReg 3806).

The United States Fish and Wildlife Service (Service) issues annual frameworks for the hunting of migratory game birds in the United States. Regulations adopted by individual states may be more restrictive than the federal frameworks, but may not be less restrictive. Responsibility for establishing seasons, bag limits, means, methods, and devices for harvesting migratory game birds within Service frameworks is delegated to the Texas Parks and Wildlife Commission (commission) under Parks and Wildlife Code, Chapter 64, Subchapter C. Parks and Wildlife Code, §64.022, authorizes the commission to delegate rulemaking authority to the executive director of the department. Under 31 TAC §65.313(f) the executive director is, after notification of the chairman of the commission, authorized to engage in rulemaking.

Typically, the Service issues the preliminary early-season (dove, teal, snipe, rails, woodcock, gallinules) frameworks in late June and the preliminary late-season (ducks, geese, cranes) frameworks in early August. Because there is no commission meeting between May and late August, the 2014-2015 early-season migratory game bird regulations are being adopted by authority delegated to the executive director.

The proposed amendments to the migratory game bird regulations published in the May 16, 2014, issue of the *Texas Register* also included amendments to §§65.318, 65.320, and 65.321, which affect late-season species of migratory game birds. The proposed amendments to §§65.318, 65.320, and 65.321 will be considered for adoption by the commission following the release of the late-season frameworks by the Service in early August, after which the department will file notice of adoption.

The amendment to §65.315, concerning Open Seasons and Bag and Possession Limits - Early Season, adjusts the season dates for early-season migratory game birds other than doves to allow for calendar shift (i.e., to ensure that seasons open on the desired day of the week, since dates from a previous year do not fall on the same days in following years). With regard to doves, the amendment adjusts the season dates to allow for calendar shift with respect to opening day in all three dove zones, including the Special White-winged Dove Area (SWWDA) regular season; however, in the North and Central zones, the season would close three days earlier in the first segment (compared to last year) and those days would be added to the end of the second segment. In the South Zone and SWWDA, the first segment would be shortened by five days compared to last year, and those days would be added to the end of the second segment. The new season structure is intended to provide additional hunting opportunity around the holiday season.

The amendment to §65.315 also implements a 16-day statewide teal season to run from September 13-28, 2014 and a 16-day early Canada goose season in the Eastern Zone to run from September 13-28, 2014.

The amendment to §65.319, concerning Extended Falconry Season--Early Season Species, adjusts season dates to reflect calendar shift.

The amendments are generally necessary to implement commission policy to provide the greatest hunter opportunity possible, consistent with hunter and landowner preference for starting dates and segment lengths, under frameworks issued by the Service. It is the policy of the commission to adopt the most liberal provisions possible, consistent with hunter preference, under the Service frameworks in order to provide maximum hunter opportunity.

Dove

The department received comments from 94 persons in opposition to adoption of the portion of proposed §65.315 that establishes season dates and bag limits for dove. Of the 94 comments, 48 offered a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow. The department notes that many of the comments contained multiple reasons for opposition; thus, the total number of comments being responded to (102) is greater than the number of commenters (48).

Three commenters opposed adoption and stated that the winter segment should be longer. The department disagrees with the comments and responds that surveys indicate a hunter and landowner preference for a longer first segment, which is traditionally when most dove hunting takes place. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that shortening the first segment and lengthening the second segment penalizes hunters who go to public hunting areas because those areas are only open during the first segment. The department disagrees with the comment and responds that not all public dove hunting areas are restricted to the first segment although some of the private lands leased by the department to provide public dove hunting opportunity are available only during the first segment. Many private landowners realize a benefit from making their lands available during the first segment, when hunting pressure is heaviest, but wish to resume ranching and farming operations after the heaviest use is over. No changes were made as a result of the comments.

Ten commenters opposed adoption and stated that the first segment should run to the end of October in the South Zone. The department disagrees with the comments and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the holidays, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, running the first segment into November would not leave enough days to cover the holiday season. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that if anything, the first segment should receive additional days instead of losing days. The department disagrees with the comments and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the holidays break, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, running the first segment into November would not leave enough days to cover the holiday season. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that the first segment in the North Zone should run later and the second segment should begin earlier. The department disagrees with the comments and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the holiday season, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, running the first segment into November would not leave enough days to cover the holiday season. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the first segment in the South Zone should close on November 8. The department disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the holiday season, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, running the first segment into November would not leave enough days to cover the holiday season. The department also notes that the department does not have the option of selecting a longer season with a lower bag limit. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that the first segment in the Central Zone should be longer. The department disagrees with the comments and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the holiday season, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, running the first segment into November would not leave enough days to cover the holiday season. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the first segment in the South Zone should not be shortened because deer season conflicts with later hunting opportunity. The department disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the holiday season, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, running the first segment into November would not leave enough days to cover the holiday season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that dove should not be hunted. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including doves. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that in the northern part of the SWWDA, the expansion of the SWWDA has resulted in loss of hunting opportunity and waste of the resource because of misidentification. The department disagrees with the comments and responds that although the expansion of the SWWDA in 2013 was authorized by the Service only on the condition of bag limit reductions, the department believes that the overall increase in hunter opportunity justified the change. The department does not have any evidence or data to suggest that mistaken harvest due to misidentification of species is occurring at a rate that poses resource concerns. No changes were made as a result of the comments.

One commenter opposed adoption and stated that there should be another split in the South Zone. The department disagrees with the comment and responds that an additional split is not possible without the prior approval of the Service. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the first segment should include more weekends. The department disagrees with the comment and responds that the seasons as adopted contain the maximum number of weekends possible under the federal frameworks. No changes were made as a result of the comment.

Three commenters opposed adoption and stated the first segment should begin on a Friday. The department disagrees with the comment and responds that hunter and landowner preference is for the earliest opening day possible under the federal frameworks, irrespective of the day of the week. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the South Zone should get as many weekends as the North and Central zones. The department disagrees with the comment and responds that any difference between the amount of weekend hunting available between zones is purely the result of the relationship between the earliest opening dates allowed under the federal frameworks and the day of the week that is selected, which for most seasons (including 2014-15) results in 11 weekends of hunting opportunity for the South Zone and 10 for the North and Central zones. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the Central Zone should open on the Saturday before Labor Day. The department disagrees with the commenter and responds that under the federal frameworks the Central Zone season cannot begin earlier than September 1. In 2014, the Saturday before Labor Day is August 30. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should begin on August 30 in the South Zone. The department disagrees with the comment and responds that under the federal frameworks, the season in the South Zone cannot begin earlier than September 17, except for four days of half-day opportunity in the SWWDA. No changes were made as a result of the comment.

One commenter opposed adoption and stated that dove season should be from September 1 to November 30 in the North Zone because there are no dove in December and January. The department disagrees with the comments and responds that season structures have historically been set in such a fashion as to allow some hunting opportunity during the Holiday season, when more people, especially youth, are able to take advantage of opportunity. No changes were made as a result of the comment.

Four commenters opposed adoption and stated that the special whitewing season should take place over the Labor Day weekend and not during the week. The department disagrees with the comment and responds that under the federal frameworks, the earliest date that hunting can occur in the SWWDA is September 1. No changes were made as a result of the comments.

Six commenters opposed adoption and stated that the season should not open on a Monday. The department disagrees with the comment and responds that hunter and landowner surveys indicate a preference for the earliest opening day possible under federal frameworks, irrespective of the day of the week. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the special whitewing season should begin September 1. The department disagrees with the comment and responds that because the department is allowed only four days of hunting opportunity during the special white wing season, the department maximizes hunting opportunity by setting the season to occupy the first two weekends in September. No changes were made as a result of the comment.

One commenter opposed adoption and stated that Wharton County should be in the Central Zone. The department disagrees with the comment and responds that such a change is not possible at this time because changes to zone boundaries must be approved in advance by the Service. No changes were made as a result of the comment.

One commenter opposed adoption and stated that southern Jefferson County should be in the Central zone. The department disagrees with the comment and responds that such a change is not possible at this time because changes to zone boundaries must be approved in advance by the Service. No changes were made as a result of the comment.

One commenter opposed adoption and stated that all of Colorado County should be in the Central Zone. The department disagrees with the comment and responds that such a change is not possible at this time because changes to zone boundaries must be approved in advance by the Service. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that the season should open statewide on September 1. The department disagrees with the comment and responds that under the federal frameworks, the seasons in the North and Central zones can be opened beginning on September 1, but the South Zone cannot begin earlier than September 17, except for four days of half-day opportunity in the SWWDA. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the second segment should be longer north of Interstate Highway 10. The department disagrees with the comments and responds that surveys indicate a hunter and landowner preference for a longer first segment, which is traditionally when most dove hunting takes place. No changes were made as a result of the comment.

One commenter opposed adoption and stated that opening day in the North and Central zones should be two weeks earlier. The department disagrees with the comment and responds that under the federal frameworks the earliest that the season can open in the North and Central zones is September 1. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be no split season in the South Zone. The department disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow hunting opportunity during the holiday season, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. No changes were made as a result of the comment.

Twenty-one commenters opposed adoption and stated that the season should open on August 30 in the North and Central zones in order to provide Labor Day weekend hunting opportunity. The department disagrees with the comment and responds that under the federal frameworks the earliest that the season can open in the North and Central zones is September 1. No changes were made as a result of the comments.

One commenter opposed adoption and stated that lawful shooting hours should begin at noon. The department disagrees with the comment and responds that the federal frameworks allow lawful shooting hours of one half-hour before sunrise until sunset and that the commission policy is to adopt the most liberal provisions possible under the federal frameworks. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the South Zone should open one week later than the Central Zone. The department disagrees with the comment and responds that under the federal frameworks, the season in the South Zone cannot begin earlier than September 17, except for four days of half-day opportunity in the SWWDA. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that the South Zone should open on September 1. The department disagrees with the comment and responds that under the federal frameworks, the season in the South Zone cannot begin earlier than September 17, except for four days of half-day opportunity in the SWWDA. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that the South Zone should open earlier. The department disagrees with the comment and responds that under the federal frameworks, the season in the South Zone cannot begin earlier than September 17, except for four days of half-day opportunity in the SWWDA. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the second segment should open two weeks later in order to prevent conflicts with the opening of duck season. The department disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow hunting opportunity during the holiday season, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that the season should begin on a Saturday. The department disagrees with the comment and responds that hunter and landowner preference are for the earliest opening day possible under the federal frameworks, irrespective of the day of the week. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the season should always open on the Saturday closest to September 1 in the South Zone. The department disagrees with the comment and responds that hunter and landowner preference is for the earliest opening day possible under the federal frameworks, irrespective of the day of the week. In addition, the Saturday closest to September 1 in 2014 is August 30. Under the federal frameworks, the season in the South Zone cannot begin earlier than September 17, except for four days of half-day opportunity in the SWWDA. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that the special whitewing season should be eliminated so that white wings could be hunted later. The department disagrees with the comment and responds that hunter and landowner surveys indicate that the special white-wing dove season is popular because it occurs in early September, which would not be possible if the four days were added to the regular South Zone season. No changes were made as a result of the comments.

Two commenters opposed adoption and stated that the special whitewing season should be August 30 and 31 and September 6 and 7 to take advantage of Labor Day weekend. The department disagrees with the comments and responds that under the federal frameworks, the special white wing dove season cannot begin earlier than September 1. No changes were made as a result of the comments.

One commenter opposed adoption and stated that two weeks should be moved from the first segment to the second segment in the North Zone and that the second segment should close on January 25. The department disagrees with the comment and responds that hunter and landowner preference is for a second segment that is approximately 15 days in length. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be a season in May and June. The department disagrees with the comment and responds that under the federal frameworks the season must occur between September and January. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that the limits should be lowered and the season lengthened in the South Zone. The department disagrees with comment and responds that the federal frameworks no longer offer Texas the option of selecting a longer season with a lower bag limit. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the special whitewing season should be September 7 and 8 in order for people to attend football games on September 6. The department disagrees with the comment and responds that hunter and landowner preference is for the special white wing season to take place during weekends. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that the second segment should be eliminated in the North and Central zones. The department disagrees with the comments and responds that hunter preference is for a split season to provide hunting opportunity during the holiday season. No changes were made as a result of the comments.

The department received 241 comments supporting adoption of the proposed amendment.

Teal

The department received 57 comments opposing adoption of the portion of proposed §65.315 that establishes season dates and bag limits for teal. Fifty-two of the commenters offered a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow. The department notes that many of the comments contained multiple reasons for opposition; thus, the total number of comments being responded to (63) is greater than the number of commenters (52).

Eight commenters opposed adoption of a nine-day season and expressed a preference for a 16-day season. The department agrees with the comments and responds that a 16-day was made available to Texas by the Service and the rule as adopted contains a 16-day season.

Three commenters opposed adoption and stated that wood ducks should be included in the early teal season bag limit. The department disagrees with the comments and responds that under the federal frameworks, the early teal season is limited to teal ducks only. No changes were made as a result of the comments.

One commenter opposed adoption and stated that black-bellied ducks should be included in the early teal season bag limit. The department disagrees with the comments and responds that under the federal frameworks, the early teal season is limited to

teal ducks only. No changes were made as a result of the comments.

Fourteen commenters opposed adoption and stated that there should be a nine-day season, with the remaining seven days added to the regular duck season. The department disagrees with the comment and responds that days cannot be taken from the September teal season and added to duck season because the duck season in Texas is already at the maximum number of days allowed under the federal frameworks. No changes were made as a result of the comments.

Eight commenters opposed adoption and stated that the early teal season should be eliminated and the days added to the regular duck season. The department disagrees with the comment and responds that days cannot be taken from the September teal season and added to duck season because the duck season in Texas is already at the maximum number of days allowed by federal law. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be a late teal season. The department disagrees with the comment and responds that the federal frameworks allow Texas to have a special early teal season of 16-days between September 1 and September 30; no other dates may be selected. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should begin one week later. The department disagrees with the comment and responds that the federal frameworks allow Texas to have a special early teal season of 16-days between September 1 and September 30; therefore, starting the season one weeks later would result in a nine-day early teal season, which is contrary to the department goal of offering the most liberal seasons and bag limits possible under the federal frameworks. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that the season should begin two weeks later. The department disagrees with the comment and responds that the federal frameworks allow Texas to have a special early teal season of 16-days between September 1 and September 30; therefore, starting the season two weeks later would result in a two-day early teal season, which is contrary to the department goal of offering the most liberal seasons and bag limits possible under the federal frameworks. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the season is meaningless because there are no teal during the proposed season. The department disagrees with the comment and responds that although there are parts of the state that do not host teal during the migration, there are areas of the state where teal congregate in huntable numbers. No changes were made as a result of the comment.

Eleven commenters opposed adoption and stated that the early teal season is useless for falconers so the department should make the teal season as short as possible and add the days to the duck season so as to shorten the split between regular duck season segments and allow better falconry opportunity. The department disagrees with the comments and responds that days cannot be taken from the September teal season and added to duck season because the duck season in Texas is already at the maximum number of days (74) allowed under the federal frameworks. No changes were made as a result of the comments.

One commenter opposed adoption and stated that people should not be hunting and killing these birds at all. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including teal. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the bag limit should be six teal per day. The department agrees with the comment and responds that the bag limit for teal is six per day. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should open one week earlier. The department disagrees with the comment and responds that hunter and landowner preference is for a teal season in late September. No changes were made as a result of the comment.

Seven commenters opposed adoption of a 16-day season and stated a preference for a nine-day season. The department disagrees with the comments and responds that surveys of hunters indicate a strong preference for the most liberal teal-hunting opportunity possible under the federal frameworks. No changes were made as a result of the comments.

The department received 210 comments supporting adoption of the proposed amendment.

Early Canada Goose Season

The department received 15 comments opposing adoption of the portion of proposed §65.315 that establishes season dates and bag limits for the early Canada goose season. Eight of the commenters offered a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Two commenters opposed adoption and stated that the season should be eliminated and 16 days added to the regular goose season. The department disagrees with the comment and responds that the federal frameworks do not allow early Canada goose hunting opportunity to be used during the regular goose seasons. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the season should start two weeks later. The department disagrees with the comment and responds that the federal frameworks allow Texas to have a special early Canada goose season between September 1 and September 30; therefore, starting the season two weeks later would result in a two-day season, which is contrary to the commission policy of providing the most liberal seasons and bag limits possible under the federal frameworks. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there are no geese in the area at that time. The department agrees that in most parts of the Eastern Goose Zone there are no migrating Canada geese present in September. The special season is provided as a management tool for states where resident populations of Canada geese are or might become a nuisance. No changes were made as a result of the comment.

One commenter opposed adoption and stated that people should not be hunting and killing these birds at all. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including Canada geese. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that geese have not migrated to Texas during the season. The department

agrees that in most parts of the Eastern Goose Zone there are no migrating Canada geese present in September. The special season is provided as a management tool for states where resident populations of Canada geese are or might become a nuisance. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the early Canada goose season should be expanded to include the Western Goose Zone. The department disagrees with the comment and responds that the federal frameworks allow early Canada goose hunting opportunity only in the Eastern Goose Zone. No changes were made as a result of the comment.

The department received 132 comments supporting adoption of the proposed amendment.

Gallinules and Moorhens

The department received one comment opposing adoption of the portion of proposed §65.315 that establishes season dates and bag limits for gallinules and moorhens. The commenter stated that people should not be hunting and killing these birds at all. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including gallinules and moorhens. No changes were made as a result of the comment.

The department received 59 comments supporting adoption of the proposed amendment.

Rails

The department received three comments opposing adoption of the portion of proposed §65.315 that establishes season dates and bag limits for rails. One commenter stated that people should not be hunting and killing these birds at all. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including rails. No changes were made as a result of the comment.

The department received 58 comments supporting adoption of the portion of proposed.

Woodcock

The department received five comments opposing adoption of the portion of proposed §65.315 that establishes season dates and bag limits for woodcock. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that there weren't any birds. The department disagrees with the comment and responds that woodcock migrate into the eastern third of Texas as cold weather moves them out of their breeding grounds in Canada and the Great Lakes region and that this migration can be erratic and unpredictable. No changes were made as a result of the comment.

One commenter opposed adoption and stated that people should not be hunting and killing these birds at all. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including woodcock. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should start November 1 and that very few people hunt woodcock due to the short season in Texas. The department disagrees with the comment and responds that the 45-day season in Texas is the maximum allowed under the frameworks and is timed to take maximum advantage of the woodcock migration. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should extend past the closing of deer season to facilitate woodcock hunting on public hunting lands. The department disagrees with the comment and responds that the federal frameworks do not allow woodcock hunting in Texas after January 31. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should begin December 1. The department disagrees with the comment and responds that that the 45-day season in Texas is the maximum allowed under the frameworks and is timed to take maximum advantage of the woodcock migration. No changes were made as a result of the comment.

The department received 72 comments supporting adoption of the proposed amendment.

Snipe

The department received three comments opposing adoption of the portion of proposed §65.315 that establishes season dates and bag limits for snipe. Two commenters articulated a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that there weren't any birds. The department disagrees with the comment and responds that snipe are widely distributed in Texas and can be found in huntable numbers during the season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that people should not be hunting and killing these birds at all. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including snipe. No changes were made as a result of the comment.

The department received 75 comments supporting adoption of the proposed amendment.

Extended Falconry Season

The department received seven comments opposing adoption of the portion of proposed §65.315 that establishes season dates and bag limits for the take of early-season migratory birds by means of falconry. Other than the 11 commenters who opposed adoption of the proposed early teal season due to falconry impacts (the department's responses to whom appear earlier in this preamble), one commenter articulated a reason or rationale for opposing adoption. The commenter stated that migratory game birds should not be killed. The department disagrees with the comment and responds that the commission is authorized under the Parks and Wildlife Code to provide a season for the take of migratory game birds, including by means of falconry. No changes were made as a result of the comment.

The department received 60 comments supporting adoption of the proposed amendment.

The amendments are adopted under Parks and Wildlife Code, Chapter 64, which authorizes the commission and the executive director to provide the open season and means, methods, and devices for the hunting and possessing of migratory game birds.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 389-4775

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 9. INTELLECTUAL DISABILITY SERVICES--MEDICAID STATE OPERATING AGENCY RESPONSIBILITIES

SUBCHAPTER D. HOME AND COMMUNITY-BASED SERVICES (HCS) PROGRAM

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §9.153, concerning definitions; §9.154, concerning description of the home and community-based services (HCS) program; §9.155, concerning eligibility criteria and suspension of HCS program services; §9.158, concerning process for enrollment of applicants; §9.159, concerning individual plan of care (IPC); §9.161, concerning level of care (LOC) determination; §9.166, concerning renewal and revision of an IPC; §9.168, concerning consumer directed services (CDS); §9.169, concerning fair hearing; §9.170, concerning reimbursement; §9.171, concerning program provider certification review and residential visit; §9.174, concerning certification principles: service delivery; §9.177, concerning certification principles: staff member and service provider requirements; §9.178, concerning certification principles: quality assurance; §9.187, concerning other program provider responsibilities; §9.190, concerning local authority requirements for providing service coordination in the HCS program; and §9.192, concerning service limits; new §9.180, concerning certification principles: prohibitions; and §9.185, concerning program provider compliance and corrective action; and the repeals of §9.185, concerning certification processes; and §9.193, concerning exception to service limits, in Subchapter D, Home and Community-based Services (HCS) Program, in Chapter 9, Intellectual Disability Services--Medicaid State Operating Agency Responsibilities. The amendments to §§9.153, 9.154, 9.158, 9.159, 9.166, 9.168, 9.170, 9.174, 9.177, 9.178, and 9.190 are adopted with changes to the proposed text published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3038). The amendments to §§9.155, 9.161, 9.169, 9.171, 9.187, and 9.192; new §9.180 and §9.185; and the repeal of §9.185 and §9.193 are adopted without changes to the proposed text.

The adopted rules implement a directive from the Centers for Medicare and Medicaid Services (CMS) to more effectively address the assurance set forth in the HCS waiver application about health and safety. To address this assurance, the adopted rules require the HCS program provider to develop a service backup plan for an HCS Program service identified by the service planning team on the person-directed plan as critical to meeting the individual's health and safety and revise the plan if the program provider determines the service backup plan is ineffective.

The adopted rules add employment assistance, a service that helps an individual locate competitive employment. This new service implements an amendment to the HCS waiver application and Texas Human Resources Code, §32.075, which requires DADS to provide employment assistance to individuals in the various Medicaid waiver programs. The adopted rules also require that the service providers of employment assistance and supported employment have (1) a bachelor's degree in specified fields and six months of paid or unpaid work experience providing services to people with disabilities, (2) an associate's degree in specified fields and one year of paid or unpaid work experience providing services to people with disabilities, or (3) a high school diploma (or a state-recognized equivalent) and two years of paid or unpaid work experience providing services to people with disabilities. These required qualifications help ensure that service providers of employment assistance and supported employment have sufficient expertise to provide these services. The adopted rules also include certain requirements a program provider must comply with to receive payment for employment assistance and supported employment such as not using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training and not providing employment assistance or supported employment to an individual with the individual present at the same time that certain other services are provided.

The adopted rules also change the definition of supported employment to allow an individual to receive this service and be self-employed or work from home. This change provides a policy consistent with other waiver programs and enhances an individual's opportunities to have a desired job or career.

In addition, the adopted rules change DADS review process of HCS providers. Specifically, the adopted rules state that DADS does not certify a provider for a new certification period if (1) at a review other than an initial review, the provider is not providing HCS Program services to any individuals, and (2) from the beginning of the certification period through the 121st day before the end of the current period, the program provider didn't provide services for at least 60 consecutive days. This requires program providers who are not actively providing services and, therefore, not acquiring necessary expertise as a program provider, to re-establish their qualifications through the contract application process if they want to be an HCS Program provider. The adopted rules further state that if DADS imposes a vendor hold against a program provider with a provisional contract, DADS initiates termination of the contract. This process helps ensure a high quality provider base by terminating the contracts of program providers who are underperforming in the initial contract period. Those providers must demonstrate their qualifications through the contract application process if they want to be an HCS Program provider. The adopted rules describe the action DADS takes if a program provider is out of compliance with certification principles based on whether the program provider's failure to comply results in a condition of a serious or pervasive

nature. This provides a fairer and more effective way to determine the action or sanction to impose. The adopted rules require DADS to conduct a follow-up review of a provider (whose non-compliance has resulted in a condition of a serious or pervasive nature) in a more prompt manner to help ensure the health and safety of individuals receiving services from an underperforming provider. The adopted rules also define "condition of a pervasive nature," "condition of a serious nature," and "hazard to health or safety" so providers will have a better understanding of how DADS determines when such conditions exist.

The adopted rules describe the process that allows a program provider to request that DADS conduct an informal review of findings of a preliminary review report with which a provider disagrees.

The adopted rules add additional eligibility criteria for an individual leaving or at risk of entering a nursing facility and who is a member of a reserved capacity group added in the HCS waiver application approved by CMS.

The adopted rules add criteria that require each service on an individual's IPC to be the most appropriate type and amount, cost effective, and necessary to enable community integration and maximize independence. These criteria help ensure that HCS Program services legitimately meet an individual's needs in a cost effective manner and address changes made to the HCS waiver application approved by CMS. The adopted rules also describe current criteria for an adaptive aid and minor home modification included on an individual's IPC.

The adopted rules allow an individual to receive the additional services of supported employment, employment assistance, cognitive rehabilitation therapy, and nursing through the consumer directed services (CDS) option. This change allows the individual more choices about service provision. The adopted rules also clarify that services are available through the CDS option if an applicant will not receive, or an individual is not receiving, residential support, supervised living, or host home/companion care.

The adopted rules require the local authority to conduct a new level of care redetermination of an individual if the individual's level-of-need (LON) changes from a LON 5, LON 8, LON 6, or LON 9 to a LON 1. This requirement addresses a concern raised by CMS that individuals be appropriately assessed to ensure continued eligibility for the waiver program.

The adopted rules replace deleted requirements (including those for complaint processes, reporting and training related to abuse, neglect, and exploitation, background checks and wage requirements for some HCS service providers) with references to requirements addressed in Chapter 49, Contracting for Community Services, as adopted elsewhere in this issue of the *Texas Register,* because new Chapter 49 applies to HCS program providers.

The adopted rules require a program provider to enter the name and phone number of an alternate chief executive officer (CEO) into the DADS data system. The adopted rules require the alternate CEO to perform the duties of the CEO during the CEO's absence and to act as the contact person in a Department of Family and Protective Services (DFPS) investigation if the CEO is named as an alleged perpetrator of abuse, neglect, or exploitation of an individual. This requirement helps ensure unbiased operation of the program provider's business and cooperation in a DFPS investigation of the CEO.

The adopted rules allow a person with three years unpaid work experience providing services similar to those in the HCS program who has participated as a member of a microboard to be employed by a program provider to oversee the provision of direct services. Currently, DADS allows only a person with three years paid work experience providing services similar to those in the HCS program to qualify for this position. The new qualification was included because DADS determined that a person with three years unpaid work experience providing services similar to those in the HCS program and who has participated on a microboard has obtained the necessary expertise to oversee the provision of direct services for a program provider. The adopted rules define a microboard based on the service industry's common understanding of a microboard.

The adopted rules add licensed clinical social workers and licensed professional counselors to the list of qualified providers of behavioral support to increase the availability of qualified providers of this service.

The adopted rules replace the term "foster/companion care" with "host home/companion care" because foster care ordinarily refers to services only provided to children.

The adopted rules remove the requirement that a program provider deliver at least one service by a service provider employed by the program provider because CMS no longer requires this practice.

The adopted rules delete the definition of "unusual incident" because the elements contained within the definition of "unusual incident" were incorporated into the definition of "critical incident" in the HCS Provider User Guide.

The adopted rules delete service limits that expired August 31, 2013, and the process created to obtain an exception to those service limits.

The adopted rules allow individuals to receive respite in a camp accredited by the American Camp Association to expand the suitable settings in which an individual may choose to receive respite.

The adopted rules emphasize DADS current policy that a program provider is not allowed to use seclusion for any reason.

The adopted rules implement DADS current policy that respite services are used if the caregiver is temporarily unavailable to provide supports for non-routine circumstances. The adopted rules define "non-routine circumstances" so providers will have a better understanding of how DADS determines that a circumstance necessitating respite is non-routine.

The adopted rules delete a description of applicants who may be offered an HCS program vacancy. Specifically, the description deleted is of those applicants for whom DADS has proposed to terminate or has terminated Texas Home Living (TxHmL) Program services because the applicant no longer has an approved TxHmL IPC or the applicant's TxHmL services do not ensure the applicant's health and welfare. This deletion is made because applicants meeting this description may be offered an HCS program vacancy as a target group in accordance with §9.158(a)(3).

The adopted rules add a definition for "related condition" to be consistent with how that term is defined in the rules governing the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program at Chapter 9, Subchapter E of this title.

The adopted rules replace outdated terminology by replacing "MRA" with "local authority;" "ICF/MR" with "ICF/IID;" "MR/RC" with "ID/RC;" and "mental retardation" with "intellectual disability." The adopted rules also replace "support methodologies" with "implementation plans;" "specialized therapies'" with "professional therapies;" "CDS" with "the CDS option;" "CDSA" with "FMSA;" and "program provider agreement" with "contract." The adopted rules also add definitions for "provisional contract" and "standard contract" as used in new Chapter 49.

The adopted rules replace "CARE" with "DADS data systems" to allow for any further data systems changes, update references to the Occupations Code for all licensed service providers who are qualified to deliver services approved in the HCS program, and make minor editorial and reorganizational changes for clarity and consistency.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose. An action taken by

DADS before the effective date of these rules is governed by the rules in effect on the date the action was taken, and the former rules continue in effect for that purpose. An action taken by DADS on or after the effective date of these rules is governed by these rules.

A change was made to the proposed rules to add a definition for "competitive employment" in §9.153(8) as "employment that pays an individual at least minimum wage if the individual is not self-employed." The agency made this change to be consistent with the assurances in the HCS waiver application which state that employment assistance assists an individual to locate a job that pays at least minimum wage and that supported employment assists an individual to sustain a job that pays at least minimum wage.

Changes were made to proposed §§9.154(c); 9.158(l)(9); 9.159(c) and (d)(2); 9.166(e)(1)(A); 9.168(b)(3); 9.170(1)(A) and (B), (4)(A) - (G), (I), and (L) - (S); and 9.190(b)(2) to change "service components" to "services" or "service component" to "service." The agency made these changes to update the terminology used in the subchapter.

A change was made to proposed §9.154(c)(1) to replace "including" with "as follows" to clarify that the list of professional therapies is exhaustive.

Changes were made to proposed §9.168(a) to clarify that the local authority does not have to comply with the requirements in paragraphs (1) - (5) if an applicant will receive residential support, supervised living, or host home/companion care.

Changes were made to proposed §9.168(c) to clarify that a local authority does not have to comply with the requirements in paragraphs (1) - (4) if an individual is receiving residential support, supervised living, or host home/companion care.

Changes were made to proposed §9.174(a)(42) to explain what is meant by being eligible for respite and for clarification.

Changes were made to proposed §9.174(a)(44)(A), (B)(iv), and (45)(A)(ii) to change "paid employment" to "competitive employment." The agency made these changes to be consistent with the assurances in the HCS waiver application, which state that employment assistance assists an individual to locate a job that pays at least minimum wage and that supported employment assists an individual to sustain a job that pays at least minimum wage.

A change was made to proposed §9.174(a)(45)(B)(i) to replace "disability" with "assessed needs" to be consistent with assurances in the HCS waiver application which state that supported employment activities performed by a service provider are related to an individual's assessed needs, not the individual's disability.

Minor editorial changes were made to proposed §9.177(r) to clarify that a service provider of employment assistance and a service provider of supported employment must not be the LAR of the individual receiving employment assistance or supported employment from the service provider.

A change was made to proposed §9.190(e)(25)(A) to replace "CDSA" with "FMSA" to correct terminology and be consistent with other sections in the subchapter.

DADS received written comments from the Providers Alliance for Community Services of Texas (PACSTX), Disability Rights Texas on behalf of Disability Rights Texas, Texas Council for Developmental Disabilities, EveryChild Inc., and The Arc of Texas, and one individual. A summary of the comments and responses follows.

Comment: One commenter recommended that for the benefit of the individuals and the LAR's, HCS Program rules with "Individual and LAR" should state "individual, as appropriate, or LAR on individual's behalf." The commenter stated that §9.153(30)(F) and (63), §9.178(j), (k)(3); and (m)(1) should be changed as suggested because some individuals with an LAR may not be able to sign his or her name or attend service planning team meetings, may not understand information provided to them on how to report allegations of abuse, neglect, or exploitation, and in some cases as decided by the individual's guardian, should not be notified after the program provider reports or is notified of an allegation that the individual has been abused, neglected or exploited or of DFPS investigation findings and the corrective action taken by the program provider in response to the DFPS investigation.

Response: The agency declines to make changes in response to this comment. The HCS Program rules use the phrase "individual or LAR" so the activity or requirement in question applies to the LAR, if one exists, or to the individual if the individual does not have an LAR. The rules include "individual and LAR" for an activity or requirement intended to apply to both the LAR and individual. It is not necessary to add "on the individual's behalf" as requested by the commenter because the definition of "LAR" in §9.153(36) includes the phrase "A person authorized by law to act on behalf of a person with regard to a matter described in this subchapter..." Section 9.178(j) requires that both the individual and LAR be informed of how to report allegations of abuse, neglect, or exploitation because an LAR may not be aware that an individual is subject to abuse, neglect, or exploitation or may be the perpetrator. Because of the seriousness of an allegation of abuse, neglect, or exploitation, §9.178(k)(3) and (m)(1) require the program provider to notify both the individual and LAR of the allegation and of the investigation report from the DFPS.

Comment: One commenter stated that "staff" by definition, means employee and that the definition in §9.153(66) for "staff member" should be defined as "An employee of an HCS program provider." Also, the definition in §9.153(64) for "service provider" should be changed to "A person, who may be a staff member or contractor, who directly provides an HCS Program service to an individual."

Response: The agency declines to make changes in response to this comment. The definition of "staff person" in this subchapter includes contractors because the program provider may use contractors as part of its work force, including some that are not service providers.

Comment: One commenter suggested that in §9.158(b) "applicant or LAR" should be changed to "applicant and LAR" because applicants and LAR's do not always live in the same home and it is vital that the LAR also receives the offer of program vacancy. The commenter suggested that delivery by regular United States mail or hand delivery should be changed to delivery by certified mail so that there is proof that the local authority delivered the offer of program vacancy. The commenter suggested that if hand delivery is allowed, that the signature of the individual or LAR should be required as proof the local authority delivered the offer of program vacancy. The commenter reported hearing that an opportunity for a program vacancy was missed because the offer of program vacancy was not received and a local authority placed the individual at the bottom of the interest list.

Response: The agency declines to make changes in response to this comment. During the time an individual's name remains on the HCS interest list, the local authority is responsible for contacting the individual or LAR (depending on who is listed as the primary contact) at least every biennium. This contact confirms (1) that the individual or LAR continues to be interested in the individual enrolling in HCS and (2) that the contact information is current. The local authority makes a concerted effort to contact and locate an individual or LAR when offering a program vacancy to an individual or LAR. DADS has determined that the current methods of delivering the offer of a program vacancy, by regular mail or hand delivery, are effective. The agency encourages program providers and any other persons to notify DADS about any individual they believe missed an opportunity to enroll because of inadequate notification by a service coordinator.

Comment: One commenter suggested that in §9.158(e)(1), "at least one family member (if possible)" should be changed to "at least one family member (if possible and appropriate)." The commenter stated that there are times when an individual does not have a family member as an LAR due to emotional or physical harm. Mandating that the local authority contact a family member, if possible, could open the applicant up to harm. The local authority, by speaking to the LAR first, should determine if contacting a family member is appropriate for the health and well-being of the consumer. This should be taken into consideration, not just the family member being available to be located.

Response: The agency declines to make changes in response to this comment. Texas Government Code, §531.042(a) states that HHSC must have rules requiring each health and human services agency to "provide to each patient or client of the agency and to at least one family member of the patient or client, if possible, information regarding all care and support options available to the patient or client, including community-based services appropriate to the needs of the patient or client, before the agency allows the patient or client to be placed in a care setting."

Comment: One commenter suggested that "the applicant or LAR" in §9.158(e)(2) should be changed to "the applicant and LAR" or "the applicant, or LAR on behalf of the applicant." The commenter stated that as written, the local authority could just send the Verification of Freedom of Choice Form, Waiver Program to document the applicant's choice regarding the HCS Program and ICF/IID Program to the applicant, who may not live with the LAR. The commenter stated that an applicant has an LAR for a reason, that having the option to send the form just to the applicant is not the right thing to do for the applicant or the LAR and that the applicant would most likely need the LAR's assistance with the form.

Response: The agency declines to make changes in response to this comment. The rules use the phrase "individual or LAR" so that the activity or requirement in question applies to the LAR, if one exists, or to the individual if the individual does not have an LAR. The local authority first determines if the applicant has an LAR, and if so, the local authority gives the form to the LAR to complete and sign the form. If the local authority determines the applicant does not have an LAR, then the local authority gives the form to the individual to complete and sign the form. It is not necessary to add "on the individual's behalf" because the definition of "LAR" in §9.153(36) includes the phrase "A person authorized by law to act on behalf of a person with regard to a matter described in this subchapter..."

Comment: One commenter suggested adding to §9.158(p) the requirement that the local authority send copies of all enrollment documentation to the program provider 30 days before an applicant's enrollment date. The commenter stated that many times program providers do not receive these packets until after the enrollment date.

Response: The agency declines to make changes in response to this comment. Requiring a local authority to provide an enrollment packet to a program provider 30 days before an individual's enrollment could delay an applicant's enrollment. The agency encourages program providers to contact the local authority's service coordinator or the service coordinator's supervisor if required copies of all enrollment documentation are not received timely and report such non-compliance to DADS. In accordance with §9.191, DADS conducts compliance reviews of each local authority to determine if the local authority is in compliance with the HCS Program rules.

Comment: One commenter stated that §9.159(c) should not require that all criteria must apply, but that when one or more criterion are met the service will be approved. To that end, the commenter suggested that in §9.159(c)(6), the "and" should be replaced with "or." The commenter also requested the deletion of "or the individual's natural supports" from the criteria in §9.159(c)(2).

Response: The agency declines to make changes in response to this comment. The criteria that each service in the IPC must meet, as described in §9.159(c), is consistent with the HCS waiver application.

Comment: One commenter stated that the requirements in §9.159(c)(1) - (5) will require program providers to document in an individual's record that the criteria is met, which will add a strain on program providers and increase the cost of meeting all the requirements. The commenter suggested that this documentation providing justification for the services should be stated in the PDP during the discussion regarding what HCS services are needed. The commenter stated that the "most appropriate type and amount to meet the individual's needs" and "cost effective" are subjective and will create problems for program providers during utilization reviews and compliance reviews.

Response: The agency declines to make changes in response to this comment and responds that, as described in §9.158(k)(4) and (l)(10) and §9.166(a)(3) and (e)(3)(B) and (C), the service coordinator has the primary responsibility for ensuring that the

IPC meets the requirements in §9.159(c). If DADS denies or reduces a program service in the IPC because one of the criteria in §9.159(c)(1) - (9) is not met, the individual may request a fair hearing as described in §9.169.

Comment: One commenter suggested that changes should be made in §9.159(c)(6)(A), by adding "or approved by DADS as appropriate based on individual need." The commenter stated that it is not appropriate to have a list of approved adaptive aids that limits consideration and approval of other adaptive aids that are justifiable based on individual needs and within the cost limit and other criteria listed in §9.159(c). Also, adaptive aids are an evolving support and it would be impossible to list all appropriate aids at any one point in time considering the constant evolution of new low-tech and high-tech technologies.

Response: The agency declines to make changes in response to this comment. The criterion described in §9.159(c)(6)(A), that an adaptive aid or minor home modification must be included on DADS approved list in the HCS Program Billing Guidelines, is consistent with the HCS waiver application. DADS monitors and, if appropriate, amends the approved list of adaptive aids to ensure the adaptive aids needed by individuals are included on the list.

Comment: One commenter stated that the term "assessment" in §9.159(d)(2), which uses "individualized assessments," needs to be defined. The commenter stated it is important for both the survey team and the programs to understand that assessments can be formal tools utilized or verbal assessments obtained from those who know the individual best.

Response: The agency declines to make changes in response to this comment. The HCS Program rules sometimes require a specific assessment tool or, if not, the program provider's own assessment tool, depending on the circumstances. Deciding if a definition for the term "assessment" is needed, and how to define the term, will require further study and is outside the scope of this project.

Comment: One commenter suggested the addition of "individual, LAR or actively involved person" in §9.161(c)(3) after "service coordinator" which would require the service coordinator to notify the individual, LAR, DADS, and the program provider if the service coordinator, individual, LAR, or actively involved person disagrees with the ID/RC Assessment. The commenter also suggested that §9.161(d) be changed to reflect that a service coordinator's, individual's, LAR's, or actively involved person's disagreement will be considered in DADS review of an ID/RC Assessment.

Response: The agency declines to make changes in response to this comment. The HCS Program rules currently do not include a process by which the individual's, LAR's, or actively involved person's agreement with the ID/RC is determined. The suggested changes are outside the scope of this project and require further discussion and study with stakeholders.

Comment: One commenter stated that the requirement in §9.161(c)(3) for the service coordinator to notify the individual, LAR, DADS, and the program provider if the service coordinator disagrees with the ID/RC Assessment should include that this must be "done the same day of the data entry" because program providers are not notified by service coordinators "in accordance with DADS instructions" as stated in the rule. The commenter stated that not having a timeframe in §9.166(e)(3)(C), such as "within 3 calendar days," allows the service coordinator not to notify the individual or LAR, the program provider, and DADS if the service coordinator disagrees that the requirements described in §9.159(c) have been met. The commenter stated it is important for a program provider to know as soon as possible if an IPC is not approved so the program provider can take immediate action.

Response: The agency responds that, based on the instructions in the HCS Handbook, a service coordinator is required to notify DADS and the program provider of a disagreement with an IPC, by using DADS Form 8579, within six days after the program provider enters the IPC into CARE. DADS will amend the HCS Handbook to require the service coordinator to notify the individual or LAR of a disagreement with the IPC within the same time frame. In addition, the instructions in the HCS Handbook require a service coordinator to notify DADS and the program provider of a disagreement with an ID/RC Assessment, by using DADS Form 8579, within seven days after the program provider transmits the ID/RC to DADS. DADS will amend the HCS Handbook to require the service coordinator to notify the individual or LAR of a disagreement with the ID/RC within the same time frame. A provider should report any alleged non-compliance with these instructions to DADS, who in accordance with §9.191, conducts compliance reviews of each local authority to determine if the local authority is in compliance with the HCS Program rules. The agency also encourages program providers to use a local authority's process for receiving and resolving complaints from a program provider, which is required by §9.190(c).

Comment: One commenter suggested that the agency make changes in §9.161(i) to narrow the requirement for a new determination of intellectual or developmental disability (DIDD) to "individuals in the borderline range of intelligence quotient (IQ) and whose LON drops to an LON 1." The commenter stated this would save the state resources and to meet the federal requirements for program eligibility. Another commenter suggested the deletion of §9.161(i) stating that it would be detrimental financially to program providers, result in DADS arbitrarily changing an individual's LON to a LON 1 without completing a standardized assessment, and be done between DADS and the local authority without notifying or involving the program provider. The commenter noted that §9.170(1)(B) states that DADS pays for host home/companion care, residential support, supervised living, and day habilitation in accordance with the individual's LON as an example of how arbitrarily changing someone from a LON 5, 8, 6 or 9 to a 1 can severely affect the program provider's ability to budget, plan and operate.

Response: The agency declines to make changes in response to these comments. CMS requires annual reevaluation of an individual's level of care. CMS recently issued a report on the HCS Program and required the agency to improve its monitoring of an individual's level of care annually. The agency developed the information in §9.161(i) which reflects its final agreement with CMS to reassess an individual with a LON of 5, 8, 6, or 9 if the individual's LON goes down to a LON 1. The change is intended to ensure that an individual continues to meet program eligibility requirements. In accordance with §9.163, DADS uses information a program provider submits to DADS, including a completed ID/RC Assessment, and, if applicable, the supporting documentation required by §9.164(c), to assign a LON to an individual. Only if an individual with a LON of 5, 8, 6, or 9 is changed to a LON 1 will a redetermination of the individual's LOC occur as described in §9.161(i). After DADS notifies a program provider of its review decision in accordance with §9.161(i), the program provider may request a reconsideration of the assignment in accordance with §9.165 and an administrative hearing in

accordance with §9.186 if the provider disagrees with the LON assigned by DADS.

Comment: One commenter, commenting on §9.161(i), recommended allowing the individual, LAR, or actively involved person to ask for a review by DADS and submit additional information to DADS, and if necessary, an opportunity to request a fair hearing when there is disagreement with an LON assignment because currently only the program provider may appeal the LON assignment.

Response: The agency declines to make changes in response to this comment. The LON assignment for an individual does not affect the type or amount of services an individual receives and, therefore, the individual or LAR is not entitled to request a fair hearing. For this reason, DADS does not believe it necessary to allow for an individual or LAR to request a review by DADS of a LON assignment. A program provider is entitled to request an administrative hearing for a LON assignment because the LON affects the amount of reimbursement a provider receives.

Comment: One commenter stated that the "one business day" timeframe in §9.166(d)(1) is not reasonable and will result in emergency services never being added to an individual's IPC or a program provider not receiving payment for the services. The commenter stated that if there is an emergency with an individual, the time is spent stabilizing the situation. The commenter also stated that the requirements in §9.166(d) could not be completed in one day if an individual goes to the dentist and the dentist needs to fill a cavity.

Response: The agency declines to make changes in response to this comment. Section 9.166(d)(1) provides for the provision of an HCS Program service that is not on the IPC or that exceeds the amount on the IPC if necessitated by an emergency to ensure the individual's health and safety. It allows the program provider to provide the service before revising the IPC. The agency disagrees with the commenter's objections and believes that the time frame of one business day to complete the requirements described in §9.166(d)(1)(A) - (C) is reasonable.

Comment: One commenter requested the deletion of "paper" in §9.166(e)(2)(B) because a service coordinator may prefer that a program provider scan and email a copy of the signed proposed renewal or revised IPC.

Response: The agency made the change suggested in §9.166(e)(2)(B) so that a program provider may scan and email a copy of the signed proposed renewal or revised IPC to the service coordinator.

Comment: One commenter suggested the deletion in §9.174(a)(42)(C) of "when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances." The commenter stated that "non-routine circumstances" is not defined and is confusing. A commenter stated that some families have respite every other weekend for dinner or some other type of down time and asked if this makes them ineligible for respite because it is routine, every other weekend, or at least once a month.

Response: The agency declines to make the requested deletion in §9.174(a)(42)(C) because this wording is used in the HCS waiver application. The agency agrees that "non-routine circumstances" in §9.174(a)(42)(C) should be defined and has added a definition for the term in §9.153. The definition of respite in the HCS waiver application and the requirement in §9.174(42) limits the use of respite to emergency circumstances or planned events that are not routine.

Comment: One commenter stated that the number of times a program provider provides copies to the service coordinator should be clarified in §9.174(a)(51)(B) and (52). The commenter stated there have been times when a program provider has sent multiple copies to a service coordinator who stated the copies were not received, which costs the program provider time and money.

Response: The agency declines to make changes in response to this comment. Changing §9.174(a)(51)(B) and (52) as requested may prevent a service coordinator from obtaining necessary information about an individual from the program provider. The agency encourages program providers to use a local authority's process for receiving and resolving complaints from a program provider, which is required by §9.190(c).

Comment: One commenter stated that §9.174(a)(55)(B) places a program provider in an adversarial position with the individual's guardian. The commenter stated that if the foster care service provider is the guardian, the guardian has the right to determine the natural supports that will provide the needed services during an emergency situation. The commenter stated that requiring a program provider to make a decision based on little or no information regarding the ability of a natural support to protect the individual's health and safety violates the rights of the guardian.

Response: The agency declines to make changes in response to this comment. Although §9.174(a)(55)(B) requires a program provider to develop a service backup plan, this requirement allows the guardian of an individual to help the program provider determine the natural supports who are able to protect the individual's health and safety and who will be included in the service backup plan.

Comment: One commenter stated that §9.177(h)(2)(B) needs to be clarified because some compliance reviewers require the letters of reference to be written and others have allowed documentation of references obtained over the telephone. The commenter pointed out that the HCS Billing Guidelines require written references and asked the agency to either correct the Billing Guidelines and remove the word "written" or add "written" to the rule so that program providers can determine the correct way to comply.

Response: The agency agrees with the comment and made changes in §9.177(h)(2)(B) to require written references.

Comment: One commenter stated that the qualifications in §9.177(r)(1) - (3) for a service provider of employment assistance or a service provider of supported employment will cause major delay in services and effectively ensure an individual does not keep his or her job. The commenter stated that program providers have difficulty locating staff, especially when it is not a full time position or there are few hours attached and that it will be nearly impossible in some areas to meet these qualifications.

Response: The agency declines to make changes in response to this comment. Section 9.177(r) represents a modified version of the more stringent qualifications DADS presented to the Texas Aging and Disability Services Council in March of 2014. The section was modified because of concerns raised by HCS providers. Although the qualifications in §9.177(r)(1) - (3) help ensure the expertise of service providers of employment assistance and supported employment (and, therefore, the quality and effectiveness of these services), the agency does not be-

lieve that the qualifications make it impossible for HCS program providers to hire such service providers. The agency notes that §9.177(r)(3) allows a person who has the equivalent of a high school diploma with two years of unpaid experience providing services to people with disabilities to qualify as a service provider of employment assistance or supported employment.

Comment: One commenter stated that adding "if applicable" after "LAR" in §9.178(m)(1) can be interpreted in several different ways and that the LAR should always be notified if there is an official guardian.

Response: The agency has deleted "if applicable" in §9.178(m)(1) to make it clear that a program provider must notify both the individual and the LAR of the DFPS investigation finding and the corrective action taken by the program provider in response to the DFPS investigation.

Comment: One commenter suggested that §9.178 be amended to exempt HCS group homes from meeting certain life safety code requirements when there is a process to certify that the residents of the homes can evacuate in a timely manner.

Response: The agency does not have the authority to regulate how a local fire authority or the State Fire Marshal's Office enforces the Life Safety Code or International Fire Code. The agency did not make changes in response to the comment.

Comment: One commenter suggested the deletion, in §9.178(y), of "after the last day of the month being reported," to shorten the timeframe for entering critical incident data in the DADS data system to no longer than 30 calendar days. The commenter stated that having almost 60 days in some cases to report critical incidents, such as serious physical injury, is not effective in enabling DADS to ensure that program providers have a system that protects health and safety.

Response: The agency is seeking to implement a new critical incident reporting system in the future that will require a program provider to enter data within a very short period of time after the incident occurs. The agency did not make changes in response to the comment.

Comment: Citing §9.185, one commenter expressed support for the addition of a provision that would allow contract termination in one or more contract areas when a program provider loses certification in one contract area, as determined using defined criteria, and asked if this would require legislative authority. The commenter stated they also support adding debarment from the ability to provide HCS services based on defined criteria, an enforcement action that does not currently exist in the HCS Program.

Response: The agency responds that these provisions can be found in the contracting rules in Chapter 49, which apply to the HCS Program. The provision in §49.534(a)(2)(N) allows DADS to terminate a contract if DADS proposed or imposed an action or sanction against another contract of the contractor. If DADS terminates a provisional or standard contract, §49.702(d), allows DADS to set an application denial period for the contractor or controlling person that applies to all programs and services for a period of time determined by DADS, but no less than 12 months after the date of termination. The agency did not make changes in response to the comment.

40 TAC §§9.153 - 9.155, 9.158, 9.159, 9.161, 9.166, 9.168 - 9.171, 9.174, 9.177, 9.178, 9.180, 9.185, 9.187, 9.190, 9.192

The amendments and new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§9.153. Definitions.

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

(1) Actively involved--Significant, ongoing, and supportive involvement with an applicant or individual by a person, as determined by the applicant's or individual's service planning team or program provider, based on the person's:

(A) interactions with the applicant or individual;

(B) availability to the applicant or individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the applicant's or individual's needs, preferences, values, and beliefs.

(2) Applicant--A Texas resident seeking services in the HCS Program.

(3) Behavioral emergency--A situation in which an individual's severely aggressive, destructive, violent, or self-injurious behavior:

(A) poses a substantial risk of imminent probable death of, or substantial bodily harm to, the individual or others;

(B) has not abated in response to attempted preventive de-escalatory or redirection techniques;

(C) is not addressed in a written behavior support plan; and

(D) does not occur during a medical or dental procedure.

(4) Business day--Any day except a Saturday, Sunday, or national or state holiday listed in Texas Government Code §662.003(a) or (b).

(5) Calendar day--Any day, including weekends and holidays.

(6) CDS option--Consumer directed services option. A service delivery option as defined in §41.103 of this title (relating to Definitions).

(7) Cognitive rehabilitation therapy--A service that:

(A) assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells or brain chemistry in order to enable the individual to compensate for lost cognitive functions; and

(B) includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new pat-

terns of cognitive activity or compensatory mechanisms for impaired neurological systems.

(8) Competitive employment--Employment that pays an individual at least minimum wage if the individual is not self-employed.

(9) Condition of a pervasive nature--A condition in which a program provider is out of compliance with a certification principle as evidenced by one of the following:

(A) the following two conditions are met:

(i) at least 50 percent of items from an initial sample of records, interviews, or observations reviewed by DADS, show non-compliance; and

(ii) at least one item from an additional sample, at least the same size as the initial sample, shows non-compliance; or

(B) if DADS is not able to obtain an additional sample as described in subparagraph (A)(ii) of this paragraph, at least 51 percent of items from an initial sample of records, interviews, or observations reviewed by DADS, show non-compliance.

(10) Condition of a serious nature--Except as provided in paragraph (23) of this section, a condition in which a program provider's noncompliance with a certification principle caused or could cause physical, emotional, or financial harm to one or more of the individuals receiving services from the program provider.

(11) Contract--A provisional contract or a standard contract.

(12) CRCG--Community resource coordination group. A local interagency group composed of public and private agencies that develops service plans for individuals whose needs can be met only through interagency coordination and cooperation. The group's role and responsibilities are described in the Memorandum of Understanding on Coordinated Services to Persons Needing Services from More Than One Agency, available on the HHSC website at www.hhsc.state.tx.us.

(13) Critical incident--An event listed in the HCS Provider User Guide found at http://www2.mhmr.state.tx.us/655/cis/training/WaiverGuide.html.

(14) DADS--The Department of Aging and Disability Services.

(15) DARS--The Department of Assistive and Rehabilitative Services.

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

(17) Emergency--An unexpected situation in which the absence of an immediate response could reasonably be expected to result in risk to the health and safety of an individual or another person.

(18) Emergency situation--An unexpected situation involving an individual's health, safety, or welfare, of which a person of ordinary prudence would determine that the LAR should be informed, such as:

(A) an individual needing emergency medical care;

(B) an individual being removed from his residence by law enforcement;

(C) an individual leaving his residence without notifying a staff member or service provider and not being located; and

(D) an individual being moved from his residence to protect the individual (for example, because of a hurricane, fire, or flood).

(19) Family-based alternative--A family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(20) FMS--Financial management services. A service, as defined in §41.103 of this title, that is provided to an individual participating in the CDS option.

(21) FMSA--Financial management services agency. As defined in §41.103 of this title, an entity that provides financial management services to an individual participating in the CDS option.

(22) Four-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than four persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that, if it is the residence of four persons, at least one of those persons receives residential support;

(D) that is not the residence of any persons other than a service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(E) that is not a dwelling described in §9.155(a)(5)(H) of this subchapter (relating to Eligibility Criteria and Suspension of HCS Program Services).

(23) Hazard to health or safety--A condition in which serious injury or death of an individual or other person is imminent because of a program provider's noncompliance with a certification principle.

(24) HCS Program--The Home and Community-based Services Program operated by DADS as authorized by the Centers for Medicare and Medicaid Services in accordance with §1915(c) of the Social Security Act.

(25) HHSC--The Texas Health and Human Services Commission.

(26) ICAP--Inventory for Client and Agency Planning.

(27) ICF/IID--A facility in which ICF/IID Program services are provided.

(28) ICF/IID Program--The Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program, which provides Medicaid-funded residential services to individuals with an intellectual disability or related conditions.

(29) ICF/MR--ICF/IID.

(30) ID/RC Assessment--A form used by DADS for LOC determination and LON assignment.

(31) Implementation Plan--A written document developed by the program provider for an individual that, for each HCS Program

service on the individual's IPC not provided through the CDS option, includes:

(A) a list of outcomes identified in the PDP that will be addressed using HCS Program services;

(B) specific objectives to address the outcomes required by subparagraph (A) of this paragraph that are:

(i) observable, measurable, and outcome-oriented; and

(ii) derived from assessments of the individual's strengths, personal goals, and needs;

(C) a target date for completion of each objective;

(D) the number of HCS Program units of service needed to complete each objective;

(E) the frequency and duration of HCS Program services needed to complete each objective; and

(F) the signature and date of the individual, LAR, and the program provider.

(32) Individual--A person enrolled in the HCS Program.

(33) Initial IPC--The first IPC for an individual developed before the individual's enrollment into the HCS Program.

(34) Intellectual disability--Significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period; referred to in some sections as mental retardation.

(35) IPC (individual plan of care)--A written plan that:

(A) states:

(i) the type and amount of each HCS Program service to be provided to the individual during an IPC year; and

(ii) the services and supports to be provided to the individual through non-HCS Program resources, including natural supports, medical services, and educational services; and

(B) is authorized by DADS.

(36) IPC cost--Estimated annual cost of HCS Program services included on an IPC.

(37) IPC year--A 12-month period of time starting on the date an initial or renewal IPC begins. A revised IPC does not change the begin or end date of an IPC year.

(38) Large ICF/IID--A non-state operated ICF/IID with a Medicaid certified capacity of 14 or more.

(39) LAR (legally authorized representative)--A person authorized by law to act on behalf of a person with regard to a matter described in this subchapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(40) LOC (level of care)--A determination given to an individual as part of the eligibility determination process based on data submitted on the ID/RC Assessment.

(41) Local authority--An entity to which the Health and Human Services Commission's authority and responsibility, as described in Texas Health and Safety Code, §531.002(11), has been delegated.

(42) LON (level of need)--An assignment given by DADS to an individual upon which reimbursement for host home/companion care, supervised living, residential support, and day habilitation is based.

(43) LVN--Licensed vocational nurse. A person licensed to practice vocational nursing in accordance with Texas Occupations Code, Chapter 301.

(44) Microboard--A program provider:

(A) that is a non-profit corporation:

(i) that is created and operated by no more than 10 persons, including an individual;

(ii) the purpose of which is to address the needs of the individual and directly manage the provision of HCS Program services; and

(iii) in which each person operating the corporation participates in addressing the needs of the individual and directly managing the provision of HCS Program services; and

(B) that has a service capacity designated in the DADS data system of no more than three individuals.

(45) MRA--Local authority.

(46) MR/RC Assessment--An ID/RC Assessment.

(47) Natural supports--Unpaid persons, including family members, volunteers, neighbors, and friends, who assist and sustain an individual.

(48) Non-routine circumstances--An event that occurs unexpectedly or does not occur on a regular basis, such as a night off, a vacation, an illness, an injury, a hospitalization, or a funeral.

(49) PDP (person-directed plan)--A written plan, based on person-directed planning and developed with an applicant or individual in accordance with the HCS Person-Directed Plan form and discovery tool found at www.dads.state.tx.us, that describes the supports and services necessary to achieve the desired outcomes identified by the applicant or individual (and LAR on the applicant's or individual's behalf) and ensure the applicant's or individual's health and safety.

(50) Person-directed planning--An ongoing process that empowers the applicant or individual (and the LAR on the applicant's or individual's behalf) to direct the development of a PDP. The process:

(A) identifies supports and services necessary to achieve the applicant's or individual's outcomes;

(B) identifies existing supports, including natural supports and other supports available to the applicant or individual and negotiates needed services system supports;

(C) occurs with the support of a group of people chosen by the applicant or individual (and the LAR on the applicant's or individual's behalf); and

(D) accommodates the applicant's or individual's style of interaction and preferences.

(51) Permanency planning--A philosophy and planning process that focuses on the outcome of family support for an applicant or individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.

(52) Permanency Planning Review Screen--A screen in the DADS data system, completed by a local authority, that identifies community supports needed to achieve an applicant's or individual's permanency planning outcomes and provides information necessary for

approval to provide supervised living or residential support to the applicant or individual.

(53) Primary correspondent--A person who may request that a local authority place an applicant's name on the HCS Program interest list.

(54) Program provider--A person, as defined in §49.102 of this title (relating to Definitions), that has a contract with DADS to provide HCS program services, excluding an FMSA.

(55) Provisional contract--An initial contract that DADS enters into with a program provider in accordance with §49.208 of this title (relating to Provisional Contract Application Approval) that has a stated expiration date.

(56) Related condition--A severe and chronic disability that:

(A) is attributed to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability, and requires treatment or services similar to those required for individuals with an intellectual disability;

(B) is manifested before the individual reaches age 22;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in at least three of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

(57) Renewal IPC--An IPC developed for an individual in accordance with §9.166(a) of this subchapter (relating to Renewal and Revision of an IPC).

(58) Restraint--

(A) A manual method, except for physical guidance or prompting of brief duration, or a mechanical device to restrict:

(i) the free movement or normal functioning of all or a portion of an individual's body; or

(ii) normal access by an individual to a portion of the individual's body.

(B) Physical guidance or prompting of brief duration becomes a restraint if the individual resists the physical guidance or prompting.

(59) RN--Registered nurse. A person licensed to practice professional nursing in accordance with Texas Occupations Code, Chapter 301.

(60) Revised IPC--An initial IPC or a renewal IPC that is revised during an IPC year in accordance with §9.166(b) or (d) of this subchapter or §9.168(h) of this subchapter (relating to CDS Option) to add a new HCS Program service or change the amount of an existing service.

(61) Seclusion--The involuntary separation of an individual away from other individuals and the placement of the individual alone in an area from which the individual is prevented from leaving.

(62) Service backup plan--A plan that ensures continuity of critical program services if service delivery is interrupted.

(63) Service coordination--A service as defined in Chapter 2, Subchapter L of this title (relating to Service Coordination for Individuals with an Intellectual Disability).

(64) Service coordinator--An employee of a local authority who provides service coordination to an individual.

(65) Service planning team--A planning team consisting of an applicant or individual, LAR, service coordinator, and other persons chosen by the applicant or individual or LAR on behalf of the applicant or individual (for example, a program provider representative, family member, friend, or teacher).

(66) Service provider--A person, who may be a staff member, who directly provides an HCS Program service to an individual.

(67) SSI--Supplemental Security Income.

(68) Staff member--An employee or contractor of an HCS Program provider.

(69) Standard contract--A contract that DADS enters into with a program provider in accordance with §49.209 of this title (relating to Standard Contract) that does not have a stated expiration date.

(70) State Medicaid claims administrator--The entity contracting with the state as the Medicaid claims administrator and fiscal agent.

(71) State supported living center--A state-supported and structured residential facility operated by DADS to provide to persons with an intellectual disability a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocational skills, but does not include a community-based facility owned by DADS.

(72) Support consultation--A service, as defined in §41.103 of this title, that is provided to an individual participating in the CDS option at the request of the individual or LAR.

(73) TANF--Temporary Assistance for Needy Families.

(74) Three-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than three persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that is not the residence of any person other than a service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(D) that is not a dwelling described in §9.155(a)(5)(H) of this subchapter.

(75) Vendor hold--A temporary suspension of payments that are due to a program provider under a contract.

§9.154. Description of the HCS Program.

(a) The HCS Program is a Medicaid waiver program approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act. It provides community-based services and supports to eligible individuals as an alternative to the ICF/IID Program. The HCS Program is operated by DADS under the authority of HHSC.

(b) Enrollment in the HCS Program is limited to the number of individuals in specified target groups and to the geographic areas approved by CMS.

(c) HCS Program services listed in this subsection are selected for inclusion in an individual's IPC to ensure the individual's health, safety, and welfare in the community, supplement rather than replace that individual's natural supports and other community services for which the individual may be eligible, and prevent the individual's admission to institutional services. The following services are defined in Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us. Services available under the HCS Program are:

(1) professional therapies provided by appropriately licensed or certified professionals as follows:

(A) physical therapy;

(B) occupational therapy;

(C) speech and language pathology;

(D) audiology;

(E) social work;

(F) behavioral support;

(G) dietary services; and

(H) cognitive rehabilitation therapy;

(2) nursing provided by an RN or LVN;

(3) residential assistance, excluding room and board, provided in one of the following three ways:

(A) host home/companion care;

(B) supervised living; or

(C) residential support;

(4) supported home living, which is not a reimbursable service for individuals receiving host home/companion care, supervised living, or residential support;

(5) respite, which includes room and board when provided in a setting other than the individual's home, but is not a reimbursable service for individuals receiving host home/companion care, supervised living, or residential support;

(6) day habilitation, provided exclusive of any other separately funded service, including public school services, rehabilitative services for persons with mental illness, other programs funded by DADS, or programs funded by DARS;

(7) employment assistance;

(8) supported employment;

(9) adaptive aids;

(10) minor home modifications;

(11) dental treatment; and

(12) if the individual is participating in the CDS option:

(A) FMS; and

(B) support consultation.

(d) DADS has grouped the counties of the state of Texas into geographical areas, referred to as "local service areas," each of which is served by a local authority. DADS has further grouped the local service areas into "waiver contract areas." A list of the counties included in each local service area and waiver contract area is found at www.dads.state.tx.us.

(1) A program provider may provide HCS Program services only to persons residing in the counties specified for the program provider in DADS automated enrollment and billing system.

(2) A program provider must have a separate contract for each waiver contract area served by the program provider.

(3) A program provider may have a contract to serve one or more local service areas within a waiver contract area, but the program provider must serve all of the counties within each local service area covered by the program provider agreement.

(4) A program provider may not have more than one contract per waiver contract area.

(e) A program provider must comply with:

(1) all applicable state and federal laws, rules, and regulations, including Chapter 49 of this title (relating to Contracting for Community Services); and

(2) DADS Information Letters regarding the HCS Program found at www.dads.state.tx.us.

(f) The CDS option is a service delivery option, described in Chapter 41 of this title (relating to Consumer Directed Services Option), in which an individual or LAR directs the services that may be provided through the CDS option, as described in §41.108 of this title (relating to Services Available Through the CDS Option).

§9.158. Process for Enrollment of Applicants.

(a) DADS notifies a local authority, in writing, of an HCS Program vacancy in the local authority's local service area and directs the local authority to offer the program vacancy to an applicant:

(1) whose registration date, assigned in accordance with §9.157(a)(1) of this subchapter (relating to Maintenance of HCS Program Interest List), is earliest on the statewide interest list for the HCS Program as maintained by DADS;

(2) whose registration date, assigned in accordance with §9.157(a)(1) of this subchapter is earliest on the local service area interest list for the HCS Program as maintained by the local authority, in accordance with §9.157 of this subchapter; or

(3) who is a member of a target group identified in the approved HCS waiver application.

(b) Except as provided in subsection (c) of this section, the local authority must make the offer of program vacancy in writing and deliver it to the applicant or LAR by regular United States mail or by hand delivery.

(c) The local authority must make the offer of program vacancy to an applicant described in subsection (a)(3) of this section who

is currently receiving services in a state supported living center or a state mental health facility as defined by §2.253 of this title (relating to Definitions) in accordance with DADS procedures.

(d) The local authority must include in a written offer that is made in accordance with subsection (a)(1), (2), or (3) of this section:

(1) a statement that:

(A) if the applicant or LAR does not respond to the offer of the program vacancy within 30 calendar days after the local authority's written offer, the local authority withdraws the offer of the program vacancy, and:

(i) for an applicant who is under 22 years of age and residing in an institution listed in §9.157(a)(1)(B)(i) - (v) of this subchapter, the local authority removes the applicant's name from the HCS Program interest list in accordance with §9.157(a)(3)(F) of this subchapter and places the applicant's name on the HCS Program interest list with a new registration date that is the date of the local authority's notification; or

(ii) for an applicant other than one described in clause (i) of this subparagraph, the local authority removes the applicant's name from the HCS Program interest list in accordance with §9.157(a)(3)(F) of this subchapter; and

(B) if the applicant is currently receiving services from the local authority that are funded by general revenue and the applicant or LAR declines the offer of the program vacancy, the local authority terminates those services that are similar to services provided under the HCS Program; and

(2) information relating to the time frame requirements described in subsection (f) of this section using the Deadline Notification form, which is found at www.dads.state.tx.us.

(e) If an applicant or LAR responds to an offer of program vacancy, the local authority must:

(1) provide the applicant, LAR, and, if the LAR is not a family member, at least one family member (if possible) both an oral and written explanation of the services and supports for which the applicant may be eligible, including the ICF/IID Program (both state supported living centers and community-based facilities), waiver programs under §1915(c) of the Social Security Act, and other community-based services and supports. The local authority must use the Explanation of Services and Supports document, which is found at www.dads.state.tx.us; and

(2) give the applicant or LAR the Verification of Freedom of Choice Form, Waiver Program which is found at www.dads.state.tx.us, to document the applicant's choice regarding the HCS Program and ICF/IID Program.

(f) The local authority must withdraw an offer of a program vacancy made to an applicant or LAR and remove the applicant's name from the HCS Program interest list if:

(1) within 30 calendar days after the local authority's offer made to the applicant or LAR in accordance with subsection (a)(1), (2), or (3) of this section, the applicant or LAR does not respond to the offer of the program vacancy;

(2) within seven calendar days after the applicant or LAR receives the Verification of Freedom of Choice, Waiver Program form from the local authority in accordance with subsection (e)(2) of this section, the applicant or LAR does not document the choice of HCS Program services over the ICF/IID Program using the Verification of Freedom of Choice, Waiver Program form; or

(3) within 30 calendar days after the applicant or LAR has received the contact information regarding all program providers in the local authority's local service area in accordance with subsection (l)(1) of this section, the applicant or LAR does not document the choice of a program provider using the Documentation of Provider Choice form.

(g) If the local authority withdraws an offer of a program vacancy made to an applicant and removes the applicant's name from the HCS Program interest list, the local authority must notify the applicant or LAR of such actions, in writing, by certified United States mail and:

(1) for an applicant who is under 22 years of age and residing in an institution listed in §9.157(a)(1)(B)(i) - (v) of this subchapter, include a statement that the applicant's name will be placed on the HCS Program interest list with a new registration date that is the date of the local authority's notification; or

(2) for an applicant other than one described in paragraph (1) of this subsection, include a statement that the applicant or the applicant's primary correspondent may request, orally or in writing, to have the applicant's name placed on the HCS Program interest list with a new registration date that is the date the applicant or LAR makes the request.

(h) If the applicant is currently receiving services from the local authority that are funded by general revenue and the applicant declines the offer of the program vacancy, the local authority must terminate those services that are similar to services provided under the HCS Program.

(i) If the local authority terminates an applicant's services in accordance with subsection (h) of this section, the local authority must notify the applicant or LAR of the termination, in writing, by certified United States mail and provide an opportunity for a review in accordance with §2.46 of this title (relating to Notification and Appeals Process).

(j) If the local authority notifies an applicant under 22 years of age or the applicant's LAR in accordance with subsection (g)(1) of this section, the local authority must coordinate with DADS to ensure the applicant's name is placed on the HCS Program interest list with a new registration date that is the date of the local authority's notification.

(k) If the applicant or LAR, on the applicant's behalf, chooses to enroll in the HCS Program the local authority must compile and maintain information necessary to process the request for enrollment in the HCS Program.

(1) If the applicant's financial eligibility for the HCS Program must be established, the local authority must initiate, monitor, and support the processes necessary to obtain a financial eligibility determination.

(2) The local authority must complete an ID/RC Assessment if an LOC determination is necessary in accordance with §9.161 and §9.163 of this subchapter (relating to LOC Determination and LON Assignment, respectively).

(A) The local authority must:

(i) perform or endorse a determination that the applicant has an intellectual disability in accordance with Chapter 5, Subchapter D of this title (relating to Diagnostic Eligibility for Services and Supports--Intellectual Disability Priority Population and Related Conditions); or

(ii) verify that the applicant has been diagnosed by a licensed physician as having a related condition as defined in §9.203 of this chapter (relating to Definitions).

(B) The local authority must administer the ICAP and recommend an LON assignment to DADS in accordance with §9.163 and §9.164 of this subchapter (relating to DADS' Review of LON).

(C) The local authority must electronically transmit the completed ID/RC Assessment to DADS for approval in accordance with §9.161(a) and §9.163(a) of this subchapter and, if applicable, submit supporting documentation as required by §9.164(c) of this subchapter.

(3) The local authority must assign a service coordinator who, together with the applicant and LAR, must develop a PDP.

(4) The local authority must develop a proposed initial IPC with the applicant or LAR in accordance with §9.159(c) of this subchapter (relating to IPC).

(l) The service coordinator must:

(1) provide names and contact information to the applicant or LAR regarding available program providers in the local authority's local service area (that is, program providers operating below their service capacity as identified in the DADS data system);

(2) arrange for meetings and visits with potential program providers as requested by the applicant or LAR;

(3) review the proposed initial IPC with potential program providers as requested by the applicant or LAR;

(4) ensure that the applicant's or LAR's choice of a program provider is documented on the Documentation of Provider Choice Form and signed by the applicant or LAR;

(5) negotiate and finalize the proposed initial IPC and the date services will begin with the selected program provider, consulting with DADS if necessary to reach agreement with the selected program provider on the content of the proposed initial IPC and the date services will begin;

(6) if an applicant or LAR chooses a program provider to deliver a service, ensure that the initial proposed IPC includes a sufficient number of RN nursing units for a program provider nurse to perform an initial nursing assessment unless, as described in §9.174(c) of this subchapter (relating to Certification Principles: Service Delivery):

(A) nursing services are not on the proposed IPC and the individual or LAR and selected program provider have determined that an unlicensed service provider will not perform a nursing task as documented on DADS form "Nursing Task Screening Tool"; or

(B) an unlicensed service provider will perform a nursing task and a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician;

(7) if an applicant or LAR refuses to include on the initial proposed IPC a sufficient number of RN nursing units to perform an initial nursing assessment as required by paragraph (6) of this subsection:

(A) inform the applicant or LAR that the refusal:

(i) will result in the applicant not receiving nursing services from the program provider; and

(ii) if the applicant needs host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, or day habilitation from the program provider, will result in the individual not receiving that service unless, as described in §9.174(d)(2) of this subchapter:

(I) the program provider's unlicensed service provider does not perform nursing tasks in the provision of the service; and

(II) the program provider determines that it can ensure the applicant's health, safety, and welfare in the provision of the service; and

(B) document the refusal of the RN nursing units on the proposed IPC for an initial assessment by the program provider's RN in the applicant's record;

(8) ensure that the applicant or LAR signs and dates the proposed initial IPC;

(9) ensure that the selected program provider signs and dates the proposed IPC, demonstrating agreement that the services will be provided to the applicant;

(10) sign and date the proposed initial IPC, which indicates that the service coordinator agrees that the requirements described in §9.159(c) of this subchapter have been met; and

(11) inform the applicant or LAR, orally and in writing, of the following reasons HCS Program services may be terminated:

(A) the individual no longer meets the eligibility criteria described in §9.155 of this subchapter (relating to Eligibility Criteria and Suspension of HCS Program Services); or

(B) the individual or LAR requests termination of HCS Program services.

(m) The local authority must:

(1) conduct permanency planning in accordance with §9.167(a) of this subchapter (relating to Permanency Planning); and

(2) discuss the CDS option with the applicant or LAR in accordance with §9.168(a) and (b) of this subchapter (relating to CDS Option).

(n) After the proposed initial IPC is finalized and signed in accordance with subsection (l) of this section, the local authority must:

(1) electronically transmit the proposed initial IPC to DADS and:

(A) keep the original proposed initial IPC in the individual's record; and

(B) ensure the electronically transmitted proposed initial IPC contains information identical to that on the original proposed initial IPC; and

(2) submit other required enrollment information to DADS.

(o) DADS notifies the applicant or LAR, the selected program provider, the FMSA, if applicable, and the local authority of its approval or denial of the applicant's enrollment. When the enrollment is approved, DADS authorizes the applicant's enrollment in the HCS Program through the DADS data system and issues an enrollment letter that includes the effective date of the applicant's enrollment in the HCS Program.

(p) Prior to the applicant's service begin date, the local authority must provide to the selected program provider and FMSA, if applicable, copies of all enrollment documentation and associated supporting documentation, including relevant assessment results and rec-

ommendations, the completed ID/RC Assessment, the proposed initial IPC, and the applicant's PDP.

(q) The selected program provider must not initiate services until notified of DADS approval of the applicant's enrollment.

(r) The selected program provider must develop an implementation plan for HCS Program services that is based on the individual's PDP and authorized IPC.

(s) The local authority must retain in the applicant's record:

(1) the Verification of Freedom of Choice, Waiver Program form documenting the applicant's or LAR's choice of services;

(2) the Documentation of Provider Choice form documenting the applicant's or LAR's choice of a program provider, if applicable;

(3) the Deadline Notification form; and

(4) any other correspondence related to the offer of a program vacancy.

(t) Copies of the following forms and letters referenced in this section are available by contacting the Department of Aging and Disability Services, Provider Services Division, P.O. Box 149030, Mail Code W-521, Austin, Texas 78714-9030:

(1) Verification of Freedom of Choice, Waiver Program;

(2) Documentation of Provider Choice form; and

(3) Deadline Notification form.

§9.159. IPC.

(a) A local authority must initiate development of a proposed initial IPC for an applicant as required by §9.158(k)(4) of this subchapter (relating to Process for Enrollment of Applicants).

(b) A program provider must initiate development of a proposed renewal and proposed revised IPC for an individual as required by §9.166 of this subchapter (relating to Renewal and Revision of an IPC).

(c) An IPC must be based on the PDP and specify the type and amount of each service to be provided to an individual, as well as services and supports to be provided by other sources during the IPC year. Each HCS program service in the IPC:

(1) must be necessary to protect the individual's health and welfare in the community;

(2) must not be available to the individual through any other source, including the Medicaid State Plan, other governmental programs, private insurance, or the individual's natural supports;

(3) must be the most appropriate type and amount to meet the individual's needs;

(4) must be cost effective;

(5) must be necessary to enable community integration and maximize independence;

(6) if an adaptive aid or minor home modification, must:

(A) be included on DADS approved list in the *HCS Program Billing Guidelines;* and

(B) be within the service limit described in §9.192 of this subchapter (relating to Service Limits);

(7) if an adaptive aid costing $500 or more, must be supported by a written assessment from a licensed professional specified by DADS in the *HCS Program Billing Guidelines;*

(8) if a minor home modification costing $1,000 or more, must be supported by a written assessment from a licensed professional specified by DADS in the *HCS Program Billing Guidelines;* and

(9) if dental services, must be within the service limit described in §9.192 of this subchapter.

(d) With the exception of an HCS program service provided through the CDS option, a program provider must:

(1) provide an HCS Program service in accordance with an individual's authorized IPC; and

(2) retain in an individual's record, results and recommendations of individualized assessments that support the individual's current need for each service included in the IPC.

§9.166. Renewal and Revision of an IPC.

(a) Renewal of the IPC. At least annually and before the expiration of an individual's IPC, the individual's IPC must be renewed in accordance with this subsection and with DADS instructions.

(1) At least 60 but no more than 90 calendar days before the expiration of an individual's IPC, the service coordinator must notify the service planning team that the individual's PDP must be reviewed and updated.

(2) Upon notification in accordance with paragraph (1) of this subsection, the service planning team must review and update the individual's PDP. The service coordinator must send a copy of the updated PDP to the program provider within 10 calendar days after the PDP is updated.

(3) The program provider must ensure that a meeting between the service planning team and the program provider occurs at least 30 but no more than 60 calendar days before the expiration of the individual's IPC to review the PDP and develop the proposed renewal IPC in accordance with §9.159(c) of this subchapter (relating to IPC), including completion of the CDS option portion of the proposed renewal IPC, if applicable, and the non-HCS Program services.

(4) The program provider must, before the effective date of the proposed renewal IPC, develop an implementation plan for HCS Program services that is based on the individual's PDP and proposed renewal IPC.

(5) Within seven calendar days after development of the proposed renewal IPC as required by paragraph (3) of this subsection, the program provider must comply with the requirements in subsection (e)(1) and (2) of this section.

(6) Within seven calendar days after the program provider electronically transmits the proposed renewal IPC to DADS as required by subsection (e)(2) of this section, the service coordinator must comply with the requirements in subsection (e)(3) of this section.

(7) The program provider must provide HCS Program services in accordance with an implementation plan that is based on the individual's PDP and authorized renewal IPC.

(b) Revisions to the IPC. The service coordinator or the program provider may determine whether an individual's IPC needs to be revised to add a new HCS Program service or change the amount of an existing service.

(1) The service coordinator must notify the program provider if the service coordinator determines that the IPC needs to be revised.

(2) The program provider must notify the service coordinator if the program provider determines that the IPC needs to be revised.

(3) Within 14 calendar days after the notification required by paragraph (1) or (2) of this subsection:

(A) the service planning team and the program provider must develop a proposed revised IPC;

(B) the service planning team must revise the PDP, if appropriate, and if the PDP is not revised, the service coordinator must document the reasons for the proposed IPC revision;

(C) the program provider must revise the implementation plan for HCS Program services that is based on the individual's PDP and proposed revised IPC; and

(D) the program provider must comply with the requirements in subsection (e)(1) and (2) of this section.

(4) Within seven calendar days after the program provider electronically transmits the proposed revised IPC to DADS as required by subsection (e)(2) of this section, the service coordinator must comply with the requirements in subsection (e)(3) of this section.

(5) The program provider must provide HCS Program services in accordance with an implementation plan that is based on the individual's PDP and the authorized revised IPC.

(c) Revision of IPC before delivery of services. Except as provided by subsection (d) of this section, if an individual's service planning team and program provider determine that the IPC must be revised to add a new HCS Program service or change the amount of an existing service, the program provider must revise the IPC in accordance with subsection (b) of this section before the delivery of a new or increased service.

(d) Emergency provision of services and revision of the IPC.

(1) If an emergency necessitates the provision of an HCS Program service to ensure the individual's health and safety and the service is not on the IPC or exceeds the amount on the IPC, the program provider may provide the service before revising the IPC. The program provider must, within one business day after providing the service:

(A) document:

(i) the circumstances that necessitated providing the new HCS Program service or the increase in the amount of the existing HCS Program service; and

(ii) the type and amount of the service provided;

(B) notify the service coordinator of the emergency provision of the service and that the IPC must be revised; and

(C) upon request, provide a copy of the documentation required by subparagraph (A) of this paragraph to the service coordinator.

(2) Within seven calendar days after providing the service:

(A) the service planning team and the program provider must develop a proposed revised IPC;

(B) the service planning team must revise the PDP, if appropriate;

(C) the program provider must revise the implementation plan for HCS Program services that is based on the individual's PDP and proposed revised IPC; and

(D) the program provider must comply with the requirements in subsection (e)(1) and (2) of this section.

(3) Within seven calendar days after the program provider electronically transmits the proposed revised IPC to DADS as required by subsection (e)(2) of this section, the service coordinator must comply with the requirements in subsection (e)(3) of this section.

(4) The program provider must provide HCS Program services in accordance with an implementation plan that is based on the individual's PDP and the authorized revised IPC.

(e) Submitting a proposed renewal and revised IPC to DADS. A proposed renewal or revised IPC must be submitted to DADS for authorization in accordance with this subsection.

(1) The program provider must:

(A) sign and date the proposed renewal or revised IPC demonstrating agreement that the services will be provided to the individual; and

(B) ensure that a proposed renewal or revised IPC is signed and dated by the individual or LAR.

(2) The program provider must:

(A) electronically transmit a proposed renewal or revised IPC to DADS;

(B) keep the original proposed renewal or revised IPC in the individual's record and, within three calendar days after electronic transmission, ensure the service coordinator receives a copy of the signed proposed renewal or revised IPC; and

(C) ensure the electronically transmitted proposed renewal or revised IPC contains information identical to that on the original proposed renewal or revised IPC.

(3) The service coordinator must review the electronically transmitted proposed renewal or revised IPC and:

(A) enter the service coordinator's name and date in the DADS data system;

(B) enter in the DADS data system whether the service coordinator agrees or disagrees that the requirements described in §9.159(c) of this subchapter have been met; and

(C) if the service coordinator disagrees that the requirements described in §9.159(c) of this subchapter have been met, notify the individual or LAR, the program provider, and DADS of the service coordinator's disagreement in accordance with DADS instructions.

§9.168. CDS Option.

(a) If supported home living, respite, nursing, employment assistance, supported employment, or cognitive rehabilitation therapy is included in an applicant's PDP, and the applicant's PDP does not include residential support, supervised living, or host home/companion care, the local authority must:

(1) inform the applicant or LAR of the applicant's right to participate in the CDS option or discontinue participation in the CDS option at any time, except as provided in §41.405(a) of this title (relating to Suspension of Participation in the CDS Option);

(2) inform the applicant or LAR that the applicant or LAR may choose to have supported home living, respite, nursing, employment assistance, supported employment, or cognitive rehabilitation therapy provided through the CDS option;

(3) provide the applicant or LAR a copy of the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities, and Employee Qualification Requirements forms, which are found at www.dads.state.tx.us and which contain information about the CDS option, including a description of FMS and support consultation;

(4) provide an oral explanation of the information contained in the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities, and Employee Qualification Requirements forms to the applicant or LAR; and

(5) provide the applicant or LAR the opportunity to choose to participate in the CDS option and document the applicant's or LAR's choice on the Consumer Participation Choice form, which is found at www.dads.state.tx.us.

(b) If an applicant or LAR chooses to participate in the CDS option, the service coordinator must:

(1) provide names and contact information to the applicant or LAR regarding all FMSAs providing services in the local authority's local service area;

(2) document the applicant's or LAR's choice of FMSA on the Consumer Participation Choice form;

(3) document, in the individual's PDP, a description of the service provided through the CDS option; and

(4) document, in the individual's PDP, a description of the individual's service backup plan, if a backup plan is required by Chapter 41 of this title (relating to Consumer Directed Services Option).

(c) For an individual who is receiving supported home living, respite, nursing, employment assistance, supported employment, or cognitive rehabilitation therapy, and is not receiving residential support, supervised living, or host home/companion care, the service coordinator must, at least annually:

(1) inform the individual or LAR of the individual's right to participate in the CDS option or discontinue participation in the CDS option at any time, except as provided in §41.405(a) of this title;

(2) provide the individual or LAR a copy of the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities, and Employee Qualification Requirements forms, which are found at www.dads.state.tx.us and which contain information about the CDS option, including FMS and support consultation;

(3) provide an oral explanation of the information contained in the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities and Employee Qualification Requirements forms to the individual or LAR; and

(4) provide the individual or LAR the opportunity to choose to participate in the CDS option and document the individual's choice on the Consumer Participation Choice form, which is found at www.dads.state.tx.us.

(d) If an individual or LAR chooses to participate in the CDS option, the service coordinator must:

(1) provide names and contact information to the individual or LAR regarding all FMSAs providing services in the local authority's local service area;

(2) document the individual's or LAR's choice of FMSA on the Consumer Participation Choice form;

(3) document, in the individual's PDP, a description of the service provided through the CDS option;

(4) document, in the individual's PDP, a description of the individual's service backup plan, if a backup plan is required by Chapter 41 of this title; and

(5) notify the program provider of the individual's or LAR's decision to participate in the CDS option.

(e) The service coordinator must document in the individual's PDP that the information described in subsections (c) and (d)(1) of this section was provided to the individual or LAR.

(f) For an individual participating in the CDS option, the service coordinator must recommend that DADS terminate the individual's participation in the CDS option (that is, terminate FMS and support consultation) if the service coordinator determines that:

(1) the individual's continued participation in the CDS option poses a significant risk to the individual's health or safety; or

(2) the individual or LAR has not complied with Chapter 41, Subchapter B of this title (relating to Responsibilities of Employers and Designated Representatives).

(g) If the service coordinator makes a recommendation in accordance with subsection (f) of this section, the service coordinator must:

(1) document:

(A) a description of the service recommended for termination;

(B) the reasons why termination is recommended;

(C) a description of the attempts to resolve the issues before recommending termination;

(2) obtain other supporting documentation, as appropriate; and

(3) notify the program provider that the IPC needs to be revised.

(h) Within seven calendar days after notification in accordance with subsection (g)(3) of this section:

(1) the service coordinator and the program provider must comply with the requirements described in §9.166(d)(2)(A) - (D) of this subchapter (relating to Renewal and Revision of an IPC); and

(2) the service coordinator must send the documentation described in subsection (g)(1) of this section to DADS.

§9.170. Reimbursement.

Program provider reimbursement.

(1) A program provider is paid for services as described in this paragraph.

(A) DADS pays for supported home living, professional therapies, nursing, respite, employment assistance, and supported employment in accordance with the reimbursement rate for the specific service.

(B) DADS pays for host home/companion care, residential support, supervised living, and day habilitation in accordance with the individual's LON and the reimbursement rate for the specific service.

(C) DADS pays for adaptive aids, minor home modifications, and dental treatment based on the actual cost of the item and, if requested, a requisition fee in accordance with the *HCS Program Billing Guidelines,* which are available at www.dads.state.tx.us.

(2) If an individual's HCS Program services are suspended or terminated the program provider must not submit a claim for services provided during the period of the individual's suspension or after the termination, except that the program provider may submit a claim for the first day of the individual's suspension or termination for the following services:

(A) day habilitation;

(B) supported home living;

(C) respite;

(D) employment assistance;

(E) supported employment;

(F) professional therapies; and

(G) nursing.

(3) If the program provider submits a claim for an adaptive aid that costs $500 or more or for a minor home modification that costs $1,000 or more, the claim must be supported by a written assessment from a licensed professional specified by DADS in the *HCS Program Billing Guidelines* and other documentation as required by the *HCS Program Billing Guidelines.*

(4) DADS does not pay the program provider for a service or recoups any payments made to the program provider for a service if:

(A) the individual receiving the service is, at the time the service was provided, ineligible for the HCS program or Medicaid benefits, or was an inpatient of a hospital, nursing facility, or ICF/IID;

(B) the service is provided to an individual during a period of time for which there is not a signed, dated, and authorized IPC for the individual;

(C) the service is not included on the signed, dated, and authorized IPC of the individual in effect at the time the service was provided, except as permitted by §9.166(d) of this subchapter (relating to Renewal and Revision of an IPC);

(D) the service provided does not meet the service definition or is not provided in accordance with the *HCS Program Billing Guidelines;*

(E) the program provider provides the supervised living or residential support service in a residence in which four individuals or other person receiving similar services live without DADS approval as required in §9.188 of this subchapter (relating to DADS Approval of Residences);

(F) the service is not documented in accordance with the *HCS Program Billing Guidelines;*

(G) the claim for the service does not meet the requirements in §49.311 of this title (relating to Claims Payment) or the *HCS Program Billing Guidelines;*

(H) the program provider does not have the documentation described in paragraph (3)of this section;

(I) DADS determines that the service would have been paid for by a source other than the HCS Program if the program provider had submitted to the other source a proper, complete, and timely request for payment for the service;

(J) before including employment assistance on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that employment assistance is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(K) before including supported employment on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that supported employment is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(L) the service is provided during a period of time for which there is not a signed and dated ID/RC Assessment for the individual;

(M) the service is provided during a period of time for which the individual did not have an LOC determination;

(N) the service is provided by a service provider who does not meet the qualifications to provide the service as delineated in the *HCS Program Billing Guidelines;*

(O) the service is not provided in accordance with a signed, dated, and authorized IPC meeting the requirements set forth in §9.159(c) of this subchapter (relating to IPC);

(P) the service is not provided in accordance with the individual's PDP or implementation plan;

(Q) the service of host home/companion care, residential support, or supervised living is provided on the day of the individual's suspension or termination of HCS Program services;

(R) the service is provided before the individual's enrollment date into the HCS Program; or

(S) the service was paid at an incorrect LON because the ID/RC Assessment electronically transmitted to DADS does not contain information identical to information on the signed and dated ID/RC Assessment.

(5) The program provider must refund to DADS any overpayment made to the program provider within 60 calendar days after the program provider's discovery of the overpayment or receipt of a notice of such discovery from DADS, whichever is earlier.

(6) DADS conducts billing and payment reviews to monitor a program provider's compliance with this subchapter and the *HCS Program Billing Guidelines.* DADS conducts such reviews in accordance with the Billing and Payment Review Protocol set forth in the *HCS Program Billing Guidelines.* As a result of a billing and payment review, DADS may:

(A) recoup payments from a program provider; and

(B) based on the amount of unverified claims, require a program provider to develop and submit, in accordance with DADS instructions, a corrective action plan that improves the program provider's billing practices.

(7) A corrective action plan required by DADS in accordance with paragraph (6)(B) of this section must:

(A) include:

(i) the reason the corrective action plan is required;

(ii) the corrective action to be taken;

(iii) the person responsible for taking each corrective action; and

(iv) a date by which the corrective action will be completed that is no later than 90 calendar days after the date the program provider is notified the corrective action plan is required;

(B) be submitted to DADS within 30 calendar days after the date the program provider is notified the corrective action plan is required; and

(C) be approved by DADS before implementation.

(8) Within 30 calendar days after the corrective action plan is received by DADS, DADS notifies the program provider if a corrective action plan is approved or if changes to the plan are required.

(9) If DADS requires a program provider to develop and submit a corrective action plan in accordance with paragraph (6)(B) of this section and the program provider requests an administrative hearing for the recoupment in accordance with §9.186 of this subchapter (relating to Program Provider's Right to Administrative Hearing), the program provider is not required to develop or submit a corrective action plan while a hearing decision is pending. DADS notifies the program provider if the requirement to submit a corrective action plan or the content of such a plan changes based on the outcome of the hearing.

(10) If the program provider does not submit the corrective action plan or complete the required corrective action within the time frames described in paragraph (7) of this section, DADS may impose a vendor hold on payments due to the program provider under the contract until the program provider takes the corrective action.

(11) If the program provider does not submit the corrective action plan or complete the required corrective action within 30 calendar days after the date a vendor hold is imposed in accordance with paragraph (10) of this section, DADS may terminate the contract.

§9.174. Certification Principles: Service Delivery.

(a) The program provider must:

(1) serve an eligible applicant who has selected the program provider unless the program provider's enrollment has reached its service capacity as identified in the DADS data system;

(2) serve an eligible applicant without regard to age, sex, race, or level of disability;

(3) provide or obtain as needed and without delay all HCS Program services;

(4) ensure that each applicant or individual, or LAR on behalf of the applicant or individual, has chosen where the individual or applicant is to reside from available options consistent with the individual's needs;

(5) encourage involvement of the LAR or family members and friends in all aspects of the individual's life and provide as much assistance and support as is possible and constructive;

(6) request from and encourage the parent or LAR of an individual under 22 years of age receiving supervised living or residential support to provide the program provider with the following information:

(A) the parent's or LAR's:

(i) name;

(ii) address;

(iii) telephone number;

(iv) driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(v) place of employment and the employer's address and telephone number;

(B) name, address, and telephone number of a relative of the individual or other person whom DADS or the program provider may contact in an emergency situation, a statement indicating the relationship between that person and the individual, and at the parent's or LAR's option:

(i) that person's driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer; and

(C) a signed acknowledgement of responsibility stating that the parent or LAR agrees to:

(i) notify the program provider of any changes to the contact information submitted; and

(ii) make reasonable efforts to participate in the individual's life and in planning activities for the individual;

(7) inform the parent or LAR that if the information described in paragraph (6) of this subsection is not provided or is not accurate and the service coordinator and DADS are unable to locate the parent or LAR as described in §9.190(e)(35) of this subchapter (relating to Local Authority Requirements for Providing Service Coordination in the HCS Program) and §9.189 of this subchapter (relating to Referral to DFPS), DADS refers the case to DFPS;

(8) for an individual under 22 years of age receiving supervised living or residential support:

(A) make reasonable accommodations to promote the participation of the LAR in all planning and decision-making regarding the individual's care, including participating in meetings conducted by the program provider;

(B) take the following actions to assist a local authority in conducting permanency planning:

(i) cooperate with the local authority responsible for conducting permanency planning by:

(I) allowing access to an individual's records or providing other information in a timely manner as requested by the local authority or HHSC;

(II) participating in meetings to review the individual's permanency plan; and

(III) identifying, in coordination with the individual's local authority, activities, supports, and services that can be provided by the family, LAR, program provider, or the local authority to prepare the individual for an alternative living arrangement;

(ii) encourage regular contact between the individual and the LAR and, if desired by the individual and LAR, between the individual and advocates and friends in the community to continue supportive and nurturing relationships;

(iii) keep a copy of the individual's current permanency plan in the individual's record; and

(iv) refrain from providing the LAR with inaccurate or misleading information regarding the risks of moving the individual to another institutional setting or to a community setting;

(C) if an emergency situation occurs, attempt to notify the parent or LAR and service coordinator as soon as the emergency situation allows and request a response from the parent or LAR; and

(D) if the program provider determines it is unable to locate the parent or LAR, notify the service coordinator of such determination;

(9) allow the individual's family members and friends access to an individual without arbitrary restrictions unless exceptional conditions are justified by the individual's service planning team and documented in the PDP;

(10) notify the service coordinator if changes in an individual's age, skills, attitudes, likes, dislikes, or conditions necessitate a change in residential, educational, or work settings;

(11) ensure that the individual who is living outside the family home is living in a residence that maximizes opportunities for interaction with community members to the greatest extent possible;

(12) ensure that the IPC for each individual is renewed, revised, and authorized by DADS in accordance with §9.166 of this subchapter (relating to Renewal and Revision of an IPC) and §9.160 of this subchapter (relating to DADS' Review of a Proposed IPC);

(13) ensure that HCS Program services identified in the individual's implementation plan are provided in an individualized manner and are based on the results of assessments of the individual's and the family's strengths, the individual's personal goals and the family's goals for the individual, and the individual's needs rather than which services are available;

(14) ensure that each individual's progress or lack of progress toward desired outcomes is documented in observable, measurable, or outcome-oriented terms;

(15) ensure that each individual has opportunities to develop relationships with peers with and without disabilities and receives support if the individual chooses to develop such relationships;

(16) ensure that individuals who perform work for the program provider are paid on the basis of their production or performance and at a wage level commensurate with that paid to persons who are without disabilities and who would otherwise perform that work, and that compensation is based on local, state, and federal regulations, including Department of Labor regulations, as applicable;

(17) ensure that individuals who produce marketable goods and services in habilitation training programs are paid at a wage level commensurate with that paid to persons who are without disabilities and who would otherwise perform that work. Compensation is based on requirements contained in the Fair Labor Standards Act, which include:

(A) accurate recordings of individual production or performance;

(B) valid and current time studies or monitoring as appropriate; and

(C) prevailing wage rates;

(18) ensure that individuals provide no training, supervision, or care to other individuals unless they are qualified and compensated in accordance with local, state, and federal regulations, including Department of Labor regulations;

(19) unless contraindications are documented with justification by the service planning team, ensure that an individual's routine provides opportunities for leisure time activities, vacation periods, religious observances, holidays, and days off, consistent with the individual's choice and the routines of other members of the community;

(20) unless contraindications are documented with justification by the service planning team, ensure that an individual of retirement age has opportunities to participate in day activities appropriate to individuals of the same age and consistent with the individual's or LAR's choice;

(21) unless contraindications are documented with justification by the service planning team, ensure that each individual is offered choices and opportunities for accessing and participating in community activities and experiences available to peers without disabilities;

(22) assist the individual to meet as many of the individual's needs as possible by using generic community services and resources in the same way and during the same hours as these generic services are used by the community at large;

(23) ensure that, for an individual receiving host home/companion care, residential support, or supervised living:

(A) the individual lives in a home that is a typical residence within the community;

(B) the residence, neighborhood, and community meet the needs and choices of the individual and provide an environment that ensures the health, safety, comfort, and welfare of the individual;

(C) unless contraindications are documented with justification by the service planning team, the individual lives near family and friends and needed or desired community resources consistent with the individual's choice, if possible;

(D) the individual or LAR is involved in planning the individual's residential relocation, except in the case of an emergency;

(E) unless contraindications are documented with justification by the service planning team, the individual has a door lock on the inside of the individual's bedroom door, if requested by the individual or LAR; and

(F) the door lock installed in accordance with subparagraph (E) of this paragraph:

(i) is a single-action lock;

(ii) can be unlocked with a key from the outside of the door by the program provider; and

(iii) is not purchased and installed at the individual's or LAR's expense;

(24) ensure that adaptive aids are provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us and include the full range of lifts, mobility aids, control switches/pneumatic switches and devices, environmental control units, medically necessary supplies, and communication aids and repair and maintenance of the aids as determined by the individual's needs;

(25) together with an individual's service coordinator, ensure the coordination and compatibility of HCS Program services with non-HCS Program services;

(26) ensure that an individual has a current implementation plan;

(27) ensure that:

(A) the following professional therapy services are provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us:

(i) audiology services;

(ii) speech/language pathology services;

(iii) occupational therapy services;

(iv) physical therapy services;

(v) dietary services;

(vi) social work services;

(vii) behavioral support; and

(viii) cognitive rehabilitation therapy; and

(B) if the service planning team determines that an individual may need cognitive rehabilitation therapy, the program provider:

(i) in coordination with the service coordinator, assists the individual in obtaining, in accordance with the Medicaid State Plan, a neurobehavioral or neuropsychological assessment and plan of care from a qualified professional as a non-HCS Program service; and

(ii) has a qualified professional as described in §9.177(q) of this subchapter (relating to Certification Principles: Staff Member and Service Provider Requirements) provide and monitor the provision of cognitive rehabilitation therapy to the individual in accordance with the plan of care described in clause (i) of this subparagraph;

(28) ensure that day habilitation is provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us, including:

(A) assisting individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the community;

(B) providing individuals with age-appropriate activities that enhance self-esteem and maximize functional level;

(C) complementing any professional therapies listed in the IPC;

(D) reinforcing skills or lessons taught in school, therapy, or other settings;

(E) training and support activities that promote the individual's integration and participation in the community;

(F) providing assistance for the individual who cannot manage personal care needs during day habilitation activities; and

(G) providing transportation during day habilitation activities as necessary for the individual's participation in day habilitation activities;

(29) ensure that dental treatment is provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us, including:

(A) emergency dental treatment;

(B) preventive dental treatment;

(C) therapeutic dental treatment; and

(D) orthodontic dental treatment, excluding cosmetic orthodontia;

(30) ensure that minor home modifications are provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us, including:

(A) purchase and repair of wheelchair ramps;

(B) modifications to bathroom facilities;

(C) modifications to kitchen facilities; and

(D) specialized accessibility and safety adaptations or additions, including repair and maintenance;

(31) ensure that nursing is provided in accordance with the individual's PDP; IPC; implementation plan; Texas Occupations Code, Chapter 301 (Nursing Practice Act); 22 TAC Chapter 217 (relating to Licensure, Peer Assistance, and Practice); 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions); and Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us and consists of performing health care activities and monitoring the individual's health conditions, including:

(A) administering medication;

(B) monitoring the individual's use of medications;

(C) monitoring health risks, data, and information, including ensuring that an unlicensed service provider is performing only those nursing tasks identified from a nursing assessment;

(D) assisting the individual to secure emergency medical services;

(E) making referrals for appropriate medical services;

(F) performing health care procedures ordered or prescribed by a physician or medical practitioner and required by standards of professional practice or law to be performed by an RN or LVN;

(G) delegating nursing tasks to an unlicensed service provider and supervising the performance of those tasks in accordance with state law and rules;

(H) teaching an unlicensed service provider about the specific health needs of an individual;

(I) performing an assessment of an individual's health condition;

(J) an RN doing the following:

(i) performing a nursing assessment for each individual:

(I) before an unlicensed service provider performs a nursing task for the individual unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician; and

(II) as determined necessary by an RN, including if the individual's health needs change;

(ii) documenting information from performance of a nursing assessment;

(iii) if an individual is receiving a service through the CDS option, providing a copy of the documentation described in clause (ii) of this subparagraph to the individual's service coordinator;

(iv) developing the nursing service portion of an individual's implementation plan, which includes developing a plan and schedule for monitoring and supervising delegated nursing tasks; and

(v) making and documenting decisions related to the delegation of a nursing task to an unlicensed service provider; and

(K) in accordance with Texas Human Resources Code, Chapter 161:

(i) allowing an unlicensed service provider to provide administration of medication to an individual without the delegation or oversight of an RN if:

(I) an RN has performed a nursing assessment and, based on the results of the assessment, determined that the individual's health permits the administration of medication by an unlicensed service provider;

(II) the medication is:

(-a-) an oral medication;

(-b-) a topical medication; or

(-c-) a metered dose inhaler;

(III) the medication is administered to the individual for a predictable or stable condition; and

(IV) the unlicensed service provider has been:

(-a-) trained by an RN or an LVN under the direction of an RN regarding the proper administration of medication; or

(-b-) determined to be competent by an RN or an LVN under the direction of an RN regarding proper administration of medication, including through a demonstration of proper technique by the unlicensed service provider; and

(ii) ensuring that an RN or an LVN under the supervision of an RN reviews the administration of medication to an individual by an unlicensed service provider at least annually and after any significant change in the individual's condition;

(32) ensure that supported home living is available to an individual living in his or her own home or the home of his or her natural or adoptive family members, or to an individual receiving foster care services from DFPS;

(33) ensure that supported home living is provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assistance with meal planning and preparation;

(C) securing and providing transportation;

(D) assistance with housekeeping;

(E) assistance with ambulation and mobility;

(F) reinforcement of professional therapy activities;

(G) assistance with medications and the performance of tasks delegated by an RN;

(H) supervision of individuals' safety and security;

(I) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(J) habilitation, exclusive of day habilitation;

(34) ensure that HCS host home/companion care is provided:

(A) by a host home/companion care provider who lives in the residence in which no more than three individuals or other persons receiving similar services are living at any one time; and

(B) in a residence in which the program provider does not hold a property interest;

(35) ensure that host home/companion care is provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us, and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assistance with meal planning and preparation;

(C) securing and providing transportation;

(D) assistance with housekeeping;

(E) assistance with ambulation and mobility;

(F) reinforcement of professional therapy activities;

(G) assistance with medications and the performance of tasks delegated by an RN;

(H) supervision of individuals' safety and security;

(I) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(J) habilitation, exclusive of day habilitation;

(36) ensure that supervised living is provided:

(A) in a four-person residence that is approved in accordance with §9.188 of this subchapter (relating to DADS Approval of Residences) or a three-person residence;

(B) by a service provider who provides services and supports as needed by the individuals residing in the residence and is present in the residence and able to respond to the needs of the individuals during normal sleeping hours; and

(C) only with approval by the DADS commissioner or designee for the initial six months and one six-month extension and only with approval by the HHSC executive commissioner after such 12-month period, if provided to an individual under 22 years of age;

(37) ensure that supervised living is provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us, and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assistance with meal planning and preparation;

(C) securing and providing transportation;

(D) assistance with housekeeping;

(E) assistance with ambulation and mobility;

(F) reinforcement of professional therapy activities;

(G) assistance with medications and the performance of tasks delegated by an RN;

(H) supervision of individuals' safety and security;

(I) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(J) habilitation, exclusive of day habilitation;

(38) ensure that residential support is provided:

(A) in a four-person residence that is approved in accordance with §9.188 of this subchapter or a three-person residence;

(B) by a service provider who is present in the residence and awake whenever an individual is present in the residence;

(C) by service providers assigned on a daily shift schedule that includes at least one complete change of service providers each day; and

(D) only with approval by the DADS commissioner or designee for the initial six months and one six-month extension and only with approval by the HHSC executive commissioner after such 12-month period, if provided to an individual under 22 years of age;

(39) ensure that residential support is provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us, and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assistance with meal planning and preparation;

(C) securing and providing transportation;

(D) assistance with housekeeping;

(E) assistance with ambulation and mobility;

(F) reinforcement of professional therapy activities;

(G) assistance with medications and the performance of tasks delegated by an RN;

(H) supervision of individuals' safety and security;

(I) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(J) habilitation, exclusive of day habilitation;

(40) if making a recommendation to the service planning team that the individual receive residential support, document the reasons for the recommendation, which may include:

(A) the individual's medical condition;

(B) a behavior displayed by the individual that poses a danger to the individual or to others; or

(C) the individual's need for assistance with activities of daily living during normal sleeping hours;

(41) ensure that respite is available on a 24-hour increment or any part of that increment to individuals living in their family homes;

(42) ensure that respite is provided in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us and:

(A) includes:

(i) training in self-help and independent living skills;

(ii) providing room and board when respite is provided in a setting other than the individual's normal residence;

(iii) assisting with:

(I) ongoing provision of needed waiver services, excluding supported home living; and

(II) securing and providing transportation; and

(B) is only provided to individuals who are:

(i) not receiving residential support, supervised living, or host home/companion care; and

(ii) in need of emergency or planned short-term care when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances;

(43) provide respite in the residence of an individual or in other locations, including residences in which host home/companion care, supervised living, or residential support is provided or in a respite facility or camp, that meet HCS Program requirements and afford an environment that ensures the health, safety, comfort, and welfare of the individual.

(A) If respite is provided in the residence of another individual, the program provider must obtain permission from that individual or LAR and ensure that the respite visit will cause no threat to the health, safety, or welfare of that individual.

(B) If respite is provided in the residence of another individual, the program provider must ensure that:

(i) no more than three individuals receiving HCS Program services and persons receiving similar services for which the program provider is reimbursed are served in a residence in which host home/companion care is provided;

(ii) no more than three individuals receiving HCS Program services and persons receiving similar services for which the program provider is reimbursed are served in a residence in which only supervised living is provided; and

(iii) no more than four individuals receiving HCS Program services and persons receiving similar services for which the program provider is reimbursed are served in a residence in which residential support is provided.

(C) If respite is provided in a respite facility, the program provider must:

(i) ensure that the facility is not a residence;

(ii) ensure that no more than six individuals receive services in the facility at any one time; and

(iii) obtain written approval from the local fire authority having jurisdiction stating that the facility and its operation meet the local fire ordinances before initiating services in the facility if more than three individuals receive services in the facility at any one time.

(D) If respite is provided in a camp setting, the program provider must ensure the camp is accredited by the American Camp Association.

(E) The program provider must not provide respite in an institution such as an ICF/IID, skilled nursing facility, or hospital;

(44) ensure that employment assistance:

(A) is assistance provided to an individual to help the individual locate competitive employment in the community;

(B) consists of a service provider performing the following activities:

(i) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

(ii) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements;

(iii) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;

(iv) transporting an individual to help the individual locate competitive employment in the community; and

(v) participating in service planning team meetings;

(C) is provided in accordance with an individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us;

(D) is not provided to an individual with the individual present at the same time that respite, supported home living, day habilitation, or supported employment is provided; and

(E) does not include using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(i) paying an employer:

(I) to encourage the employer to hire an individual; or

(II) for supervision, training, support, or adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(ii) paying an individual:

(I) as an incentive to participate in employment assistance activities; or

(II) for expenses associated with the start-up costs or operating expenses of the individual's business;

(45) ensure that supported employment:

(A) is assistance provided to an individual:

(i) who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which persons without disabilities are employed;

(ii) in order for the individual to sustain competitive employment; and

(iii) in accordance with the individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us;

(B) consists of a service provider performing the following activities:

(i) making employment adaptations, supervising, and providing training related to an individual's assessed needs;

(ii) transporting an individual to support the individual to be self-employed, work from home, or perform in a work setting; and

(iii) participating in service planning team meetings;

(C) is not provided to an individual with the individual present at the same time that respite, supported home living, day habilitation, or employment assistance is provided; and

(D) does not include:

(i) sheltered work or other similar types of vocational services furnished in specialized facilities; or

(ii) using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses such as:

(I) paying an employer:

(-a-) to encourage the employer to hire an individual; or

(-b-) to supervise, train, support, or make adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(II) paying an individual:

(-a-) as an incentive to participate in supported employment activities; or

(-b-) for expenses associated with the start-up costs or operating expenses of the individual's business;

(46) inform the service coordinator of changes related to an individual's residential setting that do not require a change to the individual's IPC;

(47) maintain a system of delivering HCS Program services that is continuously responsive to changes in the individual's personal goals, condition, abilities, and needs as identified by the service planning team;

(48) ensure that appropriate staff members, service providers, and the service coordinator are informed of a circumstance or event that occurs in an individual's life or a change to an individual's condition that may affect the provision of services to the individual;

(49) maintain current information in the DADS data system about the individual and the individual's LAR, including:

(A) the individual's full name, address, location code, and phone number; and

(B) the LAR's full name, address, and phone number;

(50) maintain a single record related to HCS Program services provided to an individual for an IPC year that includes:

(A) the IPC;

(B) the PDP;

(C) the implementation plan;

(D) a behavior support plan, if one has been developed;

(E) documentation that describes the individual's progress or lack of progress on the implementation plan;

(F) documentation that describes any changes to an individual's personal goals, condition, abilities, or needs;

(G) the ID/RC Assessment;

(H) documentation supporting the recommended LON, including the ICAP booklet, assessments and interventions by qualified professionals, and time sheets of service providers;

(I) results and recommendations from individualized assessments;

(J) documentation concerning any use of restraint as described in §9.179(c)(2) and (3) of this subchapter (relating to Certification Principles: Restraint);

(K) documentation related to the individual's suspension from HCS Program services; and

(L) for an individual under 22 years of age, a copy of the permanency plan;

(51) upon request by the service coordinator:

(A) permit the service coordinator access to the record that is required by paragraph (50) of this subsection; and

(B) provide the service coordinator a legible copy of a document in the record at no charge to the service coordinator;

(52) provide a copy of the following documents to the service coordinator:

(A) an individual's IPC; and

(B) an individual's ID/RC Assessment;

(53) notify the service coordinator if the program provider has reason to believe that an individual is no longer eligible for HCS Program services or an individual or LAR has requested termination of all HCS Program services;

(54) if a physician delegates a medical act to an unlicensed service provider in accordance with Texas Occupations Code, Chapter 157, and the program provider has concerns about the health or safety of the individual in performance of the medical act, communicate the concern to the delegating physician and take additional steps as necessary to ensure the health and safety of the individual; and

(55) for an HCS Program service identified on the PDP as critical to meeting the individual's health and safety:

(A) develop a service backup plan that:

(i) contains the name of the critical service;

(ii) specifies the period of time in which an interruption to the critical service would result in an adverse effect to the individual's health or safety; and

(iii) in the event of a service interruption resulting in an adverse effect as described in clause (ii) of this subparagraph, describes the actions the program provider will take to ensure the individual's health and safety;

(B) ensure that:

(i) if the action in the service backup plan required by subparagraph (A) of this paragraph identifies a natural support, that the natural support receives pertinent information about the individual's needs and is able to protect the individual's health and safety; and

(ii) a person identified in the service backup plan, if paid to provide the service, meets the qualifications described in this subchapter; and

(C) if the service backup plan required by subparagraph (A) of this paragraph is implemented:

(i) discuss the implementation of the service backup plan with the individual and the service providers or natural supports identified in the service backup plan to determine whether or not the plan was effective;

(ii) document whether or not the plan was effective; and

(iii) revise the plan if the program provider determines the plan was ineffective.

(b) A program provider may suspend HCS Program services because an individual is temporarily admitted to a setting described in §9.155(d) of this subchapter (relating to Eligibility Criteria and Suspension of HCS Program Services).

(1) If a program provider suspends HCS Program services, the program provider must:

(A) notify DADS of the suspension by entering data in the DADS data system in accordance with DADS instructions; and

(B) notify the service coordinator of the suspension within one business day after services are suspended.

(2) A program provider may not suspend HCS Program services for more than 270 calendar days without approval from DADS as described in §9.190(e)(20)(C) of this subchapter.

(c) A program provider may determine that an individual does not require a nursing assessment if:

(1) nursing services are not on the individual's IPC and the program provider has determined that no nursing task will be performed by an unlicensed service provider as documented on DADS form "Nursing Task Screening Tool"; or

(2) a nursing task will be performed by an unlicensed service provider and a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician.

(d) If an individual or LAR refuses a nursing assessment described in subsection (a)(31)(J)(i) of this section, the program provider must not:

(1) provide nursing services to the individual; or

(2) provide host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, or day habilitation to the individual unless:

(A) an unlicensed service provider does not perform nursing tasks in the provision of the service; and

(B) the program provider determines that it can ensure the individual's health, safety, and welfare in the provision of the service.

(e) If an individual or LAR refuses a nursing assessment and the program provider determines that the program provider cannot ensure the individual's health, safety, and welfare in the provision of a service as described in subsection (c) of this section, the program provider must:

(1) immediately notify the individual or LAR and the individual's service coordinator, in writing, of the determination; and

(2) include in the notification required by paragraph (1) of this subsection the reasons for the determination and the services affected by the determination.

(f) If notified by the service coordinator that the individual or LAR refuses the nursing assessment after the discussion with the service coordinator as described in §9.190(e)(21)(A) of this subchapter, the program provider must immediately send the written notification described in subsection (e) of this section to DADS.

§9.177. Certification Principles: Staff Member and Service Provider Requirements.

(a) The program provider must ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs.

(b) The program provider must employ or contract with a person or entity of the individual's or LAR's choice in accordance with this subsection.

(1) Except as provided by paragraph (2) of this subsection, the program provider must employ or contract with a person or entity

of the individual's or LAR's choice to provide an HCS Program service to the individual if that person or entity:

(A) is qualified to provide the service;

(B) provides the service at or below the direct services portion of the applicable HCS Program rate; and

(C) is willing to contract with or be employed by the program provider to provide the service in accordance with this subchapter.

(2) The program provider may choose not to employ or contract with a person or entity of the individual's or LAR's choice in accordance with paragraph (1) of this subsection for good cause. The program provider must document the good cause.

(3) The requirement in paragraph (1)(B) of this subsection does not prohibit the program provider and the person or entity from agreeing to payment for the service in an amount that is more than the direct services portion of the applicable HCS Program rate.

(c) The program provider must comply with each applicable regulation required by the State of Texas in ensuring that its operations and staff members and service providers meet state certification, licensure, or regulation for any tasks performed or services delivered in part or in entirety for the HCS Program.

(d) The program provider must conduct initial and periodic training that ensures:

(1) staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services, including the use of restraint in accordance with §9.179 of this subchapter (relating to Certification Principles: Restraint); and

(2) staff members, service providers, and volunteers comply with §49.310(3)(A) of this title (relating to Abuse, Neglect, and Exploitation Allegations).

(e) The program provider must implement and maintain personnel practices that safeguard individuals against infectious and communicable diseases.

(f) The program provider's operations must prevent:

(1) conflicts of interest between the program provider, a staff member, or a service provider and an individual, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit, except payment for room and board;

(2) financial impropriety toward an individual including:

(A) unauthorized disclosure of information related to an individual's finances; and

(B) the purchase of goods that an individual cannot use with the individual's funds;

(3) abuse, neglect, or exploitation of an individual;

(4) damage to or prevention of an individual's access to the individual's possessions; and

(5) threats of the actions described in paragraphs (2) - (4) of this subsection.

(g) The program provider must employ or contract with a person who oversees the provision of HCS program services to an individual. The person must:

(1) have at least three years paid work experience in planning and providing HCS Program services to an individual with an intellectual disability or related condition as verified by written statements from the person's employer; or

(2) have both of the following:

(A) at least three years of experience planning and providing services similar to HCS Program services to a person with an intellectual disability or related condition as verified by written statements from organizations or agencies that provided services to the person; and

(B) participation as a member of a microboard as verified, in writing, by:

(i) the certificate of formation of the non-profit corporation under which the microboard operates filed with the Texas Secretary of State;

(ii) the bylaws of the non-profit corporation; and

(iii) a statement by the board of directors of the non-profit corporation that the person is a member of the microboard.

(h) The program provider must ensure that a service provider of day habilitation, supported home living, host home/companion care, supervised living, residential support, and respite services is at least 18 years of age and:

(1) has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or

(2) has documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:

(A) a written competency-based assessment of the ability to document service delivery and observations of the individuals to be served; and

(B) at least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.

(i) The program provider must ensure that each service provider of professional therapies is currently qualified by being licensed by the State of Texas or certified in the specific area for which services are delivered or be providing services in accordance with state law.

(j) The program provider must ensure that a service provider of behavioral support services:

(1) is licensed as a psychologist in accordance with Texas Occupations Code, Chapter 501;

(2) is licensed as a psychological associate in accordance with Texas Occupations Code, Chapter 501;

(3) has been issued a provisional license to practice psychology in accordance with Texas Occupations Code, Chapter 501;

(4) is certified by DADS as described in §5.161 of this title (relating to TDMHMR-Certified Psychologist);

(5) is licensed as a licensed clinical social worker in accordance with Texas Occupations Code, Chapter 505;

(6) is licensed as a licensed professional counselor in accordance with Texas Occupations Code, Chapter 503; or

(7) is certified as a behavior analyst by the Behavior Analyst Certification Board, Inc.

(k) The program provider must ensure that a service provider who provides transportation:

(1) has a valid driver's license; and

(2) transports individuals in a vehicle insured in accordance with state law.

(l) The program provider must ensure that dental treatment is provided by a dentist currently qualified by being licensed in the State of Texas by the Texas State Board of Dental Examiners in accordance with Texas Occupations Code, Chapter 256.

(m) The program provider must ensure that nursing services are provided by a nurse who is currently qualified by being licensed by the Texas Board of Nursing as an RN or LVN.

(n) The program provider must comply with §49.304 of this title (relating to Background Checks).

(o) A program provider must comply with §49.312(a) of this title (relating to Personal Attendants).

(p) If the service provider of supported home living is employed by or contracts with a contractor of a program provider, the program provider must ensure that the contractor complies with subsection (o) of this section as if the contractor were the program provider.

(q) The program provider must ensure that a service provider of cognitive rehabilitation therapy is:

(1) a psychologist licensed in accordance with Texas Occupations Code, Chapter 501;

(2) a speech-language pathologist licensed in accordance with Texas Occupations Code, Chapter 401; or

(3) an occupational therapist licensed in accordance with Texas Occupations Code, Chapter 454.

(r) The program provider must ensure that a service provider of employment assistance or a service provider of supported employment is at least 18 years of age, is not the LAR of the individual receiving employment assistance or supported employment from the service provider, and has:

(1) a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;

(2) an associate's degree in rehabilitation, business, marketing, or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or

(3) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities.

(s) A program provider must ensure that the experience required by subsection (r) of this section is evidenced by:

(1) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and

(2) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

§9.178. Certification Principles: Quality Assurance.

(a) In the provision of HCS Program services to an individual, the program provider must promote the active and maximum cooperation with generic service agencies, non-HCS Program service providers, and advocates or other actively involved persons.

(b) The program provider must ensure personalized service delivery based upon the choices made by each individual or LAR and those choices that are available to persons without an intellectual disability or other disability.

(c) Before providing services to an individual in a residence in which host home/companion care, supervised living, or residential support is provided, and annually thereafter, the program provider must:

(1) conduct an on-site inspection to ensure that, based on the individual's needs, the environment is healthy, comfortable, safe, appropriate, and typical of other residences in the community, suited for the individual's abilities, and is in compliance with applicable federal, state, and local regulations for the community in which the individual lives;

(2) ensure that the service coordinator is provided with a copy of the results of the on-site inspection within five calendar days after completing the inspection;

(3) complete any action identified in the on-site inspection for a residence in which supervised living or residential support will be provided to ensure that the residence meets the needs of the individual; and

(4) ensure completion of any action identified in the on-site inspection for a residence in which host home/companion care will be provided to ensure that the residence meets the needs of the individual.

(d) The program provider must ensure that:

(1) emergency plans are maintained in each residence in which host home/companion care, supervised living or residential support is provided;

(2) the emergency plans address relevant emergencies appropriate for the type of service, geographic location, and the individuals living in the residence;

(3) the individuals and service providers follow the plans during drills and actual emergencies; and

(4) documentation of drills and responses to actual emergencies are maintained in each residence.

(e) A program provider must comply with the requirements in this subsection regarding a four-person residence.

(1) Before providing residential support in a four-person residence, the program provider must:

(A) ensure that the four-person residence meets one of the following:

(i) is certified by:

(I) the local fire safety authority having jurisdiction in the location of the residence as being in compliance with the applicable portions of the National Fire Protection Association 101: Life Safety Code (Life Safety Code) as determined by the local fire safety authority;

(II) the local fire safety authority having jurisdiction in the location of the residence as being in compliance with the applicable portions of the International Fire Code (IFC) as determined by the local fire safety authority; or

(III) the Texas State Fire Marshal's Office as being in compliance with the applicable portions of the Life Safety Code as determined by the Texas State Fire Marshal's Office; or

(ii) as described in paragraph (2) of this subsection, is certified by DADS as being in compliance with the portions of the

Life Safety Code applicable to small residential board and care facilities and most recently adopted by the Texas State Fire Marshal's Office; and

(B) obtain DADS approval of the residence in accordance with §9.188 of this subchapter (relating to DADS Approval of Residences).

(2) DADS inspects for certification as described in paragraph (1)(A)(ii) of this subsection only if the program provider submits to DADS Architectural Unit:

(A) one of the following:

(i) if the four-person residence is located in a jurisdiction with a local fire safety authority:

(I) a completed DADS Form 5606 available at www.dads.state.tx.us documenting that the local fire safety authority having jurisdiction refused to inspect for certification using the code (i.e. the Life Safety Code or IFC) for that jurisdiction; and

(II) written documentation from the Texas State Fire Marshal's Office that it refused to inspect for certification using the Life Safety Code; or

(ii) if the four-person residence is located in a jurisdiction without a local fire safety authority, written documentation from the Texas State Fire Marshal's Office that it refused to inspect for certification using the Life Safety Code; and

(B) a completed DADS form "Request for Life Safety Inspection-HCS Four-Person Home" available at www.dads.state.tx.us.

(3) The program provider must:

(A) obtain the certification required by paragraph (1)(A) of this subsection annually; and

(B) ensure that a four-person residence:

(i) contains a copy of the most recent inspection of the residence by the local fire safety authority, Texas State Fire Marshal's Office, or DADS; and

(ii) is in continuous compliance with all applicable local building codes and ordinances and state and federal laws, rules, and regulations.

(f) The program provider must establish an ongoing consumer/advocate advisory committee composed of individuals, LARs, community representatives, and family members that meets at least quarterly. The committee:

(1) at least annually, reviews the information provided to the committee by the program provider in accordance with subsection (p)(6) of this section; and

(2) based on the information reviewed, makes recommendations to the program provider for improvements to the processes and operations of the program provider.

(g) The program provider must make available all records, reports, and other information related to the delivery of HCS Program services as requested by DADS, other authorized agencies, or the Centers for Medicare and Medicaid Services and deliver such items, as requested, to a specified location.

(h) The program provider must conduct, at least annually, a satisfaction survey of individuals and LARs and take action regarding any areas of dissatisfaction.

(i) The program provider must comply with §49.309 of this title (relating to Complaint Process).

(j) The program provider must:

(1) ensure that the individual and LAR are informed of how to report allegations of abuse, neglect, or exploitation to DFPS and are provided with the DFPS toll-free telephone number (1-800-647-7418) in writing;

(2) comply with §49.310(4) of this title (relating to Abuse, Neglect, and Exploitation Allegations); and

(3) ensure that all staff members, service providers, and volunteers:

(A) are instructed to report to DFPS immediately, but not later than one hour after having knowledge or suspicion, that an individual has been or is being abused, neglected, or exploited;

(B) are provided with the DFPS toll-free telephone number (1-800-647-7418) in writing; and

(C) comply with §49.310(3)(B) of this title.

(k) If the program provider suspects an individual has been or is being abused, neglected, or exploited or is notified of an allegation of abuse, neglect, or exploitation, the program provider must take necessary actions to secure the safety of the individual, including:

(1) obtaining immediate and ongoing medical or psychological services for the individual as necessary;

(2) if necessary, restricting access by the alleged perpetrator of the abuse, neglect, or exploitation to the individual or other individuals pending investigation of the allegation; and

(3) notifying, as soon as possible but no later than 24 hours after the program provider reports or is notified of an allegation, the individual, the individual's LAR, and the service coordinator of the allegation report and the actions that have been or will be taken.

(l) Staff members, service providers, and volunteers must cooperate with the DFPS investigation of an allegation of abuse, neglect, or exploitation, including:

(1) providing complete access to all HCS Program service sites owned, operated, or controlled by the program provider;

(2) providing complete access to individuals and program provider personnel;

(3) providing access to all records pertinent to the investigation of the allegation; and

(4) preserving and protecting any evidence related to the allegation in accordance with DFPS instructions.

(m) The program provider must:

(1) promptly, but not later than five calendar days after the program provider's receipt of a DFPS investigation report:

(A) notify the individual, the LAR, and the service coordinator of:

(i) the investigation finding; and

(ii) the corrective action taken by the program provider in response to the DFPS investigation; and

(B) notify the individual or LAR of:

(i) the process to appeal the investigation finding as described in Chapter 711, Subchapter M of this title (relating to Re-

questing an Appeal if You are the Reporter, Alleged Victim, Legal Guardian, or with Disability Rights Texas); and

(ii) the process for requesting a copy of the investigative report from the program provider;

(2) report to DADS in accordance with DADS instructions the program provider's response to the DFPS investigation that involves a staff member or service provider within 14 calendar days after the program provider's receipt of the investigation report; and

(3) upon request of the individual or LAR, provide to the individual or LAR a copy of the DFPS investigative report after concealing any information that would reveal the identity of the reporter or of any individual who is not the alleged victim.

(n) If abuse, neglect, or exploitation is confirmed by the DFPS investigation, the program provider must take appropriate action to prevent the reoccurrence of abuse, neglect or exploitation, including, when warranted, disciplinary action against or termination of the employment of a staff member confirmed by the DFPS investigation to have committed abuse, neglect, and exploitation.

(o) In all respite facilities and all residences in which a service provider of residential assistance or the program provider hold a property interest, the program provider must post in a conspicuous location:

(1) the name, address, and telephone number of the program provider;

(2) the effective date of the contract; and

(3) the name of the legal entity named on the contract.

(p) At least annually, the program provider must:

(1) evaluate information about the satisfaction of individuals and LARs with the program provider's services and identify program process improvements to increase the satisfaction;

(2) review complaints, as described in §49.309 of this title, and identify program process improvements to reduce the filing of complaints;

(3) review incidents of abuse, neglect, or exploitation and identify program process improvements that will prevent the reoccurrence of such incidents and improve service delivery;

(4) review the reasons for terminating HCS Program services to individuals and identify any related need for program process improvements;

(5) evaluate critical incident data described in subsection (y) of this section and compare its use of restraint to aggregate data provided by DADS at www.dads.state.tx.us and identify program process improvements that will prevent the reoccurrence of restraints and improve service delivery;

(6) provide all information the program provider reviewed, evaluated, and created as described in paragraphs (1) - (5) of this subsection to the consumer/advocate advisory committee required by subsection (f) of this section;

(7) implement any program process improvements identified by the program provider in accordance with this subsection; and

(8) review recommendations made by the consumer/advocate advisory committee as described in subsection (f)(2) of this section and implement the recommendations approved by the program provider.

(q) The program provider must ensure that all personal information concerning an individual, such as lists of names, addresses, and records obtained by the program provider is kept confidential, that the use or disclosure of such information and records is limited to purposes directly connected with the administration of the program provider's HCS Program, and is otherwise neither directly nor indirectly used or disclosed unless the consent of the individual to whom the information applies or his or her LAR is obtained beforehand.

(r) The program provider must comply with this subsection regarding charges against an individual's personal funds.

(1) The program provider must, in accordance with this paragraph, collect a monthly amount for room from an individual who lives in a three-person or four-person residence. The cost for room must consist only of:

(A) an amount equal to:

(i) rent of a comparable dwelling in the same geographical area that is unfurnished; or

(ii) the program provider's ownership expenses, limited to the interest portion of a mortgage payment, depreciation expense, property taxes, neighborhood association fees, and property insurance; and

(B) the cost of:

(i) shared appliances, electronics, and housewares;

(ii) shared furniture;

(iii) monitoring for a security system;

(iv) monitoring for a fire alarm system;

(v) property maintenance, including personnel costs, supplies, lawn maintenance, pest control services, carpet cleaning, septic tank services, and painting;

(vi) utilities, limited to electricity, gas, water, garbage collection, and a landline telephone; and

(vii) shared television and Internet service used by the individuals who live in the residence.

(2) Except as provided in subparagraphs (B) and (C) of this paragraph, a program provider must collect a monthly amount for board from an individual who lives in a three-person or four-person residence.

(A) The cost for board must consist only of the cost of food, including food purchased for an individual to consume while away from the residence as a replacement for food and snacks normally prepared in the residence, and of supplies used for cooking and serving, such as utensils and paper products.

(B) A program provider is not required to collect a monthly amount for board from an individual if collecting such an amount may make the individual ineligible for the Supplemental Nutrition Assistance Program operated by HHSC.

(C) A program provider must not collect a monthly amount for board from an individual if the individual chooses to purchase the individual's own food, as documented in the individual's implementation plan.

(3) To determine the maximum room and board charge for each individual, a program provider must:

(A) divide the room cost described in paragraph (1) of this subsection by the number of residents receiving HCS Program services or similar services that the residence has been developed to support plus the number of service providers and other persons who live in the residence;

(B) divide the board cost described in paragraph (2) of this subsection by the number of persons consuming the food; and

(C) add the amounts calculated in accordance with subparagraphs (A) and (B) of this paragraph.

(4) A program provider must not increase the charge for room and board because a resident moves from the residence.

(5) A program provider:

(A) must not charge an individual a room and board amount that exceeds an amount determined in accordance with paragraphs (1) - (3) of this subsection; and

(B) must maintain documentation demonstrating that the room and board charge was determined in accordance with paragraphs (1) - (3) of this subsection.

(6) Before an individual or LAR selects a residence, a program provider must provide the room and board charge, in writing, to the individual or LAR.

(7) Except as provided in paragraph (8) of this subsection, a program provider may not charge or collect payment from any person for room and board provided to an individual receiving host home/companion care.

(8) If a program provider makes a payment to an individual's host home/companion care provider while waiting for the individual's federal or state benefits to be approved, the program provider may seek reimbursement from the individual for such payments.

(9) A program provider who manages personal funds of an individual who receives host home/companion care:

(A) may pay a room and board charge for the individual that is less than the foster/companion care provider's cost of room and board, as determined using the calculations described in paragraphs (1) and (2) of this subsection for a three-person or four-person residence, divided by the number of persons living in the host home/companion care provider's home;

(B) must pay the host home/companion care provider directly from the individual's account; and

(C) must not pay a host home/companion care provider a room and board charge that exceeds the host home/companion care provider's cost of room and board, as determined using the calculations described in paragraphs (1) and (2) of this subsection for a three-person or four-person residence, divided by the number of persons living in the host home/companion care provider's home.

(10) For an item or service other than room and board, the program provider must apply a consistent method in assessing a charge against the individual's personal funds that ensures that the charge for the item or service is reasonable and comparable to the cost of a similar item or service generally available in the community.

(s) The program provider must ensure that the individual or LAR has agreed in writing to all charges assessed by the program provider against the individual's personal funds before the charges are assessed.

(t) The program provider must not assess charges against the individual's personal funds for costs for items or services reimbursed through the HCS Program.

(u) At the written request of an individual or LAR, the program provider must manage the individual's personal funds entrusted to the program provider, without charge to the individual or LAR in accordance with this subsection.

(1) The program provider must not commingle the individual's personal funds with the program provider's funds.

(2) The program provider must maintain a separate, detailed record of:

(A) all deposits into the individual's account; and

(B) all expenditures from the individual's account that includes:

(i) the amount of the expenditure;

(ii) the date of the expenditure;

(iii) the person to whom the expenditure was made;

(iv) except as described in clause (vi) of this subparagraph, a written statement issued by the person to whom the expenditure was made that includes the date the statement was created and the cost of the item or service paid for;

(v) if the statement described in clause (iv) of this subparagraph documents an expenditure for more than one individual, the amount allocated to each individual identified on the statement; and

(vi) if the expenditure is made to the individual for personal spending money, an acknowledgement signed by the individual indicating that the funds were received.

(3) The program provider may accrue an expense for necessary items and services for which the individual's personal funds are not available for payment, such as room and board, medical and dental services, legal fees or fines, and essential clothing.

(4) If an expense is accrued as described in paragraph (3) of this subsection, the program provider must enter into a written payment plan with the individual or LAR for reimbursement of the funds.

(v) If the program provider determines that an individual's behavior may require the implementation of behavior management techniques involving intrusive interventions or restriction of the individual's rights, the program provider must comply with this subsection.

(1) The program provider must:

(A) obtain an assessment of the individual's needs and current level and severity of the behavior; and

(B) ensure that a service provider of behavioral support services:

(i) develops, with input from the individual, LAR, program provider, and actively involved persons, a behavior support plan that includes the use of techniques appropriate to the level and severity of the behavior; and

(ii) considers the effects of the techniques on the individual's physical and psychological well-being in developing the plan.

(2) The behavior support plan must:

(A) describe how the behavioral data concerning the behavior is collected and monitored;

(B) allow for the decrease in the use of the techniques based on the behavioral data; and

(C) allow for revision of the plan when desired behavior is not displayed or the techniques are not effective.

(3) Before implementation of the behavior support plan, the program provider must:

(A) obtain written consent from the individual or LAR to implement the plan;

(B) provide written notification to the individual or LAR of the right to discontinue implementation of the plan at any time; and

(C) notify the individual's service coordinator of the plan.

(4) The program provider must, at least annually:

(A) review the effectiveness of the techniques and determine whether the behavior support plan needs to be continued; and

(B) notify the service coordinator if the plan needs to be continued.

(w) The program provider must report the death of an individual to DADS and the service coordinator by the end of the next business day following the death or the program provider's learning of the death and, if the program provider reasonably believes that the LAR does not know of the individual's death, to the LAR as soon as possible, but not later than 24 hours after the program provider learns of the individual's death.

(x) A program provider must not discharge or otherwise retaliate against:

(1) a staff member, service provider, individual, or other person who files a complaint, presents a grievance, or otherwise provides good faith information relating to the:

(A) misuse of restraint by the program provider;

(B) use of seclusion by the program provider; or

(C) possible abuse, neglect, or exploitation of an individual; or

(2) an individual because someone on behalf of the individual files a complaint, presents a grievance, or otherwise provides good faith information relating to the:

(A) misuse of restraint by the program provider;

(B) use of seclusion by the program provider; or

(C) possible abuse, neglect, or exploitation of an individual.

(y) A program provider must enter critical incident data in the DADS data system no later than 30 calendar days after the last day of the month being reported in accordance with the HCS Provider User Guide.

(z) The program provider must ensure that:

(1) the name and phone number of an alternate to the CEO of the program provider is entered in the DADS data system; and

(2) the alternate to the CEO:

(A) performs the duties of the CEO during the CEO's absence; and

(B) acts as the contact person in a DFPS investigation if the CEO is named as an alleged perpetrator of abuse, neglect, or exploitation of an individual and complies with subsections (k) - (n) of this section.

§9.190. Local Authority Requirements for Providing Service Coordination in the HCS Program.

(a) In addition to the requirements described in Chapter 2, Subchapter L of this title (relating to Service Coordination for Individuals with an Intellectual Disability), a local authority must, in the provision of service coordination in the HCS Program, ensure compliance with the requirements in this subchapter.

(b) The local authority must employ service coordinators who:

(1) meet the minimum qualifications and local authority staff training requirements specified in Chapter 2, Subchapter L of this title; and

(2) have received training about the HCS Program, including the requirements of this subchapter and the HCS Program services specified in §9.154 of this subchapter (relating to Description of the HCS Program).

(c) A local authority must have a process for receiving and resolving complaints from a program provider related to the local authority's provision of service coordination or the local authority's process to enroll an applicant in the HCS Program.

(d) If, as a result of monitoring, the service coordinator identifies a concern with the implementation of the PDP, the local authority must ensure that the concern is communicated to the program provider and attempts made to resolve the concern. The local authority may refer an unresolved concern to DADS Consumer Rights and Services.

(e) A service coordinator must:

(1) assist an individual or LAR in exercising the legal rights of the individual as a citizen and as a person with a disability;

(2) provide an applicant or individual, LAR, or family member with a written copy of the rights of the individual as described in §9.173(b) of this subchapter (relating to Certification Principles: Rights of Individuals) and the booklet titled *Your Rights In a Home and Community-Based Services Program* (which is found at www.dads.state.tx.us.) and an oral explanation of such rights:

(A) upon enrollment in the HCS program;

(B) upon revision of the booklet;

(C) upon request; and

(D) upon change in an individual's legal status (that is when the individual turns 18 years of age, is appointed a guardian, or loses a guardian);

(3) document the provision of the rights described in §9.173(b) of this subchapter and the booklet and oral explanation required by paragraph (2) of this subsection and ensure that the documentation is signed by:

(A) the individual or LAR; and

(B) the service coordinator;

(4) ensure that, at the time an applicant is enrolled, the applicant or LAR is informed orally and in writing of the following processes for filing complaints:

(A) processes for filing complaints with the local authority about the provision of service coordination; and

(B) processes for filing complaints about the provision of HCS Program services including:

(i) the telephone number of the local authority to file a complaint;

(ii) the toll-free telephone number of DADS to file a complaint; and

(iii) the toll-free telephone number of DFPS (1-800-647-7418) to report an allegation of abuse, neglect, or exploitation;

(5) maintain for an individual for an IPC year:

(A) a copy of the IPC;

(B) the PDP;

(C) a copy of the ID/RC Assessment;

(D) documentation of the activities performed by the service coordinator in providing service coordination; and

(E) any other pertinent information related to the individual;

(6) initiate, coordinate, and facilitate person-directed planning;

(7) develop for an individual a full range of services and resources using generic service agencies, non-HCS Program service providers, and advocates or other actively involved persons to meet the needs of the individual as those needs are identified;

(8) ensure that the PDP for an applicant or individual:

(A) is developed, reviewed, and updated in accordance with:

(i) §9.158(k)(3) of this subchapter (relating to Process for Enrollment of Applicants);

(ii) §9.166 of this subchapter (relating to Renewal and Revision of an IPC); and

(iii) §2.556 of this title (relating to MRA's Responsibilities);

(B) states, for each HCS program service, whether the service is critical to the individual's health and safety as determined by the service planning team;

(9) participate in the development, renewal, and revision of an individual's IPC in accordance with §9.158 and §9.166 of this subchapter;

(10) ensure that the service planning team participates in the renewal and revision of the IPC for an individual in accordance with §9.166 of this subchapter and ensure that the service planning team completes other responsibilities and activities as described in this subchapter;

(11) notify the service planning team of the information conveyed to the service coordinator pursuant to §9.178(v)(3)(C) and (4)(B) of this subchapter (relating to Certification Principle: Quality Assurance);

(12) if a change to an individual's PDP is needed, other than as required by §9.166 of this subchapter:

(A) communicate the need for the change to the individual or LAR, the program provider, and other appropriate persons; and

(B) revise the PDP as necessary;

(13) provide an individual's program provider a copy of the individual's current PDP;

(14) monitor the delivery of HCS Program and non-HCS Program services to an individual;

(15) document whether an individual progresses toward desired outcomes identified on the individual's PDP;

(16) together with the program provider, ensure the coordination and compatibility of HCS Program services with non-HCS Program services;

(17) for an individual who has had a guardian appointed, determine, at least annually, if the letters of guardianship are current;

(18) for an individual who has not had a guardian appointed, make a referral of guardianship to a court, if appropriate;

(19) immediately notify the program provider if the service coordinator becomes aware that an emergency necessitates the provision of an HCS Program service to ensure the individual's health or safety and the service is not on the IPC or exceeds the amount on the IPC;

(20) if informed by the program provider that an individual's HCS Program services have been suspended:

(A) request the program provider enter necessary information in the DADS data system to inform DADS of the suspension;

(B) review the individual's status and document in the individual's record the reasons for continuing the suspension, at least every 90 calendar days after the effective date of the suspension; and

(C) to continue suspension of the services for more than 270 calendar days, submit to DADS written documentation of each review made in accordance with subparagraph (B) of this paragraph and a request for approval by DADS to continue the suspension;

(21) if notified by the program provider that an individual or LAR has refused a nursing assessment and that the program provider has determined it cannot ensure the individual's health, safety, and welfare in the provision of a service as described in §9.174(e) of this title (relating to Certification Principles: Service Delivery):

(A) inform the individual or LAR of the consequences and risks of refusing the assessment, including that the refusal will result in the individual not receiving:

(i) nursing services; or

(ii) host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, or day habilitation, if the individual needs one of those services and the program provider has determined that it cannot ensure the health and safety of the individual in the provision of the service; and

(B) notify the program provider if the individual or LAR continues to refuse the assessment after the discussion with the service coordinator;

(22) notify the program provider if the service coordinator becomes aware that an individual has been admitted to a setting described in §9.155(d) of this subchapter (relating to Eligibility Criteria and Suspension of HCS Program Services);

(23) if the service coordinator determines that HCS Program services provided to an individual should be terminated, including for a reason described in §9.158(l)(11) of this subchapter:

(A) document a description of:

(i) the situation that resulted in the service coordinator's determination that services should be terminated;

(ii) the attempts by the service coordinator to resolve the situation; and

(B) send a written request to terminate the individual's HCS Program services to DADS and include the documentation required by subparagraph (A) of this paragraph;

(C) provide a copy of the written request and the documentation required by subparagraph (A) of this paragraph to the program provider;

(24) if an individual requests termination of all HCS Program services, the service coordinator must, within ten calendar days after the individual's request:

(A) inform the individual or LAR of:

(i) the individual's option to transfer to another program provider;

(ii) the consequences of terminating HCS Program services; and

(iii) possible service resources upon termination; and

(B) submit documentation to DADS that:

(i) states the reason the individual is making the request; and

(ii) demonstrates that the individual or LAR was provided the information required by subparagraph (A)(ii) and (iii) of this paragraph;

(25) manage the process to transfer an individual's HCS Program services from one program provider to another or one FMSA to another in accordance with DADS instructions, including:

(A) informing the individual or LAR who requests a transfer to another program provider or FMSA that the service coordinator will manage the transfer process;

(B) informing the individual or LAR that the individual or LAR may choose to receive HCS Program services from any available program provider (that is, a program provider whose enrollment has not reached its service capacity in the DADS data system) or FMSA; and

(C) if the individual or LAR has not selected another program provider or FMSA, provide the individual or LAR a list of available HCS Program providers and FMSAs and contact information in the geographic locations preferred by the individual or LAR;

(26) be objective in assisting an individual or LAR in selecting a program provider or FMSA;

(27) at the time of assignment and as changes occur, ensure that an individual and LAR and program provider are informed of the name of the individual's service coordinator and how to contact the service coordinator;

(28) unless contraindications are documented with justification by the service planning team, ensure that a school-age individual receives educational services in a six-hour-per-day program, five days per week, provided by the local school district and that no individual receives educational services at a state supported living center or at a state center;

(29) unless contraindications are documented with justification by the service planning team, ensure that an adult individual under retirement age is participating in a day activity of the individual's choice that promotes achievement of PDP outcomes for at least six hours per day, five days per week;

(30) unless contraindications are documented with justification by the service planning team, ensure that a pre-school-age individual receives an early childhood education with appropriate activities and services, including small group and individual play with peers without disabilities;

(31) unless contraindications are documented with justification by the service planning team, ensure that an individual of retirement age has opportunities to participate in day activities appropriate to individuals of the same age and consistent with the individual's or LAR's choice;

(32) unless contraindications are documented with justification by the service planning team, ensure that each individual is offered choices and opportunities for accessing and participating in community activities and experiences available to peers without disabilities;

(33) assist an individual to meet as many of the individual's needs as possible by using generic community services and resources in the same way and during the same hours as these generic services are used by the community at large;

(34) for an individual receiving host home/companion care, residential support, or supervised living, ensure that the individual or LAR is involved in planning the individual's residential relocation, except in a case of an emergency;

(35) if the program provider notifies the service coordinator that the program provider is unable to locate the parent or LAR in accordance with §9.174(a)(8)(D) of this subchapter (relating to Certification Principles: Service Delivery) or the local authority notifies the service coordinator that the local authority is unable to locate the parent or LAR in accordance with §9.167(b)(9) of this subchapter (relating to Permanency Planning):

(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (37)(A) - (B) of this subsection; and

(B) notify DADS, no later than 30 calendar days after the date the service coordinator determines the service coordinator is unable to locate the parent or LAR, of the determination and request that DADS initiate a search for the parent or LAR;

(36) if the service coordinator determines that a parent's or LAR's contact information described in paragraph (37)(A) of this subsection is no longer current:

(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (37)(B) of this subsection; and

(B) notify DADS, no later than 30 calendar days after the date the service coordinator determines the service coordinator is unable to locate the parent or LAR, of the determination and request that DADS initiate a search for the parent or LAR;

(37) request from and encourage the parent or LAR of an individual under the age of 22 years requesting or receiving supervised living or residential support to provide the service coordinator with the following information:

(A) the parent's or LAR's:

(i) name;

(ii) address;

(iii) telephone number;

(iv) driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(v) place of employment and the employer's address and telephone number;

(B) name, address, and telephone number of a relative of the individual or other person whom DADS or the service coordinator may contact in an emergency situation, a statement indicating the relationship between that person and the individual, and at the parent's or LAR's option:

(i) that person's driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer; and

(C) a signed acknowledgement of responsibility stating that the parent or LAR agrees to:

(i) notify the service coordinator of any changes to the contact information submitted; and

(ii) make reasonable efforts to participate in the individual's life and in planning activities for the individual;

(38) within three business days after initiating supervised living or residential support to an individual under 22 years of age:

(A) provide the information listed in subparagraph (B) of this paragraph to the following:

(i) the CRCG for the county in which the individual's LAR lives (see www.hhsc.state.tx.us for a listing of CRCG chairpersons by county); and

(ii) the local school district for the area in which the three- or four-person residence is located, if the individual is at least three years of age, or the early childhood intervention (ECI) program for the county in which the residence is located, if the individual is less than three years of age (see http://www.dars.state.tx.us/ecis/searchprogram.asp to search for an ECI program by zip code or by county); and

(B) as required by subparagraph (A) of this paragraph, provide the following information to the entities described in subparagraph (A) of this paragraph:

(i) the individual's full name;

(ii) the individual's gender;

(iii) the individual's ethnicity;

(iv) the individual's birth date;

(v) the individual's social security number;

(vi) the LAR's name, address, and county of residence;

(vii) the date of initiation of supervised living or residential support;

(viii) the address where supervised living or residential support is provided; and

(ix) the name and phone number of the person providing the information; and

(39) for an applicant or individual under 22 years of age seeking or receiving supervised living or residential support:

(A) make reasonable accommodations to promote the participation of the LAR in all planning and decision making regarding the individual's care, including participating in:

(i) the initial development and annual review of the individual's PDP;

(ii) decision making regarding the individual's medical care;

(iii) routine service planning team meetings; and

(iv) decision making and other activities involving the individual's health and safety;

(B) ensure that reasonable accommodations include:

(i) conducting a meeting in person or by telephone, as mutually agreed upon by the program provider and the LAR;

(ii) conducting a meeting at a time and location, if the meeting is in person, that is mutually agreed upon by the program provider and the LAR;

(iii) if the LAR has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act, including providing an accessible meeting location or a sign language interpreter, if appropriate; and

(iv) providing a language interpreter, if appropriate;

(C) provide written notice to the LAR of a meeting to conduct an annual review of the individual's PDP at least 21 calendar days before the meeting date and request a response from the LAR regarding whether the LAR intends to participate in the annual review;

(D) before an individual who is under 18 years of age, or who is 18-22 years of age and has an LAR, moves to another residence operated by the program provider, attempt to obtain consent for the move from the LAR unless the move is made because of a serious risk to the health or safety of the individual or another person; and

(E) document compliance with subparagraphs (A) - (D) of this paragraph in the individual's record.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403646
Lawrence Hornsby
General Counsel
Department of Aging and Disability Services
Effective date: September 1, 2014
Proposal publication date: April 18, 2014
For further information, please call: (512) 438-4162

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40 TAC §9.185, §9.193

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that

operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Lawrence Hornsby
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Department of Aging and Disability Services
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For further information, please call: (512) 438-4162

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SUBCHAPTER N. TEXAS HOME LIVING (TxHmL) PROGRAM

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §9.551, concerning purpose; §9.552, concerning application; §9.553, concerning definitions; §9.554, concerning description of the Texas Home Living (TxHmL) Program; §9.555, concerning definitions of TxHmL Program service components; §9.556, concerning eligibility criteria; §9.558, concerning individual plan of care (IPC); §9.560, concerning level of care (LOC) determination; §9.561, concerning lapsed LOC; §9.562, concerning level of need (LON) assignment; §9.563, concerning DADS review of LON; §9.566, concerning notification of applicants; §9.567, concerning process for enrollment; §9.568, concerning revisions and renewals of IPCs, LOCs, and LONs for enrolled individuals; §9.570, concerning permanent discharge from TxHmL Program and suspension of TxHmL Program services; §9.571, concerning fair hearings; §9.572, concerning other program provider requirements; §9.573, concerning reimbursement; §9.574, concerning record retention; §9.575, concerning program provider's right to administrative hearing; §9.576, concerning program provider certification and review; §9.578, concerning program provider certification principles: service delivery; §9.579, concerning certification principles: qualified personnel; §9.580, concerning certification principles: quality assurance; §9.582, concerning compliance with TxHmL program principles for local authorities; and §9.583, concerning TxHmL program principles for local authorities; new §9.577, concerning program provider compliance and corrective action and §9.584, concerning certification principles: prohibitions; and the repeal of §9.557, concerning calculation of co-payment; §9.559, concerning request to increase service category limits; §9.569, concerning coordination of transfers; and §9.577, concerning program provider compliance and corrective action, in Subchapter N, Texas Home Living (TxHmL) Program, in Chapter 9, Intellectual Disability Services--Medicaid State Operating Agency Responsibilities. The amendments to §§9.553 - 9.555, 9.558, 9.567, 9.573, 9.578 - 9.580, and 9.583 are adopted with changes to the proposed text published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3078). The amendments to §§9.551, 9.552, 9.556, 9.560 - 9.563, 9.566, 9.568, 9.570 - 9.572, 9.574 - 9.576, and 9.582; new §9.577 and §9.584; and the repeal of §§9.557, 9.559, 9.569, and 9.577 are adopted without changes to the proposed text.

The adopted rules implement a directive from the Centers for Medicare and Medicaid Services (CMS) to more effectively address the assurance set forth in the TxHmL waiver application about health and safety. Specifically, to address this assurance, the adopted rules add a requirement for a TxHmL program provider to develop a service backup plan for a TxHmL Program service identified by the service planning team on the person directed plan as critical to meeting the individual's health and safety and revise the plan if the program provider determines the service backup plan is ineffective.

In addition, the adopted rules change DADS review process of TxHmL providers. Specifically, the adopted rules state that DADS does not certify a provider for a new certification period if (1) at a review other than an initial review, the provider is not providing TxHmL Program services to any individuals, and (2) from the beginning of the certification period through the 121st day before the end of the current period, the program provider did not provide services for at least 60 consecutive days. This requirement is included to ensure that program providers who are not actively providing services and, therefore, not acquiring necessary expertise as a program provider, re-establish their qualifications through the contract application process if they want to be a TxHmL Program provider. The adopted rules further state that if DADS imposes a vendor hold against a program provider with a provisional contract, DADS initiates termination of the contract. This process helps ensure a high quality provider base by terminating the contracts of program providers who are underperforming in the initial contract period, thereby requiring those providers to demonstrate their qualifications through the contract application process if they want to be a TxHmL Program provider.

The adopted rules delete the description of the action DADS takes if a program provider is out of compliance with a specific percentage of certification principles and describe DADS action based on whether the program provider's failure to comply results in a condition of a serious or pervasive nature. This provides a fairer and more effective way to determine the action or sanction to impose. The adopted rules require DADS to conduct a follow-up review of a provider (whose non-compliance has resulted in a condition of a seriousness or pervasive nature) in a more prompt manner to help ensure the health and safety of individuals receiving services from an underperforming provider. The adopted rules clarify definitions of "condition of a pervasive nature," "condition of a serious nature," and "hazard to health or safety" so providers will have a better understanding of how DADS determines when such conditions exist.

The adopted rules describe DADS process that allows a program provider to request that DADS conduct an informal review of findings in a preliminary review report with which a provider disagrees.

The adopted rules change the qualifications for service providers of employment assistance and supported employment to require that the service providers have (1) a bachelor's degree and six months of work experience providing services to people with disabilities, (2) an associate's degree and one year of work experience providing services to people with disabilities, or (3) a high school diploma (or a state-recognized equivalent) and two years of work experience providing services to people with disabilities. This change was made to help ensure that service providers of employment assistance and supported employment have suf-

ficient expertise to provide these services. The adopted rules include certain requirements the program provider must comply with to receive payment for employment assistance and supported employment, such as not using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training and not providing employment assistance or supported employment to an individual with the individual present at the same time that certain other services are provided.

The adopted rules change the definition of supported employment to allow an individual to receive this service and be self-employed or work from home. This change provides a policy that is consistent with other waiver programs and enhances an individual's opportunities to have a desired job or career. The adopted rules, for an individual receiving supported employment, remove the prohibition of a program provider being an individual's employer and related requirements about obtaining a variance to this prohibition to expand an individual's employment opportunities.

The adopted rules eliminate the two TxHmL service categories of Community Living and Technical and Professional Supports and the related service limits for those categories because the categories are not necessary for the operation of the program.

The adopted rules remove the requirement that an individual receiving community support and respite must receive both services through the consumer directed service (CDS) option if the individual chooses to have one of the services provided through the CDS option. This change is made to comply with CMS requirements.

The adopted rules add additional eligibility criteria for an individual leaving or at risk of entering a nursing facility and who is a member of a reserved capacity group in the TxHmL waiver application. This change addresses the addition of this new reserved capacity group to the application approved by CMS.

The adopted rules establish a new limit for adaptive aids of $10,000 per individual per individual plan of care year to make it consistent with the Home and Community-based Services (HCS) Program.

The adopted rules remove the term "support methodologies," replace it with "implementation plan," and include a definition of "implementation plan." The definition of implementation plan bolsters DADS expectations that a program provider will address the outcomes of TxHmL services and makes it consistent with the HCS Program.

The adopted rules replace deleted requirements (including those for complaint processes, reporting and training related to abuse, neglect, and exploitation, background checks and wage requirements for some TxHmL service providers) with references to requirements addressed in new Chapter 49, Contracting for Community Services adopted elsewhere in this issue of the *Texas Register,* because new Chapter 49 applies to TxHmL program providers.

The adopted rules require a program provider to enter the name and phone number of an alternate chief executive officer (CEO) into the DADS data system. The adopted rules require the alternate CEO to perform the duties of the CEO during the CEO's absence and to act as the contact person in a Department of Family and Protective Services (DFPS) investigation if the CEO is named as an alleged perpetrator of abuse, neglect, or exploitation of an individual. This requirement helps ensure unbiased operation of the program provider's business and cooperation in the DFPS investigation of the CEO.

The adopted rules allow a person with three years unpaid work experience providing services similar to those in the TxHmL program and who has participated as a member of a microboard to be employed by a program provider to oversee the provision of direct services. Currently, DADS allows only a person with three years paid work experience providing services similar to those in the TxHmL program to qualify for this position. The new qualification was included because DADS determined that a person with three years unpaid work experience providing services similar to those in the TxHmL program and who has participated on a microboard has obtained the necessary expertise to oversee the provision of direct services for a program provider. The adopted rules add a definition for a microboard based on the service industry's common understanding of a microboard.

To increase the availability of qualified providers of behavioral support, the adopted rules allow a person with a provisional license to practice psychology, a licensed clinical social worker, and a licensed professional counselor to provide this service.

The adopted rules remove the requirement that a program provider must provide at least one service component through a service provider employed by the program provider because CMS is no longer requiring this practice.

The adopted rules remove the description of how, for an individual required to share the cost of waiver services, the individual's co-payment is calculated. This change is made because the description in the rule is no longer accurate and the calculation method is contained in policies promulgated by the Health and Human Services Commission.

The adopted rules delete the definition of "unusual incident" because the elements contained within the definition of "unusual incident" were incorporated into the definition of "critical incident" in the TxHmL Provider User Guide.

The adopted rules allow individuals to receive respite in a camp accredited by the American Camp Association to expand the suitable settings in which an individual may choose to receive respite.

The adopted rules emphasize DADS current policy that a program provider is not allowed to use seclusion for any reason.

The adopted rules delete the explanation of billable units for community support, day habilitation, nursing, behavioral support, respite, and professional therapies because this topic is addressed in the TxHmL Billing Guidelines.

The adopted rules delete the statement that day habilitation does not include services funded under §110 of the Rehabilitation Act of 1973 or §602(16) and (17) of the Individuals with Disabilities Education Act. This change is made because this condition is not relevant to day habilitation services.

The adopted rules delete requirements for the local authority that are addressed in Chapter 41 of this title regarding the CDS option.

The adopted rules delete requirements for the local authority regarding an individual's enrollment that are addressed in the Performance Contract between DADS and a local authority.

The adopted rules repeal and move to another section the description of a service coordinator's responsibilities when an individual transfers and make the service coordinator's responsibili-

ties consistent with a service coordinator's responsibilities in the HCS Program.

The adopted rules make rules consistent with DADS current policy that respite services are used if the caregiver is temporarily unavailable to provide supports for non-routine circumstances.

The adopted rules add a definition for "related condition" to be consistent with how that term is defined in the rules governing the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program at Chapter 9, Subchapter E of this title.

The adopted rules replace outdated terminology by replacing "MRA" with "local authority;" "ICF/MR" with "ICF/IID;" "MR/RC" with "ID/RC;" and "mental retardation" with "intellectual disability." The adopted rules replace "support methodologies" with "implementation plans;" "specialized therapies'" with "professional therapies;" "CDS" with "CDS option;" "CDSA" with "FMSA;" "financial management services" with "FMS;" and "program provider agreement" with "contract." The adopted rules add definitions for "provisional contract" and "standard contract" as used in new Chapter 49.

In addition, the adopted rules replace "CARE" with "DADS data system," which will allow for any further data system changes; update references to the Occupations Code for all licensed service providers who are qualified to deliver services approved in the TxHmL program; correct cross-references in the subchapter; and make minor editorial and reorganizational changes for clarity and consistency.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose. An action taken by DADS before the effective date of these rules is governed by the rules in effect on the date the action was taken, and the former rules continue in effect for that purpose. An action taken by DADS on or after the effective date of these rules is governed by these rules.

A change was made to the proposed rules to add a definition for "competitive employment" in §9.553(6) as "employment that pays an individual at least minimum wage if the individual is not self-employed." The agency made this change to be consistent with the assurances in the TxHmL waiver application which state that employment assistance assists an individual to locate a job that pays at least minimum wage and that supported employment assists an individual to sustain a job that pays at least minimum wage.

Changes were made throughout the proposed rules to change "service components" to "services," "service component" to "service," and to update the change in the title of §9.555. The agency made these changes consistent with the deletion in §9.555 of "service component" after the name of each service.

A change was made to proposed §9.554(e) to add a reference to §41.108. The agency made this change in the description of the CDS option because §41.108 describes services available through the CDS option in the TxHmL Program and makes §9.554(e) consistent with §9.567(b)(2).

Changes were made to proposed §9.555(d)(1), (d)(2)(D), and (e)(1)(B) to change "paid employment" to "competitive employment." The agency made these changes to be consistent with the assurances in the TxHmL waiver application, which state that employment assistance assists an individual to locate a job that pays at least minimum wage and that supported employment assists an individual to sustain a job that pays at least minimum wage.

A change was made to proposed §9.555(e)(2)(A) to replace "disability" with "assessed needs" to be consistent with assurances in the TxHmL waiver application which state that supported employment activities performed by a service provider are related to an individual's assessed needs, not the individual's disability.

Changes were made to proposed §9.567(b)(2) to change "CDS" to "the CDS option" and to add a reference to §41.108. The agency made these changes to update the terminology for CDS and because §41.108 describes services available through the CDS option in the TxHmL Program.

The agency deleted proposed §9.573(b). The agency made this change because FMSA reimbursement is addressed in Chapter 41 of this title regarding the CDS option. Minor editorial changes were made to the text of proposed §9.579(i) to clarify that a service provider of employment assistance and a service provider of supported employment must not be the LAR of the individual receiving employment assistance or supported employment.

Minor editorial changes were made throughout the proposed rules to correct punctuation and grammatical errors.

DADS received written comments from the Providers Alliance for Community Services of Texas (PACSTX), Disability Rights Texas on behalf of Disability Rights Texas, Texas Council for Developmental Disabilities, EveryChild Inc., The Arc of Texas, and one individual. A summary of the comments and responses follows.

Comment: One commenter suggested deleting §9.570(a)(3) because there are inadequate due process protections from subjective interpretations of whether an individual or LAR is cooperating in the provision or planning of services. The commenter also does not support an individual experiencing termination due to the conduct or perceived cooperation of the LAR of the individual over which the individual has no control.

Response: The agency acknowledges verbal and written testimony given at the Medical Care Advisory Committee and the DADS Council in opposition to current rule requirements that allow the termination of services based on lack of cooperation by the individual or the LAR with the provision or planning of services. Revising this section is outside the scope of these rules and will require additional research. In the future, the agency will form a workgroup to examine termination provisions of this nature in TxHmL and the HCS Program. No changes were made in response to the comment.

Comment: One commenter requested the deletion in §9.570(c)(2)(A) of "including the ability of the individual to receive TxHmL Program services in the future." The commenter stated that because the word "termination" is not defined, this subparagraph indicates that the inability of the individual to receive TxHmL Program services "in the future" is a permissible consequence.

Response: Revising this subparagraph is outside the scope of these rules and will require additional research. In the future, the agency will form a workgroup to examine termination provisions of this nature in TxHmL and the HCS Program. No changes were made in response to the comment.

Comment: One commenter suggested the deletion in §9.555(j) of "when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances." The commenter stated

that "non-routine circumstances" is not defined and is confusing. Another commenter stated that some families have respite every other weekend for dinner or some other type of down time and asked if this description makes them ineligible for respite because it is routine, every other weekend, or at least once a month.

Response: The agency declines to make the requested deletion in §9.555(j) because this wording is used in the TxHmL waiver application. The agency agrees that "non-routine circumstances" in §9.555(j) should be defined and has added a definition for the term in §9.553.

The definition of respite in the TxHmL waiver application limits the use of respite to emergency circumstances or planned events that are not routine.

Comment: One commenter stated that §9.579(h)(2)(B) needs to be clarified because some compliance reviewers require the letters of reference to be written and others have allowed documentation of references obtained over the telephone. The commenter pointed out that the TxHmL Billing Guidelines require written references and asked the agency to either correct the Billing Guidelines and remove the word "written" or add "written" to the rule so that program providers can determine the correct way to comply.

Response: The agency agrees with the comment and made changes in §9.579(h)(2)(B) to require written references.

Comment: One commenter stated that adding "if applicable" after "LAR" in §9.580(f)(3) can be interpreted in several different ways and that the LAR should always be notified if there is an guardian.

Response: The agency has deleted "if applicable" in §9.580(f)(3) to make it clear that a program provider must notify both the individual and the LAR of the allegation report and the action that have been or will be taken by the program provider in response to the allegation.

Comment: One commenter suggested the deletion, in §9.580(r), of "after the last day of the month being reported," to shorten the timeframe for entering critical incident data in the DADS data system to no longer than 30 calendar days. The commenter stated that having almost 60 days in some cases to report critical incidents, such as serious physical injury, is not effective in enabling DADs to ensure that program providers have a system that protects health and safety.

Response: The agency is seeking to implement a new critical incident reporting system in the future that will require a program provider to enter data within a very short period of time after the incident occurs. The agency did not make changes in response to the comment.

Comment: Citing §9.577, one commenter expressed support for the addition of a provision that would allow contract termination in one or more contract areas when a program provider loses certification in one contract area, as determined using defined criteria, and asked if this would require legislative authority. The commenter stated they also support adding debarment from the ability to provide TxHmL services based on defined criteria, an enforcement action that does not currently exist in the TxHmL Program.

Response: These provisions can be found in the contracting rules in Chapter 49, which apply to the TxHmL Program. The provision in §49.534(a)(2)(N) allows DADS to terminate a contract if DADS proposed or imposed an action or sanction against another contract of the contractor. If DADS terminates a provisional or standard contract, §49.702(d), allows DADS to set an application denial period for the contractor or controlling person that applies to all programs and services for a period of time determined by DADS, but no less than 12 months after the date of termination. No changes were made in response to the comment.

40 TAC §§9.551 - 9.556, 9.558, 9.560 - 9.563, 9.566 - 9.568, 9.570 - 9.580, 9.582 - 9.584

The amendments and new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§9.553. Definitions.

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

(1) Applicant--A Texas resident seeking services in the TxHmL Program.

(2) Business day--Any day except a Saturday, a Sunday, or a national or state holiday listed in Texas Government Code §662.003(a) or (b).

(3) Calendar day--Any day, including weekends and holidays.

(4) CDS option--Consumer directed services option. A service delivery option as defined in §41.103 of this title (relating to Definitions).

(5) CMS--Centers for Medicare and Medicaid Services. The federal agency that administers Medicaid programs.

(6) Competitive employment--Employment that pays an individual at least minimum wage if the individual is not self-employed.

(7) Condition of a pervasive nature--A condition in which a program provider is out of compliance with a certification principle as evidenced by one of the following:

(A) the following two conditions are met:

(i) at least 50 percent of items from an initial sample of records, interviews, or observations reviewed by DADS, show non-compliance; and

(ii) at least one item from an additional sample, at least the same size as the initial sample, shows non-compliance; or

(B) if DADS is not able to obtain an additional sample as described in subparagraph (A)(ii) of this paragraph, at least 51 percent of items from an initial sample of records, interviews, or observations reviewed by DADS, show non-compliance.

(8) Condition of a serious nature--Except as provided in paragraph (14) of this section, a condition in which a program provider's noncompliance with a certification principle caused or could cause physical, emotional, or financial harm to one or more of the individuals receiving services from the program provider.

(9) Contract--A provisional contract or a standard contract.

(10) Critical incident--An event listed in the TxHmL Provider User Guide found at http://www2.mhmr.state.tx.us/655/cis/training/txhmlGuide.html.

(11) DADS--The Department of Aging and Disability Services.

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

(13) FMS--Financial management services. A service, as defined in §41.103 of this title, that is provided to an individual participating in the CDS option.

(14) FMSA--Financial management services agency. As defined in §41.103 of this title, an entity that provides financial management services to an individual participating in the CDS option.

(15) Hazard to health or safety--A condition in which serious injury or death of an individual or other person is imminent because of a program provider's noncompliance with a certification principle.

(16) HCS Program--The Home and Community-based Services Program operated by DADS as authorized by CMS in accordance with §1915(c) of the Social Security Act.

(17) HHSC--The Texas Health and Human Services Commission.

(18) ICAP--Inventory for Client and Agency Planning.

(19) ICF/IID--A facility in which ICF/IID Program services are provided.

(20) ICF/IID Program--The Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program, which provides Medicaid-funded residential services to individuals with an intellectual disability or related conditions.

(21) ICF/MR Program--ICF/IID Program.

(22) ID/RC Assessment--A form used by DADS for LOC determination and LON assignment.

(23) Implementation Plan--A written document developed by a program provider for an individual that, for each TxHmL Program service on the individual's IPC not provided through the CDS option, includes:

(A) a list of outcomes identified in the PDP that will be addressed using TxHmL Program services;

(B) specific objectives to address the outcomes required by subparagraph (A) of this paragraph that are:

(i) observable, measurable, and outcome-oriented; and

(ii) derived from assessments of the individual's strengths, personal goals, and needs;

(C) a target date for completion of each objective;

(D) the number of TxHmL Program units of service needed to complete each objective;

(E) the frequency and duration of TxHmL Program services needed to complete each objective; and

(F) the signature and date of the individual, LAR, and the program provider.

(24) Individual--A person enrolled in the TxHmL Program.

(25) Intellectual disability--Significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(26) IPC--Individual plan of care. A document that describes the type and amount of each TxHmL Program service to be provided to an individual and medical and other services and supports to be provided through non-TxHmL Program resources.

(27) IPC cost--Estimated annual cost of program services included on an IPC.

(28) IPC year--A 12-month period of time starting on the date an authorized initial or renewal IPC begins.

(29) LAR--Legally authorized representative. A person authorized by law to act on behalf of a person with regard to a matter described in this subchapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(30) LOC--Level of care. A determination made by DADS about an applicant or individual as part of the TxHmL Program eligibility determination process based on data electronically transmitted on the ID/RC Assessment.

(31) Local authority--An entity described in Texas Health and Safety Code, §531.002(11) to which the executive commissioner of HHSC has delegated authority and responsibility in accordance with Texas Health and Safety Code, §533.035(a).

(32) LON--Level of need. An assignment given by DADS for an applicant or individual that is derived from the service level score obtained from the administration of the Inventory for Client and Agency Planning (ICAP) to the individual and from selected items on the ID/RC Assessment.

(33) LVN--Licensed vocational nurse. A person licensed to practice vocational nursing in accordance with Texas Occupations Code, Chapter 301.

(34) Microboard--A program provider:

(A) that is a non-profit corporation;

(i) that is created and operated by no more than 10 persons, including an individual;

(ii) the purpose of which is to address the needs of the individual and directly manage the provision of the TxHmL Program services; and

(iii) in which each person operating the corporation participates in addressing the needs of the individual and directly managing the provision of TxHmL Program services; and

(B) that has a service capacity designated in the DADS data system of no more than three individuals.

(35) Non-routine circumstances--An event that occurs unexpectedly or does not occur on a regular basis, such as a night off, a vacation, an illness, an injury, a hospitalization, or a funeral.

(36) Own home or family home--A residence that is not:

(A) an ICF/IID licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 252 or certified by DADS;

(B) a nursing facility licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 242;

(C) an assisted living facility licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 247;

(D) a residential child-care operation licensed or subject to being licensed by DFPS unless it is a foster family home or a foster group home;

(E) a facility licensed or subject to being licensed by the Department of State Health Services;

(F) a residential facility operated by the Department of Assistive and Rehabilitative Services;

(G) a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison; or

(H) a setting in which two or more dwellings, including units in a duplex or apartment complex, single family homes, or facilities listed in subparagraphs (A) - (G) of this paragraph, but excluding supportive housing under Section 811 of the National Affordable Housing Act of 1990, meet all of the following criteria:

(i) the dwellings create a residential area distinguishable from other areas primarily occupied by persons who do not require routine support services because of a disability;

(ii) most of the residents of the dwellings are persons with an intellectual disability; and

(iii) the residents of the dwellings are provided routine support services through personnel, equipment, or service facilities shared with the residents of the other dwellings.

(37) Performance contract--A written agreement between DADS and a local authority for the provision of one or more functions as described in THSC, §533.035(b).

(38) PDP--Person-directed plan. A plan developed for an applicant in accordance with §9.567 of this subchapter (relating to Process for Enrollment) that describes the supports and services necessary to achieve the desired outcomes identified by the applicant or LAR on behalf of the applicant.

(39) Program provider--A person, as defined in §49.102 of this title (relating to Definitions), that has a contract with DADS to provide TxHmL Program services, excluding an FMSA.

(40) Provisional contract--An initial contract that DADS enters into with a program provider in accordance with §49.208 of this title (relating to Provisional Contract Application Approval) that has a stated expiration date.

(41) Related condition--A severe and chronic disability that:

(A) is attributed to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability, and requires treatment or services similar to those required for individuals with an intellectual disability;

(B) is manifested before the individual reaches age 22;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in at least three of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

(42) Respite facility--A site that is not a residence and that is owned or leased by a program provider for the purpose of providing out-of-home respite to not more than six individuals receiving TxHmL Program services or other persons receiving similar services at any one time.

(43) RN--Registered nurse. A person licensed to practice professional nursing in accordance with Texas Occupations Code, Chapter 301.

(44) Seclusion--The involuntary separation of an individual away from other individuals and the placement of the individual alone in an area from which the individual is prevented from leaving.

(45) Service backup plan--A plan that ensures continuity of a service that is critical to an individual's health and safety if service delivery is interrupted.

(46) Service coordinator--An employee of a local authority who is responsible for assisting an applicant, individual, or LAR to access needed medical, social, educational, and other appropriate services including TxHmL Program services.

(47) Service planning team--A planning team constituted by a local authority consisting of an applicant or individual, LAR, service coordinator, and other persons chosen by the applicant, individual, or LAR.

(48) Service provider--A person, who may be a staff member, who directly provides a TxHmL Program service to an individual.

(49) Staff member--An employee or contractor of a TxHmL Program provider.

(50) Standard contract--A contract that DADS enters into with a program provider in accordance with §49.209 of this title (relating to Standard Contract) that does not have a stated expiration date.

(51) State supported living center--A state-supported and structured residential facility operated by DADS to provide to persons with an intellectual disability a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocational skills, but does not include a community-based facility owned by DADS.

(52) Support consultation--A service, as defined in §41.103 of this title, that is provided to an individual participating in the CDS option at the request of the individual or LAR.

(53) TAC--Texas Administrative Code. A compilation of state agency rules published by the Texas Secretary of State in accordance with Texas Government Code, Chapter 2002, Subchapter C.

(54) THSC--Texas Health and Safety Code. Texas statutes relating to health and safety.

(55) TxHmL Program--The Texas Home Living Program, operated by DADS and approved by CMS in accordance with §1915(c) of the Social Security Act, that provides community-based services and supports to eligible individuals who live in their own homes or in their family homes.

(56) Vendor hold--A temporary suspension of payments that are due to a program provider under a contract.

§9.554. Description of the TxHmL Program.

(a) The TxHmL Program is a Medicaid waiver program approved by the CMS pursuant to §1915(c) of the Social Security Act. It provides community-based services and supports to eligible individuals who live in their own homes or in their family homes. The TxHmL Program is operated by DADS under the authority of HHSC.

(b) DADS has grouped the counties of the state of Texas into geographical areas, referred to as "local service areas," each of which is served by a local authority. DADS has further grouped the local service areas into "waiver contract areas." A list of the counties included in each local service area and waiver contract area is available at www.dads.state.tx.us.

(1) A program provider may provide TxHmL Program services only to persons residing in the counties specified in its contract.

(2) A program provider must have a separate contract for each waiver contract area served by the program provider.

(3) A program provider may have a contract to serve one or more local service areas within a waiver contract area, but the program provider must serve all of the counties within each local service area covered by the contract.

(4) A program provider may not have more than one contract per waiver contract area.

(c) The local authority must provide service coordination to an individual who is enrolled in the TxHmL Program in accordance with this subchapter.

(d) TxHmL Program services, as defined in §9.555 of this subchapter (relating to Definitions of TxHmL Program Services), are selected by the service planning team for inclusion in an applicant's or individual's IPC to:

(1) ensure the applicant's or individual's health and welfare in the community;

(2) supplement rather than replace the applicant's or individual's natural supports and other non-TxHmL Program sources for which the applicant or individual may be eligible; and

(3) prevent the applicant's or individual's admission to institutional services.

(e) The CDS option is a service delivery option, as described in Chapter 41 of this title (relating to Consumer Directed Services Option), in which an individual or LAR employs and retains service providers and directs the delivery of one or more services that may be provided through the CDS option, as described in §41.108 of this title (relating to Services Available Through the CDS Option).

(f) A program provider must comply with all applicable state and federal laws, rules, and regulations, including Chapter 49 of this title (relating to Contracting for Community Services).

§9.555. Definitions of TxHmL Program Services Service Components.

(a) Community support provides services and supports in an individual's home and at other community locations that are necessary to achieve outcomes identified in an individual's PDP.

(1) Community support provides habilitative or support activities that:

(A) provide or foster improvement of or facilitate an individual's ability to perform functional living skills and other activities of daily living;

(B) assist an individual to develop competencies in maintaining the individual's home life;

(C) foster improvement of or facilitate an individual's ability and opportunity to:

(i) participate in typical community activities including activities that lead to successful employment;

(ii) access and use of services and resources available to all citizens in the individual's community;

(iii) interact with members of the community;

(iv) access and use available non-TxHmL Program services or supports for which the individual may be eligible; and

(v) establish or maintain relationships with people who are not paid service providers that expand or sustain the individual's natural support network.

(2) Community support, as determined by an assessment conducted by an RN, provides assistance with medications and the performance of tasks delegated by an RN in accordance with state law and rules, unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician.

(3) Community support does not include payment for room or board.

(4) Community support may not be provided to the individual at the same time that any of the following services is provided:

(A) respite;

(B) day habilitation;

(C) employment assistance with the individual present; or

(D) supported employment with the individual present.

(b) Day habilitation assists an individual to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life.

(1) Day habilitation provides:

(A) individualized activities consistent with achieving the outcomes identified in the individual's PDP;

(B) activities necessary to reinforce therapeutic outcomes targeted by other waiver services, school, or other support providers;

(C) services in a group setting other than the individual's home for normally up to five days a week, six hours per day;

(D) personal assistance for an individual who cannot manage personal care needs during the day habilitation activity;

(E) as determined by an assessment conducted by an RN, assistance with medications and the performance of tasks delegated by an RN in accordance with state law and rules, unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician; and

(F) transportation during the day habilitation activity necessary for the individual's participation in day habilitation activities.

(2) Day habilitation may not be provided at the same time that any of the following services is provided:

(A) respite;

(B) community support;

(C) employment assistance with the individual present; or

(D) supported employment with the individual present.

(c) Nursing provides treatment and monitoring of health care procedures ordered or prescribed by a practitioner and as required by standards of professional practice or state law to be performed by an RN or LVN. Nursing includes:

(1) administering medication;

(2) monitoring an individual's use of medications;

(3) monitoring an individual's health risks, data, and information, including ensuring that an unlicensed service provider is performing only those nursing tasks identified in a nursing assessment;

(4) assisting an individual or LAR to secure emergency medical services for the individual;

(5) making referrals for appropriate medical services;

(6) performing health care procedures as ordered or prescribed by a practitioner and required by standards of professional practice or law to be performed by an RN or LVN;

(7) delegating nursing tasks assigned to an unlicensed service provider and supervising the performance of those tasks in accordance with state law and rules;

(8) teaching an unlicensed service provider about the specific health needs of an individual;

(9) performing an assessment of an individual's health condition;

(10) an RN doing the following:

(A) performing a nursing assessment for each individual:

(i) before an unlicensed service provider performs a nursing task for the individual unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician; and

(ii) as determined necessary by an RN, including if the individual's health needs change;

(B) documenting information from performance of a nursing assessment;

(C) if an individual is receiving a service through CDS, providing a copy of the documentation described in described in subparagraph (B) of this paragraph to the individual's service coordinator;

(D) developing the nursing service portion of an individual's implementation plan required by §9.578(c)(2) of this subchapter (relating to Program Provider Certification Principles: Service Delivery), which includes developing a plan and schedule for monitoring and supervising delegated nursing tasks; and

(E) making and documenting decisions related to the delegation of a nursing task to an unlicensed service provider;

(11) in accordance with Texas Human Resources Code, Chapter 161:

(A) allowing an unlicensed service provider to provide administration of medication to an individual without the delegation or oversight of an RN if:

(i) an RN has performed a nursing assessment and, based on the results of the assessment, determined that the individual's health permits the administration of medication by an unlicensed service provider;

(ii) the medication is:

(I) an oral medication;

(II) a topical medication; or

(III) a metered dose inhaler;

(iii) the medication is administered to the individual for a predictable or stable condition; and

(iv) the unlicensed service provider has been:

(I) trained by an RN or an LVN under the direction of an RN regarding the proper administration of medication; or

(II) determined to be competent by an RN or an LVN under the direction of an RN regarding proper administration of medication, including through a demonstration of proper technique by the unlicensed service provider; and

(B) ensuring that an RN or an LVN under the supervision of an RN reviews the administration of medication to an individual by an unlicensed service provider at least annually and after any significant change in the individual's condition.

(d) Employment assistance:

(1) is assistance provided to an individual to help the individual locate competitive employment in the community;

(2) consists of a service provider performing the following activities:

(A) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

(B) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements;

(C) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;

(D) transporting the individual to help the individual locate competitive employment in the community; and

(E) participating in service planning team meetings;

(3) is not provided to an individual with the individual present at the same time that respite, community support, day habilitation, or supported employment is provided;

(4) does not include using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(A) paying an employer:

(i) to encourage the employer to hire an individual; or

(ii) for supervision, training, support, or adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(B) paying the individual:

(i) as an incentive to participate in employment assistance activities; or

(ii) for expenses associated with the start-up costs or operating expenses of an individual's business; and

(5) as determined by an assessment conducted by an RN, provides assistance with medications and the performance of tasks delegated by an RN in accordance with state law and rules, unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician.

(e) Supported employment:

(1) is assistance provided to an individual:

(A) who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed; and

(B) in order for the individual to sustain competitive employment;

(2) consists of a service provider performing the following activities:

(A) making employment adaptations, supervising, and providing training related to an individual's assessed needs;

(B) transporting the individual to support the individual to be self-employed, work from home, or perform in a work setting; and

(C) participating in service planning team meetings;

(3) is not provided to an individual with the individual present at the same time that respite, community support, day habilitation, or employment assistance is provided;

(4) does not include sheltered work or other similar types of vocational services furnished in specialized facilities, or using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(A) paying an employer:

(i) to encourage the employer to hire an individual; or

(ii) to supervise, train, support, or make adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(B) paying the individual:

(i) as an incentive to participate in supported employment activities; or

(ii) for expenses associated with the start-up costs or operating expenses of an individual's business; and

(5) as determined by an assessment conducted by an RN, provides assistance with medications and the performance of tasks delegated by an RN in accordance with state law and rules, unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician.

(f) Behavioral support provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life. Behavioral support includes:

(1) assessment and analysis of assessment findings of the behavior(s) to be targeted necessary to design an appropriate behavioral support plan;

(2) development of an individualized behavioral support plan consistent with the outcomes identified in the individual's PDP;

(3) training of and consultation with the LAR, family members, or other support providers and, as appropriate, with the individual in the purpose/objectives, methods and documentation of the implementation of the behavioral support plan or revisions of the plan;

(4) monitoring and evaluation of the success of the behavioral support plan implementation; and

(5) modification, as necessary, of the behavioral support plan based on documented outcomes of the plan's implementation.

(g) Adaptive aids enable an individual to increase mobility, the ability to perform activities of daily living, or the ability to perceive, control, or communicate with the environment in which the individual lives. Adaptive aids include devices, controls, appliances, or supplies and the repair or maintenance of such aids, if not covered by warranty, as specified in the *TxHmL Program Billing Guidelines.*

(1) Adaptive aids are provided to address specific needs identified in an individual's PDP and are limited to:

(A) lifts;

(B) mobility aids;

(C) positioning devices;

(D) control switches/pneumatic switches and devices;

(E) environmental control units;

(F) medically necessary supplies;

(G) communication aids;

(H) adapted/modified equipment for activities of daily living; and

(I) safety restraints and safety devices.

(2) Adaptive aids may be provided up to a maximum of $10,000 per individual per IPC year.

(3) Adaptive aids do not include items or supplies that are not of direct medical or remedial benefit to the individual or that are available to the individual through the Medicaid State Plan, through other governmental programs, or through private insurance.

(h) Minor home modifications are physical adaptations to the individual's home that are necessary to ensure the health, welfare, and safety of the individual or to enable the individual to function with greater independence in the home and the repair or maintenance of such adaptations, if not covered by warranty.

(1) Minor home modifications may be provided up to a lifetime limit of $7,500 per individual. After the $7,500 lifetime limit has been reached, an individual is eligible for an additional $300 per IPC year for additional modifications or maintenance of home modifications.

(2) Minor home modifications do not include adaptations or improvements to the home that are of general utility, are not of direct medical or remedial benefit to the individual, or add to the total square footage of the home.

(3) Minor home modifications are limited to:

(A) purchase and repair of mobility/wheelchair ramps;

(B) modifications to bathroom facilities;

(C) modifications to kitchen facilities; and

(D) specialized accessibility and safety adaptations.

(i) Dental treatment may be provided up to a maximum of $1,000 per individual per IPC year for the following treatments:

(1) emergency dental treatment;

(2) preventive dental treatment;

(3) therapeutic dental treatment; and

(4) orthodontic dental treatment, excluding cosmetic orthodontia.

(j) Respite is provided for the planned or emergency short-term relief of the unpaid caregiver of an individual when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances.

(1) Respite includes:

(A) assistance with activities of daily living and functional living tasks;

(B) assistance with planning and preparing meals;

(C) transportation or assistance in securing transportation;

(D) assistance with ambulation and mobility;

(E) as determined by an assessment conducted by an RN, assistance with medications and the performance of tasks delegated by an RN in accordance with state law and rules, unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician;

(F) habilitation and support that facilitate:

(i) an individual's inclusion in community activities, use of natural supports and typical community services available to all people;

(ii) an individual's social interaction and participation in leisure activities; and

(iii) development of socially valued behaviors and daily living and independent living skills.

(2) Reimbursement for respite provided in a setting other than the individual's residence includes payment for room and board.

(3) Respite may be provided in the individual's residence or, if certification principles stated in §9.578(p) of this subchapter are met, in other locations.

(k) Professional therapies provide assessment and treatment by a licensed professional who meets the qualifications specified in §9.579 of this subchapter (relating to Certification Principles: Qualified Personnel) and include training and consultation with an individual's LAR, family members or other support providers. Professional therapies available under the TxHmL Program are:

(1) audiology services;

(2) speech/language pathology services;

(3) occupational therapy services;

(4) physical therapy services;

(5) dietary services;

(6) social work services; and

(7) behavioral support.

(l) FMS are provided if the individual participates in the CDS option.

(m) Support consultation is provided at the request of the individual or LAR if the individual participates in the CDS option.

§9.558. Individual Plan of Care (IPC).

(a) An initial IPC must be developed for each applicant in accordance with §9.567 of this subchapter (relating to Process for Enrollment) and reviewed and revised for each individual whenever the individual's needs for services and supports change, but no less than annually, in accordance with §9.568 of this subchapter (relating to Revisions and Renewals of Individual Plans of Care (IPCs), Levels of Care (LOCs), and Levels of Need (LONs) for Enrolled Individuals).

(b) The IPC must specify the type and amount of each service to be provided to the individual, as well as services and supports to be provided by other non-TxHmL Program sources during the IPC year. The type and amount of each service must be supported by:

(1) documentation that non-TxHmL Program sources for the service are unavailable and the service supplements rather than replaces natural supports or non-TxHmL Program services;

(2) assessments of the individual that identify specific services necessary for the individual to continue living in the community, to ensure the individual's health and welfare in the community, and to prevent the individual's admission to institutional services; and

(3) documentation of the deliberations and conclusions of the service planning team that the TxHmL Program services are necessary for the individual to live in the community; are necessary to prevent the individual's admission to institutional services, and are sufficient, when combined with services or supports available from non-TxHmL Program sources (if applicable), to ensure the individual's health and welfare in the community.

(c) Before electronic transmission to DADS, an individual's IPC must be signed and dated by the required service planning team members indicating concurrence that the services recommended in the IPC meet the requirements of subsection (b) of this section.

(d) DADS reviews an electronically transmitted initial, revised, or renewal IPC and approves, modifies, or does not approve the IPC. DADS does not approve an IPC having a total cost that exceeds the combined cost limit specified in Appendix C of the TxHmL Program waiver application approved by CMS.

(e) An electronically transmitted IPC must contain information identical to the information contained on the signed copy of the IPC described in subsection (c) of this section.

(f) DADS may review an IPC at any time to determine if the type and amount of each service specified in the IPC are appropriate. The service coordinator must submit documentation supporting the IPC to DADS in accordance with a request from DADS for documentation.

§9.567. Process for Enrollment.

(a) If an applicant or LAR chooses participation in the TxHmL Program, the local authority must assign a service coordinator who develops, in conjunction with the service planning team, a PDP. At a minimum, the PDP must include the following:

(1) a description of the services and supports the applicant requires to continue living in the applicant's own home or family home;

(2) a description of the applicant's current existing natural supports and non-TxHmL Program services that will be available if the applicant is enrolled in the TxHmL Program;

(3) a description of individual outcomes to be achieved through TxHmL Program services and justification for each service to be included in the IPC;

(4) documentation that the type and amount of each service included in the applicant's IPC do not replace existing natural supports or non-TxHmL Program sources for the services for which the applicant may be eligible;

(5) documentation for each TxHmL program service of whether the service is critical to the individual's health and safety, as determined by the service planning team;

(6) a description of actions and methods to be used to reach identified service outcomes, projected completion dates, and person(s) responsible for completion;

(7) a statement that the applicant was provided the information regarding the CDS option as required by subsection (b) of this section;

(8) if the applicant chooses to participate in the CDS option, a description of the services provided through the CDS option; and

(9) if the applicant chooses to participate in the CDS option, a description of the applicant's service backup plan.

(b) The local authority must, in accordance with Chapter 41, Subchapter D of this title (relating to Enrollment, Transfer, Suspension, and Termination):

(1) inform the applicant or LAR of the applicant's right to participate in the CDS option;

(2) inform the applicant or LAR that the applicant or LAR may choose to have one or more services provided through the CDS option, as described in §41.108 of this title (relating to Services Available Through the CDS Option); and

(3) inform the applicant or LAR of the applicant's right to discontinue participation in the CDS option at any time.

(c) The local authority must compile and maintain information necessary to process the applicant's or LAR's request for enrollment in the TxHmL Program.

(1) The local authority must complete an ID/RC Assessment.

(A) The local authority must:

(i) determine or validate a determination that the applicant has an intellectual disability in accordance with Chapter 5, Subchapter D of this title (relating to Diagnostic Eligibility for Services and Supports--Intellectual Disability Priority Population and Related Conditions); or

(ii) verify that the applicant has been diagnosed by a licensed physician as having a related condition as defined in §9.203 of this chapter (relating to Definitions).

(B) The local authority must administer the Inventory for Client and Agency Planning (ICAP) or validate a current ICAP and recommend an LON assignment to DADS in accordance with §9.562 of this subchapter (relating to Level of Need (LON) Assignment).

(2) The local authority must develop a proposed IPC with the applicant or LAR based on the PDP and §9.555 of this subchapter (relating to Definitions of TxHmL Program Services).

(d) If an applicant or LAR chooses to receive a TxHmL Program service provided by a program provider, the service coordinator must:

(1) provide names and contact information to the applicant or LAR regarding all program providers in the local authority's local service area;

(2) review the proposed IPC with potential program providers selected by the applicant or the LAR;

(3) arrange for meetings or visits with potential program providers as desired by the applicant or the LAR;

(4) ensure that the applicant's or LAR's choice of a program provider is documented, signed by the applicant or LAR, and retained by the local authority in the applicant's record;

(5) negotiate and finalize the proposed IPC with the selected program provider;

(6) ensure that the proposed IPC includes a sufficient number of RN nursing units for the program provider's RN to perform an initial nursing assessment, unless, as described in §9.578(r) of this subchapter (relating to Program Provider Certification Principles: Service Delivery):

(A) nursing services are not on the proposed IPC and the applicant or LAR and selected program provider have determined that no nursing tasks will be performed by an unlicensed service provider as documented on DADS form "Nursing Task Screening Tool"; or

(B) a nursing task will be performed by an unlicensed service provider and a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician; and

(7) if an applicant or LAR refuses to include a sufficient number of RN nursing units on the proposed IPC for the program provider's RN to perform an initial nursing assessment as required by paragraph (6) of this subsection:

(A) inform the applicant or LAR that the refusal:

(i) will result in the applicant not receiving nursing services from the program provider; and

(ii) if the applicant needs community support, day habilitation, employment assistance, supported employment, or respite from the program provider, will result in the applicant not receiving the service unless, as described in §9.578(s) of this subchapter:

(I) the program provider's unlicensed service provider does not perform nursing tasks in the provision of the service; and

(II) the program provider determines that it can ensure the applicant's health, safety, and welfare in the provision of the service; and

(B) document the refusal of the RN nursing units on the proposed IPC for an initial assessment by the program provider's RN in the applicant's record.

(e) After the selected program provider agrees to provide the services listed on the IPC, the local authority must submit enrollment information, including the completed ID/RC Assessment and the proposed IPC to DADS. DADS notifies the applicant or LAR, the selected

program provider and FMSA, if applicable, and the local authority of its approval or denial of the applicant's program enrollment based on the eligibility criteria described in §9.556 of this subchapter relating to Eligibility Criteria).

(f) If a selected program provider initiates services before DADS notification of enrollment approval, the program provider may not be reimbursed in accordance with §9.573(a)(5)(M) of this subchapter (relating to Reimbursement).

§9.573. Reimbursement.

(a) Program provider reimbursement.

(1) DADS pays the program provider for services as described in this paragraph:

(A) Community support, nursing, respite, day habilitation, employment assistance, supported employment, behavioral support, and professional therapies are paid for in accordance with the reimbursement rate for the specific service.

(B) Adaptive aids, minor home modifications, and dental treatment are paid for based on the actual cost of the item or service and an allowed requisition fee.

(2) To be paid for the provision of a service, a program provider must submit a service claim that meets the requirements in §49.311 of this title (relating to Claims Payment) and the *TxHmL Program Billing Guidelines.*

(3) If an individual's TxHmL Program services are suspended or terminated, the program provider must not submit a claim for services provided during the period of the individual's suspension or after the termination except the program provider may submit a claim for a service provided on the first calendar day of the suspension or termination.

(4) If the program provider submits a claim for an adaptive aid that costs $500 or more or for a minor home modification that costs $1,000 or more, the claim must be supported by a written assessment from a licensed professional specified by DADS in the *TxHmL Program Billing Guidelines* and other documentation as required by the *TxHmL Program Billing Guidelines.*

(5) DADS does not pay the program provider for a service or recoups any payments made to the program provider for a service if:

(A) the individual receiving the service was, at the time the service was provided, ineligible for the TxHmL Program or Medicaid benefits, or was an inpatient of a hospital, nursing facility, or ICF/IID;

(B) the service was not included on the signed and dated IPC of the individual in effect at the time the service was provided;

(C) the service c provided did not meet the service definition as described in §9.555 of this subchapter (relating to Definitions of TxHmL Program Services) or was not provided in accordance with the *TxHmL Program Billing Guidelines;*

(D) the service was not documented in accordance with the *TxHmL Program Billing Guidelines;*

(E) the claim for the service was not prepared and submitted in accordance with the *TxHmL Program Billing Guidelines;*

(F) the program provider does not have the documentation described in paragraph (4);

(G) before including employment assistance on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that employment assistance is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(H) before including supported employment on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that supported employment is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(I) DADS determines that the service would have been paid for by a source other than the TxHmL Program;

(J) the service was provided by a service provider who did not meet the qualifications to provide the service as described in the *TxHmL Program Billing Guidelines;*

(K) the service was not provided in accordance with a signed and dated IPC meeting the requirements set forth in §9.558 of this subchapter (relating to Individual Plan of Care (IPC));

(L) the service was not provided in accordance with the PDP and the implementation plan;

(M) the service was provided before the individual's enrollment date into the TxHmL Program; or

(N) the service was not provided.

(6) The program provider must refund to DADS any overpayment made to the program provider within 60 days after the program provider's discovery of the overpayment or receipt of a notice of such discovery from DADS, whichever is earlier.

(7) Payments by DADS to a program provider are not withheld in the event the local authority erroneously fails to electronically transmit a renewal of an enrolled individual's LOC or IPC and the program provider continues to provide services in accordance with the most recent IPC as approved by DADS.

(b) Billing and payment reviews.

(1) DADS conducts billing and payment reviews to monitor a program provider's compliance with this subchapter and the *TxHmL Program Billing Guidelines.* DADS conducts such reviews in accordance with the *TxHmL Billing and Payment Review Protocol* set forth in the *TxHmL Program Billing Guidelines.* As a result of a billing and payment review, DADS may:

(A) recoup payments from a program provider; and

(B) based on the amount of unverified claims, require a program provider to develop and submit, in accordance with DADS instructions, a corrective action plan that improves the program provider's billing practices.

(2) A corrective action plan required by DADS in accordance with paragraph (1)(B) of this subsection must:

(A) include:

(i) the reason the corrective action plan is required;

(ii) the corrective action to be taken;

(iii) the person responsible for taking each corrective action; and

(iv) a date by which the corrective action will be completed that is no later than 90 calendar days after the date the program provider is notified the corrective action plan is required;

(B) be submitted to DADS within 30 calendar days after the date the program provider is notified the corrective action plan is required; and

(C) be approved by DADS before implementation.

(3) Within 30 calendar days after the corrective action plan is received by DADS, DADS notifies the program provider if the corrective action plan is approved or if changes to the plan are required.

(4) If DADS requires a program provider to develop and submit a corrective action plan in accordance with paragraph (1)(B) of this subsection and the program provider requests an administrative hearing for the recoupment in accordance with §9.575 of this chapter (relating to Program Provider's Right to Administrative Hearing), the program provider is not required to develop or submit a corrective action plan while a hearing decision is pending. DADS notifies the program provider if the requirement to submit a corrective action plan or the content of such a plan changes based on the outcome of the hearing.

(5) If the program provider does not submit the corrective action plan or complete the required corrective action within the time frames described in paragraph (2) of this subsection, DADS may impose a vendor hold on payments due to the program provider under the contract until the program provider takes the corrective action.

(6) If the program provider does not submit the corrective action plan or complete the required corrective action within 30 calendar days after the date a vendor hold is imposed in accordance with paragraph (5) of this subsection, DADS may terminate the contract.

§9.578. Program Provider Certification Principles: Service Delivery.

(a) A program provider must serve an eligible applicant or individual who selects the program provider unless the program provider's enrollment has reached its service capacity as identified in the DADS data system.

(b) The program provider must maintain a separate record for each individual enrolled with the provider. The individual's record must include:

(1) a copy of the individual's current PDP as provided by the local authority;

(2) a copy of the individual's current IPC as provided by the local authority; and

(3) a copy of the individual's current ID/RC Assessment as provided by the local authority.

(c) The program provider must:

(1) participate as a member of the service planning team, if requested by the individual or LAR; and

(2) develop, in conjunction with the individual, the individual's family or LAR a written implementation plan.

(d) The program provider must ensure that service provision is accomplished in accordance with the individual's PDP and the implementation plan described in subsection (c)(2) of this section.

(e) The program provider must ensure that services and supports provided to an individual assist the individual to achieve the outcomes identified in the PDP.

(f) The program provider must ensure that an individual's progress or lack of progress toward achieving the individual's identified outcomes is documented in observable, measurable terms that directly relate to the specific outcome addressed, and that such documentation is available for review by the service coordinator.

(g) The program provider must communicate to the individual's service coordinator changes needed to the individual's PDP or IPC as such changes are identified by the program provider or communicated to the program provider by the individual or LAR.

(h) The program provider must ensure that an individual who performs work for the program provider is paid at a wage level commensurate with that paid to a person without disabilities who would otherwise perform that work. The program provider must comply with local, state, and federal employment laws and regulations.

(i) The program provider must ensure that an individual provides no training, supervision, or care to another individual unless the individual is qualified and compensated in accordance with local, state, and federal regulations.

(j) The program provider must ensure that an individual who produces marketable goods and services during habilitation activities is paid at a wage level commensurate with that paid to a person without disabilities who would otherwise perform that work. Compensation must be paid in accordance with local, state, and federal regulations.

(k) The program provider must offer an individual opportunity for leisure time activities, vacation periods, religious observances, holidays, and days off, consistent with the individual's choice and the routines of other members of the community.

(l) The program provider must offer an individual of retirement age opportunities to participate in activities appropriate to individuals of the same age and provide supports necessary for the individual to participate in such activities consistent with the individual's or LAR's choice and the individual's PDP.

(m) The program provider must offer an individual choices and opportunities for accessing and participating in community activities including employment opportunities and experiences available to peers without disabilities and provide supports necessary for the individual to participate in such activities consistent with an individual's or LAR's choice and the individual's PDP.

(n) The program provider must provide all TxHmL Program services:

(1) authorized in an individual's IPC;

(2) in accordance with the applicable service definition as specified in §9.555 of this subchapter (relating to Definitions of TxHmL Program Services); and

(3) in accordance with an individual's PDP, the implementation plan, and Appendix C of the TxHmL Program waiver application approved by CMS and found at www.dads.state.tx.us.

(o) A program provider must develop a written service backup plan for a TxHmL Program service identified on the PDP as critical to meeting an individual's health and safety.

(1) A service backup plan must:

(A) contain the name of the service;

(B) specify the period of time in which an interruption to the service would result in an adverse effect to the individual's health or safety; and

(C) in the event of a service interruption resulting in an adverse effect as described in subparagraph (B) of this paragraph, describe the actions the program provider will take to ensure the individual's health and safety.

(2) A program provider must ensure that:

(A) if the action in the service backup plan required by paragraph (1) of this subsection identifies a natural support, that the natural support receives pertinent information about the individual's needs and is able to protect the individual's health and safety; and

(B) a person identified in the service backup plan, if paid to provide the service, meets the qualifications described in this subchapter.

(3) If a service backup plan is implemented, a program provider must:

(A) discuss the implementation of the service backup plan with the individual and the service providers or natural supports identified in the service backup plan to determine whether or not the plan was effective;

(B) document whether or not the plan was effective; and

(C) revise the plan if the program provider determines the plan was ineffective.

(p) If respite is provided in a location other than an individual's family home, the location must be acceptable to the individual or LAR and provide an accessible, safe, and comfortable environment for the individual that promotes the health and welfare of the individual.

(1) Respite may be provided in the residence of another individual receiving TxHmL Program services or similar services if the program provider has obtained written approval from the individuals living in the residence or their LARs and:

(A) no more than three individuals receiving TxHmL Program services and other persons receiving similar services are provided services at any one time; or

(B) no more than four individuals receiving TxHmL Program services and other persons receiving similar services are provided services in the residence at any one time and the residence is approved in accordance with §9.188 of this chapter (relating to DADS Approval of Residences).

(2) Respite may be provided in a respite facility if the program provider provides or intends to provide respite to more than three individuals receiving TxHmL Program services or persons receiving similar services at the same time; and

(A) the program provider has obtained written approval from the local fire authority having jurisdiction stating that the facility and its operation meet the local fire ordinances; and

(B) the program provider obtains such written approval from the local fire authority having jurisdiction on an annual basis.

(3) If respite is provided in a camp setting, the program provider must ensure the camp is accredited by the American Camp Association.

(4) Respite must not be provided in an institution such as an ICF/IID, skilled nursing facility, or hospital.

(q) The program provider must ensure that nursing is provided in accordance with:

(1) Texas Occupations Code, Chapter 301 (Nursing Practice Act);

(2) 22 TAC Chapter 217 (relating to Licensure, Peer Assistance, and Practice);

(3) 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); and

(4) 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).

(r) A program provider may determine that an individual does not require a nursing assessment if:

(1) nursing services are not on the individual's IPC and the program provider has determined that no nursing task will be performed by the program provider's unlicensed service provider as documented on DADS form "Nursing Task Screening Tool"; or

(2) a nursing task will be performed by the program provider's unlicensed service provider and a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician.

(s) If an individual or LAR refuses a nursing assessment described in §9.555(c)(10)(A) of this subchapter (relating to Definitions of TxHmL Program Services), the program provider must not:

(1) provide nursing services to the individual; or

(2) provide community support, day habilitation, employment assistance, supported employment, or respite to the individual unless:

(A) an unlicensed service provider does not perform nursing tasks in the provision of the service; and

(B) the program provider determines that it can ensure the individual's health, safety, and welfare in the provision of the service.

(t) If an individual or LAR refuses a nursing assessment and the program provider determines that the program provider cannot ensure the individual's health, safety, and welfare in the provision of a service as described in subsection (s) of this section, the program provider must:

(1) immediately notify the individual or LAR and the individual's service coordinator, in writing, of the determination; and

(2) include in the notification required by paragraph (1) of this subsection the reasons for the determination and the services affected by the determination.

(u) If notified by the service coordinator that the individual or LAR refuses the nursing assessment after the discussion with the service coordinator as described in §9.583(k)(6) of this subchapter (relating to TxHmL Program Principles for Local Authorities), the program provider must immediately send the written notification described in subsection (t) of this section to DADS.

(v) The program provider must, if a physician delegates a medical act to an unlicensed service provider in accordance with Texas Occupations Code, Chapter 157, and the program provider has concerns about the health or safety of the individual in performance of the medical act, communicate the concern to the delegating physician and take additional steps as necessary to ensure the health and safety of the individual.

§9.579. Certification Principles: Qualified Personnel.

(a) The program provider must ensure the continuous availability of trained and qualified employees and contractors to provide the services in an individual's IPC.

(b) The program provider must comply with applicable laws and regulations to ensure that:

(1) its operations meet necessary requirements; and

(2) its employees or contractors possess legally necessary licenses, certifications, registrations, or other credentials and are in good standing with the appropriate professional agency before performing any function or delivering services.

(c) The program provider must employ or contract with a service provider of the individual's or LAR's choice if that service provider:

(1) is qualified to provide the service;

(2) provides the service within the direct services portion of the applicable TxHmL Program rate; and

(3) contracts with or is employed by the program provider.

(d) The program provider must conduct initial and periodic training that ensures:

(1) staff members and service providers are trained and qualified to deliver services as required by the current needs and characteristics of the individual to whom they deliver services; and

(2) staff members, service providers, and volunteers comply with §49.310(3)(A) of this title relating to Abuse, Neglect, and Exploitation Allegations).

(e) The program provider must implement and maintain personnel practices that safeguard an individual against infectious and communicable diseases.

(f) The program provider must prevent:

(1) conflicts of interest between program provider personnel and an individual;

(2) financial impropriety toward an individual;

(3) abuse, neglect, or exploitation of an individual; and

(4) threats of harm or danger toward an individual's possessions.

(g) The program provider must employ or contract with a person who oversees the provision of TxHmL Program services to an individual. The person must:

(1) have at least three years paid work experience in planning and providing TxHmL Program services to an individual with an intellectual disability or related condition as verified by written statements from the person's employer; or

(2) have both of the following:

(A) at least three years of experience planning and providing services similar to TxHmL Program services to a person with an intellectual disability or related condition as verified by written statements from organizations or agencies that provided services to the person; and

(B) participation as a member of a microboard, as verified in writing by:

(i) the certificate of formation of the non-profit corporation under which the microboard operates filed with the Texas Secretary of State;

(ii) the bylaws of the non-profit corporation; and

(iii) a statement by the board of directors of the non-profit corporation that the person is a member of the microboard.

(h) The program provider must ensure that a service provider of community support, day habilitation, or respite is at least 18 years of age and:

(1) has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or

(2) has documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:

(A) written competency-based assessment of the ability to document service delivery and observations of an individual to be served; and

(B) at least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for an individual being served.

(i) The program provider must ensure that a service provider of employment assistance or a service provider of supported employment is at least 18 years of age, is not the LAR of the individual receiving employment assistance or supported employment from the service provider, and has:

(1) a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;

(2) an associate's degree in rehabilitation, business, marketing, or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or

(3) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities.

(j) A program provider must ensure that the experience required by subsection (i) of this section is evidenced by:

(1) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and

(2) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

(k) The program provider must ensure that a service provider who provides transportation:

(1) has a valid driver's license; and

(2) transports individuals in a vehicle insured in accordance with state law.

(l) The program provider must ensure that dental treatment is provided by a dentist licensed in accordance with Texas Occupations Code, Chapter 256.

(m) The program provider must ensure that nursing is provided by an RN or an LVN.

(n) The program provider must ensure that adaptive aids meet applicable standards of manufacture, design, and installation.

(o) The program provider must ensure that the provider of behavioral support is:

(1) licensed as a psychologist in accordance with Texas Occupations Code, Chapter 501;

(2) licensed as a psychological associate in accordance with Texas Occupations Code, Chapter 501;

(3) certified by DADS as described in §5.161 of this title (relating to TDMHMR-Certified Psychologist);

(4) certified as a behavior analyst by the Behavior Analyst Certification Board, Inc.;

(5) issued a provisional license to practice psychology in accordance with Texas Occupations Code, Chapter 501;

(6) licensed as a licensed clinical social worker in accordance with Texas Occupations Code, Chapter 505; or

(7) licensed as a licensed professional counselor in accordance with Texas Occupations Code, Chapter 503.

(p) The program provider must ensure that minor home modifications are delivered by contractors who provide the service in accordance with state and local building codes and other applicable regulations.

(q) The program provider must ensure that a provider of professional therapies is licensed for the specific therapeutic service provided as follows:

(1) for audiology services, an audiologist licensed in accordance with Texas Occupations Code, Chapter 401;

(2) for speech and language pathology services, a speech-language pathologist or licensed assistant in speech-language pathology licensed in accordance with Texas Occupations Code, Chapter 401;

(3) for occupational therapy services, an occupational therapist or occupational therapy assistant licensed in accordance with Texas Occupations Code, Chapter 454;

(4) for physical therapy services, a physical therapist or physical therapist assistant licensed in accordance with Texas Occupations Code, Chapter 453;

(5) for dietary services, a licensed dietitian licensed in accordance with Texas Occupations Code, Chapter 701; and

(6) for social work services, a social worker licensed in accordance with Texas Occupations Code, Chapter 505.

(r) The program provider must comply with §49.304 of this title (relating to Background Checks).

(s) A program provider must comply with §49.312(a) of this title (relating to Personal Attendants).

(t) If the service provider of community support is employed by or contracts with a contractor of a program provider, the program provider must ensure that the contractor complies with subsection (s) of this section as if the contractor were the program provider.

§9.580. Certification Principles: Quality Assurance.

(a) The program provider must:

(1) assist the individual or LAR in understanding the requirements for participation in the TxHmL Program and include the individual or LAR in planning service provision and any changes to the plan for service provision if changes become necessary;

(2) assist and cooperate with the individual's or LAR's request to transfer to another program provider;

(3) assist the individual to access public accommodations or services available to all citizens;

(4) assist the individual to manage the individual's financial affairs upon documentation of the individual's or LAR's written request for such assistance;

(5) ensure that any restriction affecting the individual is approved by the individual's service planning team before the imposition of the restriction;

(6) inform the individual or LAR about the individual's health, mental condition, and related progress;

(7) inform the individual or LAR of the name and qualifications of any person serving the individual and the option to choose among various available service providers;

(8) provide the individual or LAR access to TxHmL Program records, including, if applicable, financial records maintained on the individual's behalf, about the individual and the delivery of services by the program provider to the individual;

(9) assist the individual to communicate by phone or by mail during the provision of TxHmL Program services unless the service planning team has agreed to limit the individual's access to communicating by phone or by mail;

(10) assist the individual, as specified in the individual's PDP, to attend religious activities as chosen by the individual or LAR;

(11) ensure the individual is free from unnecessary restraints during the provision of TxHmL Program services;

(12) regularly inform the individual or LAR about the individual's or program provider's progress or lack of progress made in the implementation of the PDP;

(13) receive and act on complaints about the program services provided by the program provider;

(14) ensure that the individual is free from abuse, neglect, or exploitation by program provider personnel;

(15) provide active, individualized assistance to the individual or LAR in exercising the individual's rights and exercising self-advocacy, including:

(A) making complaints;

(B) registering to vote;

(C) obtaining citizenship information and education;

(D) obtaining advocacy services; and

(E) obtaining information regarding legal guardianship;

(16) provide the individual privacy during treatment and care of personal needs;

(17) include the individual's LAR in decisions involving the planning and provision of TxHmL Program services;

(18) inform the individual or LAR of the process for reporting a complaint to DADS or the local authority when the program provider's resolution of a complaint is unsatisfactory to the individual or LAR, including the DADS Office of Consumer Rights and Services telephone number to initiate complaints (1-800-458-9858) or the local authority telephone number to initiate complaints;

(19) ensure the individual is free from seclusion;

(20) inform the individual or LAR, orally and in writing, of the requirements described in paragraphs (1) - (19) of this subsection:

(A) when the individual is enrolled in the program provider's program;

(B) if the requirements described in paragraphs (1) - (19) of this subsection are revised;

(C) at the request of the individual or LAR; and

(D) if the legal status of the individual changes;

(21) obtain an acknowledgement stating that the information described in paragraph (20) of this subsection was provided to the individual or LAR and that is signed by:

(A) the individual or LAR;

(B) the program provider staff person providing such information; and

(C) a third-party witness; and

(22) notify the individual's service coordinator of an individual's or LAR's expressed interest in the CDS option and document such notification.

(b) The program provider must make available all records, reports, and other information related to the delivery of TxHmL Program services as requested by DADS, other authorized agencies, or CMS and deliver such items, as requested, to a specified location.

(c) At least annually, the program provider must conduct a satisfaction survey of individuals, their families, and LARs, and take action regarding any areas of dissatisfaction.

(d) The program provider must comply with §49.309 of this title (relating to Complaint Process).

(e) The program provider must:

(1) ensure that the individual and the LAR are informed of how to report allegations of abuse, neglect, or exploitation to DFPS and are provided with the DFPS toll-free telephone number (1-800-647-7418) in writing;

(2) comply with §49.310(4) of this title (relating to Abuse, Neglect, and Exploitation Allegations); and

(3) ensure that all staff members, service providers, and volunteers:

(A) are instructed to report to DFPS immediately, but not later than one hour after having knowledge or suspicion, that an individual has been or is being abused, neglected, or exploited; and

(B) are provided with the DFPS toll-free telephone number (1-800-647-7418) in writing; and

(C) comply with §49.310(3)(B) of this title.

(f) Upon suspicion that an individual has been or is being abused, neglected, or exploited or notification of an allegation of abuse, neglect or exploitation, the program provider must take necessary actions to secure the safety of the individual, including:

(1) obtaining immediate and on-going medical and other appropriate supports for the individual, as necessary;

(2) restricting access by the alleged perpetrator of the abuse, neglect, or exploitation to the individual or other individuals pending investigation of the allegation, when an alleged perpetrator is an employee or contractor of the program provider; and

(3) notifying, as soon as possible but no later than 24 hours after the program provider reports or is notified of an allegation, the individual, the individual's LAR, and the local authority of the allegation report and the actions that have been or will be taken.

(g) The program provider must ensure that staff members, service providers, and volunteers cooperate with the DFPS investigation of an allegation of abuse, neglect, or exploitation, including:

(1) providing complete access to all TxHmL Program service sites owned, operated, or controlled by the program provider;

(2) providing complete access to individuals and program provider personnel;

(3) providing access to all records pertinent to the investigation of the allegation; and

(4) preserving and protecting any evidence related to the allegation in accordance with DFPS instructions.

(h) The program provider must:

(1) report the program provider's response to the finding of a DFPS investigation of abuse, neglect, or exploitation to DADS in accordance with DADS procedures within 14 calendar days of the program provider's receipt of the investigation findings;

(2) promptly, but not later than five calendar days from the program provider's receipt of the DFPS investigation finding, notify the individual and LAR of:

(A) the investigation finding;

(B) the corrective action taken by the program provider if DFPS confirms that abuse, neglect, or exploitation occurred;

(C) the process to appeal the investigation finding as described in Chapter 711, Subchapter M of this title (relating to Requesting an Appeal if You are the Reporter, Alleged Victim, Legal Guardian, or with Disability Rights Texas); and

(D) the process for requesting a copy of the investigative report from the program provider; and

(3) upon request of the individual or LAR, provide to the individual or LAR a copy of the DFPS investigative report after concealing any information that would reveal the identity of the reporter or of any individual who is not the individual.

(i) If the DFPS investigation confirms that abuse, neglect, or exploitation by program provider personnel occurred, the program provider must take appropriate action to prevent the recurrence of abuse, neglect or exploitation including, when warranted, disciplinary action against or termination of the employment of program provider personnel confirmed by the DFPS investigation to have committed abuse, neglect, or exploitation.

(j) In all respite facilities, the program provider must post in a conspicuous location:

(1) the name, address, and telephone number of the program provider;

(2) the effective date of the contract; and

(3) the name of the legal entity named on the contract.

(k) At least quarterly, the program provider must review incidents of abuse, neglect, or exploitation, complaints, temporary suspensions, terminations, transfers, and critical incidents to assess trends and identify program operation modifications that will prevent the recurrence of such incidents and improve service delivery.

(l) A program provider must ensure that all personal information maintained by the program provider or its contractors concerning an individual, such as lists of names, addresses, and records created or obtained by the program provider or its contractor, is kept confidential, that the use or disclosure of such information and records is limited to purposes directly connected with the administration of the TxHmL Program, and is otherwise neither directly nor indirectly used or disclosed unless the written permission of the individual to whom the information applies or the individual's LAR is obtained before the use or disclosure.

(m) The program provider must ensure that:

(1) the individual or LAR has agreed in writing to all charges assessed by the program provider against the individual's personal funds before the charges are assessed; and

(2) charges for items or services are reasonable and comparable to the costs of similar items and services generally available in the community.

(n) The program provider must not charge an individual or LAR for costs for items or services reimbursed through the TxHmL Program.

(o) At the written request of an individual or LAR, the program provider:

(1) must manage the individual's personal funds entrusted to the program provider;

(2) must not commingle the individual's personal funds with the program provider's funds; and

(3) must maintain a separate, detailed record of all deposits and expenditures for the individual.

(p) When a behavioral support plan includes techniques that involve restriction of individual rights or intrusive techniques, the program provider must ensure that the implementation of such techniques includes:

(1) approval by the individual's service planning team;

(2) written consent of the individual or LAR;

(3) verbal and written notification to the individual or LAR of the right to discontinue participation in the behavioral support plan at any time;

(4) assessment of the individual's needs and current level/severity of the behavior targeted by the plan;

(5) use of techniques appropriate to the level/severity of the behavior targeted by the plan;

(6) a written behavior support plan developed by a psychologist or behavior analyst with input from the individual, LAR, the individual's service planning team, and other professional personnel;

(7) collection and monitoring of behavioral data concerning the targeted behavior;

(8) allowance for the decrease in the use of intervention techniques based on behavioral data;

(9) allowance for revision of the behavioral support plan when the desired behavior is not displayed or techniques are not effective;

(10) consideration of the effects of the techniques in relation to the individual's physical and psychological well-being; and

(11) at least annual review by the individual's service planning team to determine the effectiveness of the program and the need to continue the techniques.

(q) The program provider must report the death of an individual to the local authority and DADS by the end of the next business day following the death of the individual or the program provider's knowledge of the death and, if the program provider reasonably believes that the individual's LAR or family does not know of the individual's death, to the individual's LAR or family as soon as possible, but not later than 24 hours after the program provider learns of the individual's death.

(r) A program provider must enter critical incident data in the DADS data system no later than 30 calendar days after the last calendar day of the month being reported in accordance with the TxHmL Provider User Guide.

(s) The program provider must ensure that:

(1) the name and phone number of an alternate to the CEO of the program provider is entered in the DADS data system; and

(2) the alternate to the CEO:

(A) performs the duties of the CEO during the CEO's absence; and

(B) acts as the contact person in a DFPS investigation if the CEO is named as an alleged perpetrator of abuse, neglect, or exploitation of an individual and complies with subsections (f) - (i) of this section.

§9.583. TxHmL Program Principles for Local Authorities.

(a) A local authority must notify an applicant of a TxHmL Program vacancy in accordance with §9.566 of this subchapter (relating to Notification of Applicants).

(b) A local authority must process requests for enrollment in the TxHmL Program in accordance with §9.567 of this subchapter (relating to Process for Enrollment).

(c) A local authority must have a mechanism to ensure objectivity in the process to assist an individual or LAR in the selection of a program provider and a system for training all local authority staff who may assist an individual or LAR in such process.

(d) A local authority must ensure that its employees and contractors possess legally necessary licenses, certifications, registrations, or other credentials and are in good standing with the appropriate professional agency before performing any function or delivering services.

(e) A local authority must ensure that an individual or LAR is informed orally and in writing of the following processes for filing complaints about service provision:

(1) processes for filing complaints with the local authority about the provision of service coordination; and

(2) processes for filing complaints about the provision of TxHmL Program services including:

(A) the telephone number of the local authority to file a complaint;

(B) the toll-free telephone number of DADS to file a complaint; and

(C) the toll-free telephone number of DFPS (1-800-647-7418) to file a complaint of abuse, neglect, or exploitation.

(f) A local authority must maintain for each individual:

(1) a current IPC;

(2) a current PDP;

(3) a current ID/RC Assessment; and

(4) current service information.

(g) For an individual receiving TxHmL Program services within the local authority's local service area, the local authority must provide the individual's program provider a copy of the individual's current PDP, IPC, and ID/RC Assessment.

(h) A local authority must employ service coordinators who:

(1) meet the minimum qualifications and staff training requirements specified in Chapter 2, Subchapter L of this title (relating to Service Coordination for Individuals with an Intellectual Disability); and

(2) have received training about the TxHmL Program, including the requirements of this subchapter and the TxHmL Program

services as specified in §9.555 of this subchapter relating to Definitions of TxHmL Program Services).

(i) A local authority must ensure that a service coordinator:

(1) initiates, coordinates, and facilitates the person-directed planning process to meet the desires and needs as identified by an individual and LAR in the individual's PDP, including documenting on the PDP whether, for each TxHmL Program service identified on the PDP, the service is critical to meeting the individual's health and safety as determined by the service planning team;

(2) coordinates the development and implementation of the individual's PDP;

(3) submits a correctly completed request for authorization of payment from non-TxHmL Program sources for which an individual may be eligible;

(4) coordinates and develops an individual's IPC based on the individual's PDP;

(5) coordinates and monitors the delivery of TxHmL Program and non-TxHmL Program services;

(6) integrates various aspects of services delivered under the TxHmL Program and through non-TxHmL Program sources;

(7) records each individual's progress;

(8) develops a plan required by §9.570(c)(2) of this subchapter (relating to Termination and Suspension of TxHmL Program Services) that addresses assistance for the individual after termination of the individual's TxHmL Program services; and

(9) keeps records as they pertain to the implementation of an individual's PDP.

(j) A local authority must ensure that an individual or LAR is informed of the name of the individual's service coordinator and how to contact the service coordinator.

(k) A service coordinator must:

(1) assist the individual or LAR in exercising the legal rights of the individual as a citizen and as a person with a disability;

(2) assist the individual's LAR or family members to encourage the individual to exercise the individual's rights;

(3) inform the individual or LAR orally and in writing of:

(A) the eligibility criteria for participation in the TxHmL Program;

(B) the services and supports provided by the TxHmL Program and the limits of those services and supports; and

(C) the reasons an individual's TxHmL Program services may be terminated as described in §9.570(a);

(4) ensure that the individual and LAR participate in developing a personalized PDP and IPC that meet the individual's identified needs and service outcomes and that the individual's PDP is updated when the individual's needs or outcomes change but not less than annually;

(5) ensure that a restriction affecting the individual is approved by the individual's service planning team before the imposition of the restriction;

(6) if notified by the program provider that an individual or LAR has refused a nursing assessment and that the program provider has determined that it cannot ensure the individual's health, safety, and welfare in the provision of a service as described in §9.578(t) of this subchapter (relating to Program Provider Certification Principles: Service Delivery), a service coordinator must:

(A) inform the individual or LAR of the consequences and risks of refusing the assessment, including that the refusal will result in the individual not receiving:

(i) nursing services; or

(ii) community support, day habilitation, employment assistance, supported employment, or respite, if the individual needs one of those services and the program provider has determined that it cannot ensure the health, safety, and welfare of the individual in the provision of the service; and

(B) notify the program provider if the individual or LAR continues to refuse the assessment after the discussion with the service coordinator;

(7) ensure that the individual or LAR is informed of decisions regarding denial or termination of services and the individual's or LAR's right to request a fair hearing as described in §9.571 of this subchapter (relating to Fair Hearings);

(8) ensure that, if needed, the individual or LAR participates in developing a plan required by §9.570(c)(2) of this subchapter that addresses assistance for the individual after termination of the individual's TxHmL Program services; and

(9) manage the process to transfer an individual's TxHmL Program services from one program provider to another or one FMSA to another in accordance with DADS instructions, including:

(A) informing the individual or LAR who requests a transfer to another program provider or FMSA that the service coordinator will manage the transfer process;

(B) informing the individual or LAR that the individual or LAR may choose to receive TxHmL Program services from any program provider or FMSA; and

(C) if the individual or LAR has not selected another program provider or FMSA, provide the individual or LAR a list of and contact information for available TxHmL Program providers and FMSAs in the geographic locations preferred by the individual or LAR.

(l) When a change to an individual's PDP or IPC is indicated, the service coordinator must discuss the need for the change with the individual or LAR, the individual's program provider, and other appropriate persons as necessary.

(m) At least 30 calendar days before the expiration of an individual's IPC, the service coordinator must:

(1) update the individual's PDP in conjunction with the individual's service planning team; and

(2) if the individual receives a TxHmL Program service from a program provider, submit the updated PDP to the program provider for the program provider to complete an implementation plan to accomplish the outcomes identified in the updated PDP.

(n) A service coordinator must:

(1) review the status of an individual whose services have been suspended at least every 90 calendar days following the effective date of the suspension and document in the individual's record the reasons for continuing the suspension; and

(2) if the suspension continues 270 calendar days, submit written documentation of the 90, 180, and 270 calendar day reviews to DADS for review and approval to continue the suspension status.

(o) A service coordinator must:

(1) inform the individual or LAR orally and in writing, of the requirements described in subsection (k) of this section:

(A) upon receipt of DADS approval of the enrollment of the individual;

(B) if the requirements described in subsection (k) of this section are revised;

(C) at the request of the individual or LAR; and

(D) if the legal status of the individual changes; and

(2) document that the information described in paragraph (1) of this subsection was provided to the individual or LAR.

(p) A service coordinator must comply with Chapter 41, Subchapter D of this title (relating to Enrollment, Transfer, Suspension, and Termination) and document compliance in the individual's record.

(q) If an individual or LAR chooses to participate in the CDS option, the service coordinator must:

(1) provide names and contact information to the individual or LAR regarding all FMSAs providing services in the local authority's local service area;

(2) document the individual's or LAR's choice of FMSA on Form 1584;

(3) document, in the individual's PDP, a description of the services provided through the CDS option; and

(4) document, in the individual's PDP, a description of the individual's service backup plan.

(r) For an individual participating in the CDS option, the local authority must recommend to DADS that FMS and support consultation, if applicable, be terminated if the service coordinator determines that:

(1) the individual's continued participation in the CDS option poses a significant risk to the individual's health, safety or welfare; or

(2) the individual or LAR has not complied with Chapter 41, Subchapter B of this title (relating to Responsibilities of Employers and Designated Representatives).

(s) If a local authority makes a recommendation under subsection (r) of this section, the local authority must:

(1) electronically transmit the individual's IPC to DADS; and

(2) in accordance with Chapter 41, Subchapter D of this title, submit documentation required by DADS in writing, to the Department of Aging and Disability Services, Access and Intake, Program Enrollment, P.O. Box 149030, Mail Code W-551, Austin, Texas 78714-9030.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Lawrence Hornsby
General Counsel
Department of Aging and Disability Services
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Proposal publication date: April 18, 2014
For further information, please call: (512) 438-4162

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40 TAC §§9.557, 9.559, 9.569, 9.577

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER Q. ENROLLMENT OF MEDICAID WAIVER PROGRAM PROVIDERS

40 TAC §§9.701 - 9.712

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts the repeal of §§9.701 - 9.712, concerning purpose; applications; definitions; pre-application orientation; application process; provisional certification; waiver program provider agreement; provider certification; additional provider certification; waiver program provider agreement assignment; references; and distribution, in Subchapter Q, Enrollment of Medicaid Waiver Program Providers, in Chapter 9, Intellectual Disability Services--Medicaid State Operating Agency Responsibilities, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3112).

The repeals are adopted to delete rules in Chapter 9, Subchapter Q in conjunction with new Chapter 49, Contracting for Commu-

nity Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including contractors in the Home and Community-Based Services Program and the Texas Home Living Program, which are currently governed by Chapter 9, Subchapter Q. Therefore, the repealed rules are addressed by the adopted new Chapter 49, as well as adopted amendments to Chapter 9, Subchapter D, Home and Community-Based Services (HCS) Program, and Subchapter N, Texas Home Living (TxHmL) Program.

A contract application approved by DADS before the effective date of these rules is governed by the rules in effect on the date the application was approved and the former rules continue in effect for that purpose.

DADS received no comments regarding adoption of the repeals.

Statutory Authority

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 15. LICENSING STANDARDS FOR PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts new Chapter 15, Licensing Standards for Prescribed Pediatric Extended Care Centers. New §§15.3, 15.5, 15.101, 15.105, 15.107, 15.118 - 15.121, 15.205 - 15.207, 15.209 - 15.211, 15.301, 15.309, 15.402, 15.404, 15.406, 15.409, 15.410, 15.415, 15.502, 15.507, 15.508, 15.511, 15.607, 15.901, 15.1101, 15.1102, and 15.1207 are adopted with changes to the proposed text published in the April 4, 2014, issue of the *Texas Register* (39 TexReg 2413). New §§15.1, 15.2, 15.4, 15.102 - 15.104, 15.106, 15.108 - 15.117, 15.122, 15.201 - 15.204, 15.208, 15.302 - 15.308, 15.310, 15.311, 15.401, 15.403, 15.405, 15.407, 15.408, 15.411 - 15.414, 15.416 - 15.419, 15.501, 15.503 - 15.506, 15.509, 15.510, 15.601 - 15.606, 15.608, 15.701 - 15.708, 15.801 - 15.803, 15.902 - 15.906, 15.1001 - 15.1004, 15.1201 - 15.1206, 15.1208 - 15.1224, 15.1301 - 15.1305, and 15.1401 - 15.1409 are adopted without changes to the proposed text and will not be republished.

The adoption establishes rules to license and regulate prescribed pediatric extended care centers (centers) in Texas in response to Senate Bill 492, 83rd Legislature, Regular Session, 2013, which enacted Texas Health and Safety Code (THSC) Chapter 248A. A center provides services to individuals younger than 21 years of age who are medically and technologically dependent.

The adoption authorizes a licensed center to provide a location where individuals with medically complex conditions may receive daily medical care in a non-residential setting. When prescribed by a physician, an individual may receive medical, nursing, psychosocial, therapeutic, and developmental services in a center for up to 12 hours per day if the services are appropriate to the individual's medical condition and developmental status.

The adoption establishes licensing procedures and requirements, provides definitions for the program, establishes minimum standards designed to protect the health and safety of individuals served by a center, and establishes procedures for enforcement actions that DADS may take against a center.

Senate Bill 492 prohibits the operation of a center without a license after December 31, 2014.

In §15.5(13), (43), (65), (77), (98), regarding definitions, the agency clarified the use of restraints by classifying certain devices as protective in nature and restricting the definitions related to restraints. Thus, the agency amended the definitions of "chemical restraint," "quiet time," "protective device," "sedation," "restraint," and "physical restraint," and added a new definition for "mechanical restraint." The definition of "chemical restraint" was amended to clarify that a chemical restraint restricts the free movement of a minor's body. The new definition of mechanical restraint was added to distinguish it from physical and chemical restraint. The definition of "physical restraint" was amended to be substantially similar to definitions used in other agency programs. The definition of "protective device" was revised and a reference to sedation was added. The definition of "quiet time" was amended to allow it to be initiated by center staff or by the minor. The definition of "timeout" was deleted because it is covered by the revised definition of "quiet time," which is person-centered in focus.

In §15.105(a), the agency deleted the requirement that an alternate administrator, nursing director, and alternate nursing director must complete the pre-licensing training before an applicant may submit an initial license application. The agency determined it is sufficient for only the administrator to complete the training as part of the responsibilities of the position before submitting the license application. Additionally, the persons holding these positions will not be identified on an application for an initial license.

In §15.105(b)(3) and §15.108(c)(3), the agency amended the section to allow DADS to accept documentation other than a letter of credit to demonstrate an applicant's financial viability because a letter of credit, which guarantees payment of an amount

under specified circumstances, may not be the appropriate instrument to show financial viability.

In §15.119(a), the agency removed the requirement that the center must report any changes in the individuals serving in the roles of alternate administrator, nursing director, and alternate nursing director because these individuals will not be identified on the initial application or other agency records.

In §15.120, the agency made a minor grammatical correction to the section, revising "at the center" to "in the center" and making "center" possessive to clarify the meaning of the section.

In §15.121, the agency made a minor grammatical correction to the section, revising "at the center" to "in the center."

In §15.205(b), the agency restructured the subsection for ease in readability and deleted the specific information that must be provided on the DADS Fire Drill Report Form.

In §15.206, in accordance with other changes to the chapter to distinguish the use of protective devices from the use of restraints, which may only be used in an emergency, the agency explicitly prohibits the use of any planned restraint or timeout as part of a minor's person-centered guidance program. This change was made to clarify that these actions are not considered positive behavior support. The term "timeout" has also been replaced with "quiet time." In addition, the section has been revised to provide that during quiet time a minor may not be placed in a room alone, regardless of whether the room is locked. This change was made to increase the supervision and safety of a minor who is having quiet time. The agency made other minor corrections and removed unnecessary and duplicative wording.

In §15.207, the agency renamed the section "Protective Devices and Restraints" in an effort to distinguish between the use of restraints and protective devices, and to clarify the permitted uses of protective devices. The changes clarify the agency's intent to prohibit use of restraints as part of person-centered direction and guidance. The changes reorganize the section to ensure protective devices are used only as part of a therapeutic regimen; during medical, nursing, diagnostic, and dental procedures, as prescribed by a physician's order; and in a medical emergency to protect the health and safety of a minor.

In §15.209(c)(1), the agency made a minor grammatical correction by deleting the word "or."

In §15.301(f), the agency added the phrase "in writing" to clarify that a license holder must designate an administrator in writing. This change is consistent with other sections requiring similar documentation.

In §15.309, in accordance with the modified requirement regarding designation of the nursing director and the alternate nursing director in §15.105, the agency changed the requirement for the completion of pre-licensing program training to be later in the licensing process. The training by the nursing director and alternate nursing director must be completed before designation to the position.

In §15.402, §15.404, §15.406, §15.409, and §15.411, the agency made amendments to allow center administration to recruit and train staff with less work experience, while providing additional oversight, supervision, training, and direction until the staff are fully qualified for the positions for which they are hired.

DADS received written comments from Disability Rights Texas, EveryChild, Inc., Texas Council for Developmental Disabilities, Texas Education Agency, and The Arc of Texas. A summary of the comments and the responses follows.

Comment: Concerning §15.3(c), four commenters stated that the rule should be revised to more clearly indicate a center cannot accept delegation of responsibility from a local education agency to provide a minor's free and appropriate public education.

Response: The agency agrees with the comment and has revised §15.3(c) to prohibit a center from acting as the primary education provider or accepting delegation of responsibility for a minor's education from an education provider, such as a local education agency.

Comment: Four commenters requested that the United States Code citation for the Individuals with Disabilities Education Act (IDEA) be included in the rule.

Response: The agency agrees the citation would be helpful and has amended the section to include the citation for IDEA, as well as for §504 of the Rehabilitation Act.

Comment: Concerning §15.3, one commenter recommended that the rule clarify that centers are not intended to provide a place for school-age children to receive educational services but, instead, are intended to provide specialized care for children before and after school and on days that public schools are closed.

Response: The agency responds that a center is required to ensure a minor receives basic services, as defined in Texas Health and Safety Code, §248A.001(1), based on the needs of the minor and as ordered by the minor's prescribing physician. While §15.508 prohibits a center from acting as the primary education provider for a minor, prohibiting a center from serving minors during public school hours would deny access to a less restrictive environment for minors who are currently homebound. Section 15.508 allows educational services to be provided at a center only if it is determined, by the education provider, that the center is the least restrictive environment for the delivery of educational services to the minor. Additionally, §15.508 prohibits a center from interfering with a minor's compulsory school attendance requirements. The agency did not revise the rule as requested.

Comment: Concerning §15.5(9)(A)(ii), three commenters requested the definition of "basic services" be revised to include that the protocol of care is approved by a minor's parent or an adult minor to ensure family oversight and choice.

Response: The agency responds that the definition of "basic services" is consistent with the statutory definition in Texas Health and Safety Code, §248A. 001. Section 15.607 requires a plan of care to be developed in collaboration with and approved by a minor's parent and an adult minor. The agency did not revise the rules as requested.

Comment: Concerning §15.5(10), three commenters requested the definition of "behavioral emergency" be revised to narrow the scope of what is considered to be a behavioral emergency. The commenters requested the term "imminent" be replaced with "immediate" and the term "considered" be removed so a behavioral emergency only occurs after techniques have been attempted.

Response: The agency agrees that "immediate" is a more appropriate word in this context because, to constitute a behavioral emergency, death or serious bodily harm may only be "probable," rather than certain, but the risk must be immediate, meaning it will occur without delay. In addition, the agency agrees that,

to constitute a behavioral emergency, preventative and de-escalating techniques must be tried, not just considered. The reference to "oral" techniques has been eliminated because the techniques must be aimed at preventing or de-escalating the dangerous situation, regardless of whether the techniques are oral or through other means of communication. In addition, the requirement that the minor attempt to harm the minor or others is not relevant if the situation results in the described outcome. The agency has revised the definition to reflect these differences.

Comment: Concerning §15.5, three commenters requested the addition of a definition for "critical incident" and requirements for centers to analyze and report to DADS critical incidents occurring at the center. Additionally, the commenters requested that centers be added to the DADS Long Term Care Quality Reporting System (QRS) to allow members of the public to obtain information about the performance of centers and compare services provided by centers to identify centers that meet their families' needs.

Response: Section 15.1002 requires a center to develop, implement, and maintain a quality assessment and performance improvement program that includes a system for collecting and analyzing data to measure the quality, effectiveness, and safety of services provided to minors and identify opportunities for improvement, but the term "critical incident" is not used in the rule and the agency does not believe the term is necessary. Therefore, the agency did not revise §15.5 to include a definition for "critical incident" or revise the rules to require centers to report those incidents to DADS. The agency agrees with the comment to add centers to the DADS QRS site to help the public evaluate the quality of center services but that does not require a revision to the rule.

Comment: Concerning §15.5(74), three commenters requested the definition of "prescribing physician" be revised to prohibit the center's medical director from acting as a prescribing physician. The commenters stated that allowing a medical director to act as a prescribing physician places a physician in the difficult position of balancing employment loyalty with the physician's fiduciary duty to a patient. Including this prohibition will ensure a minor has the benefit of both a center's medical director and an outside prescribing physician.

Response: The agency responds that the population served by a center is unique and has a limited resource of physicians. Prohibiting this relationship could create an access to care issue for minors and create a staffing issue for centers by requiring an already limited resource of physicians to act in only one of the two roles. The employment status of the physician should not interfere with the physician's duty of care to a patient. The agency did not revise the rule as requested.

Comment: Concerning §15.5, three commenters requested the addition of a definition for "transition support" to clarify a term used but not defined in §15.605(b) relating to initial and updated comprehensive assessments.

Response: The agency agrees with the comment and has revised §15.5 to add a definition for "transition support" to clarify the meaning of the term, which is used in §15.605(b) and (f).

Comment: Concerning §15.205, three commenters requested the addition of a requirement that a center ensure that minors served in the center are protected from the effects of secondhand smoke by prohibiting the use of tobacco-related products at the center and during center transport.

Response: The agency agrees with the comment and has revised §15.205 to prohibit the use of tobacco products at the center. Section 15.1102(d)(3) prohibits the use of tobacco in transportation vehicles.

Comment: Concerning §15.207, relating to restraints, three commenters requested the addition of a "purpose" statement to assist with interpretation of this section.

Response: The agency responds that adding a purpose statement to §15.207 and not to other sections would be inconsistent. The rule is intended to set forth the minimum standards with which a center must comply. However, DADS is committed to developing guidance through provider education to clarify the permissible use of restraints at a center. The agency did not revise the rule as requested.

Comment: Concerning §15.207, three commenters requested the addition of a requirement that the interdisciplinary team create a "special precautions plan" related to the use of restraints. The plan would minimize the frequency of restraints with the goal of eliminating the need for restraint completely; be developed in consideration of the minor's physical, mental, and medical conditions; identify the minor's known conditions to mitigate the risk of using restraints; and be evaluated and revised on a specified frequency.

Response: The agency responds that the requirements requested by the commenters are addressed in §15.504. The agency did not revise the rule as requested.

Comment: Concerning §15.207(b)(3), three commenters requested the addition of a requirement that postural support devices be used in accordance with an approved plan of care from a licensed occupational or physical therapist.

Response: The agency responds that §15.607 requires medical equipment, which includes postural support devices, to be used in accordance with an approved plan of care. The plan of care and prescription of the use of a postural device may be approved by disciplines other than a licensed occupational or physical therapist. The agency did not revise the rule as requested.

Comment: Concerning §15.207(h), three commenters stated the description of staff training requirements is vague and requested that the rule specify the type and frequency of staff training that must occur for staff whose job responsibilities will include the use of restraints.

Response: The agency agrees with the comment and revised §15.207(b)(5) to require that a staff member whose job responsibilities will include the use or application of restraints is properly trained in accordance with §15.415(b)(8)(G) relating to staff policies for staff orientation, development, and training. The agency added a new clause in §15.415(b)(8)(G) that outlines the training requirements as requested by the commenters.

Comment: Concerning §15.207(j), three commenters requested a requirement that a center obtain written or verbal authorization of a restraint within one hour after the initiation of a restraint. The commenters also requested that a center be required to review and update a minor's "special precautions plan" with a physician within 24 hours of each incident of restraint.

Response: The agency responds that §15.207(b)(6)(E) and (b)(7)(B)(iv) require an RN to conduct an assessment of the minor's condition immediately following a restraint and notify the minor's physician of the minor's condition if the assessment determines a change in the minor's condition or a negative

reaction to the restraint. Within three days after the use of a restraint, an RN must conduct an assessment of the minor to determine if it is necessary to develop and implement a psychosocial treatment and services program for the minor, and review and update the minor's plan of care and psychosocial treatment and services program as appropriate. The agency did not revise the rule as requested.

Comment: Concerning §15.307, three commenters requested a limit be placed on the number of centers for which a physician may serve as medical director. The commenters stated this limit would help to ensure quality of care and medical oversight.

Response: The agency responds that there is a limited number of physicians specializing in the care of minors with medically and technologically dependent needs. Setting a limit on the number of centers for which a physician may serve as medical director could create a access to care and services staffing issue for centers. A center is responsible for ensuring a physician hired to serve as medical director performs all responsibilities described in §15.308. The agency did not revise the rules as requested.

Comment: Concerning §15.502(c), three commenters requested the frequency with which a nursing director or designee must communicate with a minor's prescribing physician be revised from every 180 days to every 30 days. Additionally, the commenters requested the addition of a requirement for a nursing director to communicate with a minor's prescribing physician at the request of the parent or adult minor. The commenters stated these revisions will provide greater oversight by the prescribing physician.

Response: The agency responds that it agrees that increasing the frequency of communication between a nursing director and a minor's prescribing physician would be beneficial to the minor and revised §15.502(c) to require a nursing director or designee to communicate with a minor's prescribing physician at least every 90 days or more frequently when there is a health status or physical status change in the minor's condition. The agency believes that additional communication between the nursing director and prescribing physician should occur when the director and physician determine such communication is necessary and the agency declines to require a nursing director to communicate with a minor's prescribing at the request of a minor's parent.

Comment: Concerning §15.508, one commenter requested a more clear delineation between the types of services provided by centers and the educational and related services provided by public schools.

Response: The agency responds that §15.508 states that a center must not be the provider of educational services to a minor. If educational services will be provided at the center by an education provider such as a public school, §15.508 outlines the requirements a center must meet. A center is also required to provide a parent with the contact information for the local education agency for the area in which the minor resides.

Comment: Concerning §15.508, one commenter requested the addition of a statement that determinations relating to educational services, including where those services are provided, are exclusively made by the student's admission, review, and dismissal (ARD) committee or the responsible committee required by §504 of the Rehabilitation Act.

Response: The agency agrees that decisions relating to the provision of educational services, including where those services are delivered, should be exclusively made by the education provider. Section 15.508(c) states that the education provider, including a local education agency's ARD or responsible committee required by §504 of the Rehabilitation Act, determines where a minor receives educational services. Section 15.508(e) prohibits a center from duplicating services or providing services that conflict with a minor's education program. The agency did not revise the rule as requested.

Comment: Concerning §15.508, one commenter requested the addition of requirements to ensure that centers and administrators have an understanding of public schools' responsibilities under IDEA and responsible committee required by §504 of the Rehabilitation Act, as well as the broad range of services that schools provide to children with disabilities to enable them to participate and benefit from public education in a regular education environment to the maximum extent possible.

Response: The agency responds that §15.305 requires an administrator and alternate administrator to complete training on specific topics, including the Americans with Disabilities Act, which includes information about IDEA and the responsible committee required by §504 of the Rehabilitation Act. The rules in both §15.3 and §15.508 prohibit a center from providing educational services, having decision-making authority for educational services, and interfering with a minor's education program to ensure minors participate and benefit from public education in a regular education environment to the maximum extent possible, as determined by local education agency. The agency did not revise the rules as requested.

Comment: Concerning §15.508(a), three commenters requested revisions to emphasize that centers must facilitate access to available early intervention and educational services in the least restrictive environment.

Response: The agency agrees with the comment and revised §15.508(a) as requested.

Comment: Concerning §15.508, three commenters requested that a center be prohibited from interfering with the compulsory school attendance requirements of Texas Education Code §25.085 and §25.086.

Response: The agency agrees with the comment and added §15.508(e)(2) to address the concern.

Comment: Concerning §15.508(a), three commenters requested that a center be required to cooperate with "child find" activities of local early intervention programs and local education authorities.

Response: The agency responds that §15.507(b) requires a center to refer a minor to Early Childhood Intervention within seven days of identification of a developmental delay or risk of developmental delay. Section 15.508(d) requires a center to provide a minor and a minor's parent with the contact information for the local education agency where the minor resides if the minor is not currently receiving educational services. The agency did not revise the rules as requested.

Comment: Concerning §15.508(c), three commenters requested that a center not be allowed to make a determination that educational services may be provided to a minor at the center if the center is determined to be the least restrictive environment for the delivery of educational services because the commenters want to ensure that a center is not the primary location where a minor receives educational services.

Response: The agency responds that §15.508(c) provides that a center must not be the primary location for an education provider to deliver services to a minor unless it is determined by the education provider, in collaboration with the minor's parent and the minor's prescribing physician, that the center is the least restrictive environment. The agency recognizes that currently, in the absence of centers, the least restrictive environment for some children is a homebound setting as determined by the education provider. However, the education provider may determine that a center is a less restrictive environment for the child to receive educational services. The agency prefers to allow an education provider to determine the setting that would provide a less restrictive environment for the receipt of educational services. The agency did not revise the rules as requested.

Comment: Concerning §15.509, three commenters requested the addition of a requirement that parents receive training about their legal rights and about the complaint and appeal procedures.

Response: The agency responds that §15.901 requires a center to adopt and enforce written policies and procedures to ensure a minor's legal rights are observed and protected. Section 15.901 also provides that a center, before providing services to a minor, must provide an adult minor and a minor's parent oral and written notification, in a language and format understandable to the minor and parent, of the minor's rights at the center, including requirements related to complaints. The rules do not include requirements for a center to have appeal procedures. The agency did not revise the rules as requested.

Comment: Concerning §15.601(a)(1), three commenters requested revisions to require a prescribing physician to perform an in-person assessment of a minor when determining the appropriateness of a minor's admission to a center to prevent situations in which minors with certain disabilities or characteristics are automatically placed in centers or are placed in centers after perfunctory assessments.

Response: The agency responds that requiring a physician to perform an in-person assessment before prescribing center services would prohibit situations in which access to care issues are alleviated through telemedicine. Furthermore, depending on a minor's needs or location, an in-person assessment by a minor's physician is not appropriate. The agency did not revise the rules as requested.

Comments: Concerning §15.601, three commenters requested that a provision similar to §15.3(b) be added to §15.601 to enforce that admission to a center is not intended to supplant the Texas Medicaid private duty nursing benefit when such a benefit is medically necessary.

Response: The agency responds that the statement in §15.3(b) that admission to a center is not intended to supplant the Texas Medicaid private duty nursing benefit when medically necessary does not need to be repeated in another section of the chapter. The agency did not revise the rules as requested.

Comment: Concerning §15.606(f), three commenters requested a requirement that a minor's plan of care include anticipated or estimated timeframes for the minor to transition to the most integrated education or community setting appropriate.

Response: The agency responds that §15.606(f) requires the center to develop a plan of care that includes discharge planning when the plan's goals and objectives are met. Based on the unique needs of each minor, it may not be possible for a center to meet particular timeframes for every minor's transition out of the center. The agency did not revise the rules as requested.

Comment: Concerning §15.607(g), three commenters requested a requirement that copies of the plan of care be provided in a language and format that the recipient understands.

Response: The agency agrees with the comment and revised §15.607(g) as requested.

Comment: Concerning §15.608, three commenters requested that written notification be required to be provided to a minor's parent or an adult minor on the rights to appeal a decision to discharge or transfer a minor and procedures for appealing the decision.

Response: The agency responds that there is no statutory basis for requiring a center to implement an appeals process for discharge or transfer decisions. The agency did not revise the rules as requested.

Comment: Concerning §15.803(d), three commenters requested that a center be required to maintain a list of minors receiving early intervention and education services at the center as part of the census information.

Response: The agency responds that §15.803(d) requires the actual and daily census to include the services provided to a minor and the provider responsible for the delivery of each service. The term "services" is interpreted to include all services ordered by a minor's physician and coordinated by the minor's interdisciplinary team, including early intervention and education services. The agency did not revise the rule as requested.

Comment: Concerning §15.901(c)(5)(A), requiring a center to inform an adult minor and parent that complaints about a center may be directed to the center's administrator, three commenters requested that the rule specifically refer to alleged failures of the center to meet required standards.

Response: The agency responds that the term "complaints" includes alleged failures of the center to meet required standards. The agency did not revise the rules as requested.

Comment: Concerning §15.901(c)(11), three commenters requested the agency clarify that a parent or adult minor's consent is required before most changes are made to the plan of care.

Response: The agency agrees with the comment and revised §15.901(c)(11) to clarify that consent to changes in services is necessary, except when a delay would compromise the immediate health and safety of a minor.

Comment: Concerning §15.901(c)(17), three commenters requested that information about other programs be required to be provided regardless of whether a minor's condition improves enough to transition to another program.

Response: The agency agrees with the comment and revised §15.901(c)(17) to delete the condition that the information be provided only if a minor's condition improves sufficiently to transfer to other programs.

Comment: Concerning §15.903(a)(1) and (c), three commenters requested that the rule state that abuse also includes inappropriate, unnecessary, or excessive use of restraints.

Response: The agency responds that the term "abuse" is a defined term in Texas Health and Safety Code, Chapter 260A, which applies to centers. The revision requested is not consistent with the statutory definition of "abuse" but the statutory def-

inition would include inappropriate, unnecessary, or excessive use of restraints under certain circumstances. The agency did not revise the rules as requested.

Comment: Concerning §15.1101(a), three commenters requested that a center be required to provide transportation services to a minor as authorized by an adult minor or a minor's parent, in addition to a prescribing physician.

Response: The agency agrees with the comment and revised §15.1101(a) to clarify that a center must ensure transportation services are provided to a minor, as authorized by an adult minor, the minor's parent, and the minor's prescribing physician.

Comment: Concerning §15.1102(d)(3), three commenters requested the use of electronic cigarettes be prohibited in a center's vehicle.

Response: The agency agrees with the comment and revised §15.1102(d)(3) to prohibit electronic cigarettes in a center vehicle.

Comment: Concerning §15.1207(i), three commenters requested that a center be required to provide an area for the completion of homework.

Response: The agency responds that §15.508(e)(7) requires a center to support a minor's education program activities at the center by providing a well-lighted room, private space, or other adequate workspace. The agency did not revise the rules as requested.

Comment: Concerning §15.1301(a), three commenters requested that the rule state that DADS may facilitate and assist in inspections and investigations by appropriate federal and state agencies conducting such visits for official purpose.

Response: The agency responds that §15.1301(a) provides that DADS performs inspections and other contact visits at a center as deemed appropriate or as required to determine compliance with the chapter. A specific statement in rule that DADS may assist or facilitate an inspection or investigation of another federal or state agency is not necessary for DADS to perform such activities. The agency did not revise the rules as requested.

Comment: Concerning §15.1303(a), three commenters requested the addition of a statement that a license holder consents to entry or inspection of the center's premises and operations by appropriate federal and state agencies conducting official business.

Response: The agency responds that §15.1303(a) is specific to inspections and visits conducted by DADS to verify compliance with state statute and rules. It is not necessary to state in this chapter that a center is subject to entry or inspection by other agencies that have the authority to enter or inspect under other statutes.

Comment: Concerning §15.1402(a), three commenters requested authority for DADS to suspend a center's license for a violation of the civil rights of a minor and for an unacceptable number of critical incidents.

Response: The agency responds that §15.1402(a) authorizes suspension for violations of civil rights of a minor and for unacceptable numbers of critical incidents under paragraph (1) as a violation of THSC Chapter 248A or a standard in Chapter 15; it is not necessary to include specific language regarding every manner in which a violation that might occur.

Comment: Concerning §15.3(b), §15.201(a)(2), §15.205, §15.207(l)(3), §15.311(a), §15.501 - 15.511, §15.802, and §15.1102(d)(4), three commenters expressed strong support for the emphasis on person-centered direction.

Response: The agency greatly appreciates the support expressed by the commenters.

SUBCHAPTER A. PURPOSE, SCOPE, LIMITATIONS, COMPLIANCE, AND DEFINITIONS

40 TAC §§15.1 - 15.5

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.3. Limitations.

(a) Requirements established by private or public funding sources such as health maintenance organizations or other private third-party insurance, Medicaid (Title XIX of the Social Security Act), Medicare (Title XVIII of the Social Security Act), or state-sponsored funding programs are separate and apart from the requirements in this chapter for a center. Notwithstanding the funding source requirements that apply, a center must comply with the applicable provisions of THSC Chapter 248A and this chapter. A center is responsible for researching the availability of funding to pay for the services the center provides.

(b) Admission to a center is not intended to supplant a minor's right to a Medicaid private duty nursing benefit when private duty nursing is medically necessary for the minor.

(c) The services of a center must not supplant services afforded to a minor by the Individuals with Disabilities Education Act, United States Code, Title 20, §1400 et seq., and Section 504 of the Rehabilitation Act of 1973, United States Code, Title 29, §794. A center must not act as the primary education provider or accept a delegation of responsibility for the provision of a minor's education from an education provider, such as a local education agency.

§15.5. Definitions.

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

(1) Active Play--Any physical activity from which a minor derives amusement, entertainment, enjoyment, or satisfaction by taking a participatory rather than a passive role. Active play includes various forms of activities, from the exploration of objects and toys to the structured play of formal games, sports, and hobbies.

(2) Actual census--The number of minors at a center at any given time.

(3) Administration of medication--The direct application of a medication to the body of a minor by any route. This includes

removing an individual or unit dose from a previously dispensed, correctly labeled container, verifying it with the medication order, giving the correct medication and the correct dose to the correct minor at the correct time by the correct route, and accurately recording the time and dose given.

(4) Administrator--The person who is responsible for implementing and supervising the administrative polices and operations of a center and for administratively supervising the provision of services to minors and their parents on a day-to-day basis.

(5) Adult minor--A minor who is 18 years of age or older or is emancipated, and has not been adjudged incompetent.

(6) Affiliate--With respect to an applicant or license holder that is:

(A) a corporation--means an officer, director, or stockholder with direct ownership or disclosable interest of at least five percent, a subsidiary, or a parent company;

(B) a limited liability company--means an officer, member, or parent company;

(C) an individual--means:

(i) the individual's spouse;

(ii) each partnership and each partner thereof of which an individual or any affiliate of an individual is a partner; and

(iii) each corporation in which an individual is an officer, director, or stockholder with a direct ownership of at least five percent;

(D) a partnership--means a partner or a parent company of the partnership; and

(E) a group of co-owners under any other business arrangement means an officer, director, or the equivalent under the specific business arrangement or a parent company.

(7) Applicant--A person who applies for a license under THSC Chapter 248A and this chapter. The applicant is the person in whose name DADS issues the license.

(8) Audiologist--A person who has a valid license under Texas Occupations Code, Chapter 401, as an audiologist.

(9) Basic services--Include:

(A) the development, implementation, and monitoring of a comprehensive protocol of care that:

(i) is provided to a medically dependent or technologically dependent minor;

(ii) is developed in conjunction with the minor's parent; and

(iii) specifies the medical, nursing, psychosocial, therapeutic, and developmental services required by the minor; and

(B) the caregiver training needs of a medically dependent or technologically dependent minor's parent.

(10) Behavioral emergency--A situation that occurs after which preventative, or de-escalating techniques are attempted and determined to be ineffective and it is immediately necessary to restrain a minor to prevent immediate probable death or substantial bodily harm to the minor or to others because the minor is attempting serious bodily harm or immediate physical harm to the minor or to others.

(11) Business day--Any day except a national or state holiday listed in Texas Government Code §662.003(a) or (b). The term includes Saturday or Sunday if the center is open on that day.

(12) Center--A prescribed pediatric extended care center. A facility operated for profit or on a nonprofit basis that provides nonresidential basic services to four or more medically dependent or technologically dependent minors who require the services of the facility and who are not related by blood, marriage, or adoption to the owner or operator of the facility.

(13) Chemical restraint--The use of any chemical, including pharmaceuticals, through topical application, oral administration, injection, or other means, to restrict the free movement of all or a portion of a minor's body for the purpose of modifying or controlling the minor's behavior and which is not a standard treatment for a minor's medical or psychosocial condition.

(14) Chief financial officer--An individual who is responsible for supervising and managing all financial activities for a center.

(15) Clinical note--A notation of a contact with a minor or a minor's family member that is written and dated by any staff providing services on behalf of a center and that describes signs and symptoms of the minor, and treatments and medications administered to the minor, including the minor's reaction or response, and any changes in physical, emotional, psychosocial, or spiritual condition of the minor during a given period of time.

(16) Commission--The Texas Health and Human Services Commission.

(17) Commissioner--The commissioner of the Department of Aging and Disability Services (DADS).

(18) Community disaster resources--A local, statewide, or nationwide emergency system that provides information and resources during a disaster, including weather information, transportation, evacuation and shelter information, disaster assistance and recovery efforts, evacuee and disaster victim resources, and resources for locating evacuated friends and relatives.

(19) Complaint--An allegation against a center or involving services provided at a center that involves a violation of this chapter or THSC Chapter 248A.

(20) Continuous face-to-face observation--Maintaining an in-person line of sight of a minor that is uninterrupted and free from distraction.

(21) Contractor--An individual providing services ordered by a prescribing physician on behalf of a center that the center would otherwise provide by its employees.

(22) Controlling person--A person who has the ability, acting alone or in concert with others, to directly or indirectly influence, direct, or cause the direction of the management of, expenditure of money for, or policies of a center or other person.

(A) A controlling person includes:

(i) a management company, landlord, or other business entity that operates or contracts with another person for the operation of a center;

(ii) any person who is a controlling person of a management company or other business entity that operates a center or that contracts with another person for the operation of a center; and

(iii) any other person who, because of a personal, familial, or other relationship with the owner, manager, landlord, tenant, or provider of a center, is in a position of actual control of or authority

with respect to the center, regardless of whether the person is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the center.

(B) Notwithstanding any other provision of this paragraph, a controlling person of a center or of a management company or other business entity described by subparagraph (A)(i) of this paragraph that is a publicly traded corporation or is controlled by a publicly traded corporation means an officer or director of the corporation. The term does not include a shareholder or lender of the publicly traded corporation.

(C) A controlling person described by subparagraph (A)(iii) of this paragraph does not include a person, including an employee, lender, secured creditor, or landlord, who does not exercise any formal or actual influence or control over the operation of the center.

(23) Conviction--An adjudication of guilt based on a finding of guilt, a plea of guilty, or a plea of nolo contendere.

(24) DADS--Department of Aging and Disability Services.

(25) Daily census--The number of minors served at a center during a center's hours of operation for a 24-hour period, starting at midnight.

(26) Day--A calendar day, unless otherwise specified in the text. A calendar day includes Saturday, Sunday, and a holiday.

(27) Dietitian--A person who has a valid license under the Licensed Dietitian Act, Texas Occupations Code, Chapter 701, as a licensed dietitian or provisional licensed dietitian, or who is registered as a dietitian by the Commission on Dietetic Registration of the American Dietetic Association.

(28) Emergency situation--An impending or actual situation that:

(A) interferes with normal activities of a center or minors at a center;

(B) may:

(i) cause injury or death to a minor or individual at the center; or

(ii) cause damage to the center's property;

(C) requires the center to respond immediately to mitigate or avoid injury, death, damage, or interference; and

(D) does not include a situation that arises from the medical condition of a minor such as cardiac arrest, obstructed airway, or cerebrovascular accident.

(29) Executive commissioner--The executive commissioner of the Texas Health and Human Services Commission.

(30) Functional assessment--An evaluation of a minor's abilities, wants, interests, and needs related to self-care, communication skills, social skills, motor skills, play with toys or objects, growth, and development appropriate for age.

(31) Health care provider--An individual or facility licensed, certified, or otherwise authorized to administer health care in the ordinary course of business or professional practice.

(32) Health care setting--A location at which licensed, certified, or otherwise regulated health care is administered.

(33) IDT--Interdisciplinary team. Individuals who work together to meet the medical, nursing, psychosocial, and developmental needs of a minor and a minor's parent's training needs.

(34) Inactive medical record--A record for a minor who was admitted by a center to receive services and was subsequently discharged by the center.

(35) Inspection--An on-site examination or audit of a center by DADS to determine compliance with THSC Chapter 248A and this chapter.

(36) Isolation--The involuntary confinement of a minor in a room of a center for the purposes of infection control, assessment, and observation away from other minors in a room at the center. When in isolation, a minor is physically prevented from contact with other minors.

(37) Joint training--Training provided by DADS to service providers and DADS inspectors on subjects that address the 10 most commonly cited violations of state law governing centers, as published in DADS annual reports. DADS determines the frequency of joint training.

(38) Licensed assistant in speech-language pathology--A person who has a valid license under Texas Occupations Code, Chapter 401, as a licensed assistant in speech-language pathology and who provides speech language support services under the supervision of a licensed speech-language pathologist.

(39) Licensed vocational nurse--LVN. A person who has a valid license under Texas Occupations Code, Chapter 301, as a licensed vocational nurse.

(40) Life Safety Code--A publication of the National Fire Protection Association (NFPA), also known as NFPA 101, 2000 edition.

(41) Local emergency management agencies--The local emergency management coordinator, fire, police, and emergency medical services.

(42) Local emergency management coordinator--The person identified as the emergency management coordinator by the mayor or county judge for the geographical area in which a center is located.

(43) Mechanical restraint--The use of any mechanical device, material, or equipment to restrict the free movement of all or a portion of a minor's body for the purpose of modifying or controlling the minor's behavior.

(44) Medical director--A physician who has the qualifications described in §15.307 of this chapter (relating to Medical Director Qualifications and Conditions) and has the responsibilities described in §15.308 of this chapter (relating to Medical Director Responsibilities).

(45) Medical record--A record composed first-hand for a minor who has or is receiving services at a center.

(46) Medically dependent or technologically dependent--The condition of an individual who, because of an acute, chronic, or intermittent medically complex or fragile condition or disability, requires ongoing, technology-based skilled nursing care prescribed by a physician to avert death or further disability, or the routine use of a medical device to compensate for a deficit in a life-sustaining body function. The term does not include a controlled or occasional medical condition that does not require continuous nursing care, including asthma or diabetes, or a condition that requires an epinephrine injection.

(47) Medication administration record--A record used to document the administration of a minor's medications and pharmaceuticals.

(48) Medication list--A list that includes all prescriptions, over-the-counter pharmaceuticals, and supplements that a minor is pre-

scribed or taking, including the dosage, preparation, frequency, and the method of administration.

(49) Minor--An individual younger than 21 years of age who is medically dependent or technologically dependent.

(50) Mitigation--An action taken to eliminate or reduce the probability of an emergency or public health emergency, or reduce an emergency's severity or consequences.

(51) Nursing director--The individual responsible for supervising skilled services provided at a center and who has the qualifications described in §15.309 of this chapter (relating to the Nursing Director and Alternate Nursing Director Qualifications and Conditions).

(52) Nutritional counseling--Advising and assisting an adult minor or a minor's parent or family on appropriate nutritional intake by integrating information from a nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status, with the goal being health promotion, disease prevention, and nutrition education. The term includes:

(A) dialogue with an adult minor or a minor's parent to discuss current eating habits, exercise habits, food budget, and problems with food preparation;

(B) discussion of dietary needs to help an adult minor or the minor's parent understand why certain foods should be included or excluded from the minor's diet and to help with adjustment to the new or revised or existing diet plan;

(C) a personalized written diet plan as ordered by the minor's physician, to include instructions for implementation;

(D) providing the adult minor or the minor's parent with motivation to help them understand and appreciate the importance of the diet plan in getting and staying healthy; or

(E) working with the adult minor or the minor's parent by recommending ideas for meal planning, food budget planning, and appropriate food gifts.

(53) Occupational therapist--A person who has a valid license under Texas Occupations Code, Chapter 454, as an occupational therapist.

(54) Occupational therapy assistant--A person who has a valid license under Texas Occupations Code, Chapter 454, as an occupational therapy assistant who assists in the practice of occupational therapy under the general supervision of an occupational therapist.

(55) Operating hours--The days of the week and the hours of day a center is open for services to a minor as identified in a center's written policy as required by §15.201 of this chapter (relating to Operating Hours).

(56) Overnight--The hours between 9:00 p.m. and 5:00 a.m. during the days of the week a center operates.

(57) Over-the-counter pharmaceuticals--A drug or formulary for which a physician's prescription is not needed for purchase or administration.

(58) Parent--A person authorized by law to act on behalf of a minor with regard to a matter described in this chapter. The term includes:

(A) a biological, adoptive, or foster parent;

(B) a guardian;

(C) a managing conservator; and

(D) a non-parent decision-maker as authorized by Texas Family Code §32.001.

(59) Parent company--A person, other than an individual, who has a direct 100 percent ownership interest in the owner of a center.

(60) Person--An individual, firm, partnership, corporation, association, or joint stock association, and the legal successor thereof.

(61) Person with a disclosable interest--A person who owns at least a five percent interest in any corporation, partnership, or other business entity that is required to be licensed under THSC Chapter 248A. A person with a disclosable interest does not include a bank, savings and loan, savings bank, trust company, building and loan association, credit union, individual loan and thrift company, investment banking firm, or insurance company, unless these entities participate in the management of the center.

(62) Personal care services--Services required by a minor, including:

(A) bathing;

(B) maintaining personal hygiene;

(C) routine hair and skin care;

(D) grooming;

(E) dressing;

(F) feeding;

(G) eating;

(H) toileting;

(I) maintaining continence;

(J) positioning;

(K) mobility and bed mobility;

(L) transfer and ambulation;

(M) range of motion;

(N) exercise; and

(O) use of durable medical equipment.

(63) Pharmaceuticals--Of or pertaining to drugs, including over-the-counter drugs and those requiring a physician's prescription for purchase or administration.

(64) Pharmacist--A person who is licensed to practice pharmacy under Texas Occupations Code, Chapter 558.

(65) Pharmacy--A facility at which a prescription drug or medication order is received, processed, or dispensed as defined in Texas Occupations Code §551.003.

(66) Physical restraint--The use of physical force, except for physical guidance or prompting of brief duration, that restricts the free movement of all or a portion of a minor's body for the purpose of modifying or controlling the minor's behavior.

(67) Physical therapist--A person who has a valid license under Texas Occupations Code, Chapter 453, as a physical therapist.

(68) Physical therapist assistant--A person who has a valid license under Texas Occupations Code, Chapter 453, as a physical therapist assistant and:

(A) who assists and is supervised by a physical therapist in the practice of physical therapy; and

(B) whose activities require an understanding of physical therapy.

(69) Physician--A person who:

(A) has a valid license in Texas to practice medicine or osteopathy in accordance with Texas Occupations Code, Chapter 155;

(B) has a valid license in Arkansas, Louisiana, New Mexico, or Oklahoma to practice medicine, who is the treating physician of a minor, and orders services for the minor, in accordance with Texas Occupations Code, Chapter 151; or

(C) is a commissioned or contract physician or surgeon who serves in the United States uniformed services or Public Health Service if the person is not engaged in private practice, in accordance with Texas Occupations Code, Chapter 151.

(70) Place of business--An office of a center where medical records are maintained and from which services are directed.

(71) Plan of care--A protocol of care.

(72) Positive intervention--An intervention that is based on or uses a minor's preferences as positive reinforcement, and focuses on positive outcomes and wellness for the minor.

(73) Pre-licensing program training--Computer-based training, available on DADS website, designed to acquaint center staff with licensure standards.

(74) Preparedness--Actions taken in anticipation of a disaster including a public health disaster.

(75) Prescribing physician--A physician who is authorized to write and issue orders for services at a center.

(76) Progress note--A dated and signed written notation summarizing facts about services provided to a minor and the minor's response during a given period of time.

(77) Protective device--A mechanism or treatment, including sedation, that is:

(A) used:

(i) for body positioning;

(ii) to immobilize a minor during a medical, dental, diagnostic, or nursing procedure;

(iii) to permit wounds to heal; or

(iv) for a medical condition diagnosed by a physician; and

(B) not used as a restraint to modify or control behavior.

(78) Protocol of care--A comprehensive, interdisciplinary plan of care that includes the medical physician's plan of care, nursing care plan and protocols, psychosocial needs, and therapeutic and developmental service needs required by a minor and family served.

(79) Psychologist--A person who has a valid license under Texas Occupations Code, Chapter 501, as a psychologist.

(80) Psychosocial treatment--The provision of skilled services to a minor under the direction of a physician that includes one or more of the following:

(A) assessment of alterations in mental status or evidence of suicide ideation or tendencies;

(B) teaching coping mechanisms or skills;

(C) counseling activities; or

(D) evaluation of a plan of care.

(81) Public health disaster declaration--A governor's announcement based on a determination by the Department of State Health Services that there exists an immediate threat from a communicable disease that:

(A) poses a high risk of death or serious long-term disability to a large number of people; and

(B) creates a substantial risk of public exposure because of the disease's high level of contagion or the method by which the disease is transmitted.

(82) Quiet time--A behavior management technique used to provide a minor with an opportunity to regain self-control, where the minor enters and remains for a limited period of time in a designated area from which egress is not prevented.

(83) Recovery--Activities implemented during and after a disaster response, including a public health disaster response, designed to return a center to its normal operations as quickly as possible.

(84) Registered nurse--RN. A person who has a valid license under Texas Occupations Code, Chapter 301, to practice professional nursing.

(85) Relocation--The closing of a center and the movement of its business operations to another location.

(86) Respiratory therapist--A person who has a valid license under Texas Occupations Code, Chapter 604, as a respiratory care practitioner.

(87) Response--Actions taken immediately before an impending disaster or during and after a disaster, including a public health disaster, to address the immediate and short-term effects of the disaster.

(88) Restraint-- Physical restraint, chemical restraint, or mechanical restraint.

(89) RN delegation--Delegation of tasks by an RN in accordance with 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments).

(90) Sedation--The act of allaying nervous excitement by administering medication that commonly induces the nervous system to calm. Sedation is a protective device.

(91) Social worker--A person who has a valid license under Texas Occupations Code, Chapter 505, as a social worker.

(92) Speech-language pathologist--A person who has a valid license under Texas Occupations Code, Chapter 401, as a speech-language pathologist.

(93) Substantial compliance--A finding in which a center receives no recommendation for enforcement action after an inspection.

(94) Supervision--Authoritative procedural guidance by a qualified person that instructs another person and assists in accomplishing a function or activity. Supervision includes initial direction and periodic inspection of the actual act of accomplishing the function or activity.

(95) Support services--Social, spiritual, and emotional care provided to a minor and a minor's parent by a center.

(96) THSC--Texas Health and Safety Code.

(97) Total census--The total number of minors with active plans of care at a center.

(98) Transition support--Planning, coordination, and assistance to move the location of services provided to a minor from a center to the least restrictive setting appropriate.

(99) Violation--A finding of noncompliance with this chapter or THSC Chapter 248A resulting from an inspection.

(100) Volunteer--An individual who provides assistance to a center without compensation other than reimbursement for actual expenses.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. LICENSING APPLICATION, MAINTENANCE, AND FEES

40 TAC §§15.101 - 15.122

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.101. Criteria and Eligibility for a License.

(a) To obtain a license, a person must meet the application requirements in this subchapter and meet the criteria for a license.

(b) A center must be located in Texas. The center must have a Texas mailing address.

(c) A person may not operate a center on the same premises as:

(1) a child-care center licensed in accordance with Texas Human Resource Code, Chapter 42; or

(2) any other facility licensed by DADS or the Department of State Health Services.

(d) A separate license is required for each center located on separate premises, regardless of whether the centers are owned or operated by the same person.

(e) The actual census for a center must not exceed the capacity authorized by DADS, as indicated on the license.

(f) Before issuing a license, DADS considers the background and qualifications of:

(1) the applicant;

(2) a controlling person of the applicant;

(3) a person with a disclosable interest;

(4) an affiliate of the applicant;

(5) the administrator; and

(6) the chief financial officer, if the center has a chief financial officer.

(g) An applicant must affirmatively show that the center:

(1) obtained approval of building plans through plan review by DADS Architectural Unit as required by Subchapter E of this chapter (relating to Building Requirements);

(2) meets local building ordinances;

(3) is approved by the local fire authority;

(4) meets the standards of the Life Safety Code and the requirements in Subchapter E of this chapter; and

(5) meets the requirements of this chapter based on an on-site health inspection by DADS.

§15.105. Initial License Application Procedures and Issuance.

(a) The center's administrator must complete pre-licensing program training before an applicant may submit an initial application for a license.

(b) An applicant for an initial license must submit:

(1) a complete and correct application including all documents and information that DADS requires as part of the application process;

(2) the correct license fee established in §15.112 of this subchapter (relating to Licensing Fees);

(3) a letter of credit for $250,000 from a bank that is insured by the Federal Deposit Insurance Corporation, or other documentation acceptable to DADS, to demonstrate an applicant's financial viability; and

(4) all other documents described in the instructions provided on the application and on the DADS website.

(c) After DADS receives an application for an initial license and the correct license fee, DADS reviews the application and notifies the applicant if additional information is needed to complete the application.

(d) An applicant must submit written notice to DADS that the center is ready for a Life Safety Code inspection.

(1) The written notice must be submitted:

(A) with the application; or

(B) no later than 120 days after DADS Licensing and Credentialing Unit receives the application.

(2) After DADS receives the written notice for a Life Safety Code inspection and an applicant has satisfied the application submission requirements, DADS staff conducts an on-site Life Safety Code inspection.

(e) The center must meet the building requirements described in Subchapter E of this chapter (relating to Building Requirements). If a center fails to meet the building requirements and fails to implement

an approved written plan of correction no later than 120 days after the initial Life Safety Code inspection, DADS denies the license application.

(f) If a center meets the building requirements in Subchapter E of this chapter, the center may admit no more than three minors. If the center admits a minor, the applicant must send written notice to DADS indicating the center is ready for a health inspection. The health inspection request must be submitted no later than 120 days after the date the center meets the building requirements.

(1) DADS conducts an on-site health inspection to determine compliance with this chapter.

(2) If the center fails to comply with this chapter and fails to implement an approved written plan of correction no later than 120 days after the date of the initial health inspection, DADS denies the license application.

(g) If an applicant receives a notice from DADS that some or all of the information is missing or incomplete, an applicant must submit the requested information no later than 30 days after the date of the notice. If the applicant fails to timely submit the requested information, DADS denies the application. If DADS denies the application, DADS does not refund the license fee.

(h) DADS issues an initial license if it determines that an applicant has met the provisions of this chapter and THSC Chapter 248A.

(i) The issuance of an initial license constitutes DADS notice to the center of the approval of the application.

(j) DADS issues a center license to the license holder named on the license at the place of business listed on the license. The license is not transferable or assignable.

(k) The license includes:

(1) the license holder's name;

(2) the name of the center;

(3) the center's place of business;

(4) the center's licensed capacity;

(5) a statement that the center provides services to minors for 12 hours or less in a 24-hour period but no overnight care; and

(6) the effective date of the license.

(l) DADS may deny an application for an initial license if the applicant, a controlling person, or a person required to submit background and qualification information fails to meet the criteria for a license established in §15.101 of this subchapter (relating to Criteria and Eligibility for a License) or for any reason specified in §15.115 of this subchapter (relating to Criteria for Denial of a License).

(m) If DADS denies an application for an initial license, DADS sends the applicant written notice of the denial and informs the applicant of the right to request an administrative hearing to appeal the denial. The administrative hearing is held in accordance with 1 TAC Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act) and Chapter 91 of this title (relating to Hearings Under the Administrative Procedure Act).

(n) An initial license expires on the second anniversary after the effective date of the initial license.

§15.107. Change of Ownership.

(a) A change of ownership occurs under the following circumstances:

(1) for a license holder who is a sole proprietor:

(A) the sole proprietor sells or otherwise transfers operation of the center to another person; or

(B) the sole proprietor dies and another person operates the center;

(2) for a license holder that is a general partnership as defined in the Texas Business Organizations Code, §1.002:

(A) a partner is added to the general partnership;

(B) the general partnership is sold or otherwise transferred to another person;

(C) the general partnership sells or otherwise transfers operation of the center to another person;

(D) for any reason other than correction of an error, the federal taxpayer identification number of the general partnership changes; or

(E) the general partnership is dissolved and another person operates the center;

(3) for a license holder that is a limited partnership as defined in the Texas Business Organizations Code, §1.002:

(A) a general partner is added to the limited partnership;

(B) the limited partnership is sold or otherwise transferred to another person;

(C) the limited partnership sells or otherwise transfers operation of the center to another person;

(D) for any reason other than correction of an error, the federal taxpayer identification number of the limited partnership changes; or

(E) the limited partnership is dissolved and another person operates the center;

(4) for a license holder that is a nonprofit organization:

(A) the nonprofit organization is sold or otherwise transferred to another person;

(B) the nonprofit organization sells or otherwise transfers operation of the center to another person;

(C) for any reason other than correction of an error, the federal taxpayer identification number of the nonprofit organization changes; or

(D) the nonprofit organization is dissolved and another person operates the center;

(5) for a license holder that is a for-profit corporation or limited liability company:

(A) the corporation or limited liability company is sold or otherwise transferred to another person;

(B) the corporation or limited liability company sells or otherwise transfers operation of the center to another person;

(C) for any reason other than correction of an error, the federal taxpayer identification number of the corporation or limited liability corporation changes; or

(D) the corporation or limited liability company is dissolved and another person operates the center;

(6) for a license holder that is a city, county, state, or federal government authority, hospital district, or hospital authority:

(A) the city, county, state, or federal government authority, hospital district, or hospital authority sells or otherwise transfers operation of the center to another person; or

(B) the city, county, state, or federal government authority, hospital district or hospital authority ceases to exist and another person operates the center;

(7) for a license holder that is a trust, living trust, estate, or any other entity type not included in paragraphs (1) - (6) of this subsection:

(A) the trust, living trust, estate, or other entity type is sold or otherwise transferred to another person;

(B) the trust, living trust, estate, or any other entity type sells or otherwise transfers operation of the center to another person;

(C) for any reason other than correction or an error, the federal taxpayer identification number of the trust, living trust, estate, or other entity type changes; or

(D) the trust, living trust, estate, or any other entity type ceases to exist and another person operates the center.

(b) An action described in subsection (a)(1) - (7) of this section that occurs at a level of the ownership structure above the license holder will not be considered a change of ownership but must be reported to DADS. The license holder must submit the background and qualifications of any new controlling persons for DADS consideration. DADS may propose to take enforcement action against a center's license if any controlling person or any person required to submit background and qualification information fails to meet the criteria for a license established in §15.115 of this subchapter (relating to Criteria for Denial of a License) or §15.1402 of this chapter (relating to License Suspension) and §15.1404 of this chapter (relating to License Revocation). At its discretion, DADS conducts a desk review or on-site survey of a center that reports an action described in subsection (a)(1) - (7) of this section that occurs at a level of the ownership structure above the license holder.

(c) The substitution of the administrator, executor, or personal representative of a decedent's estate for a license holder is not the addition of a controlling person for purposes of subsection (a)(1) - (7) of this section; however, DADS will not renew a license if the license holder is deceased. An administrator, executor, or personal representative must submit an initial license application for a center license in accordance with §15.101 of this subchapter (relating to Criteria and Eligibility for a License) if the administrator, executor, or personal representative operates the center after the license expiration date.

(d) A conversion, as described in Chapter 10, Subchapter C, of the Texas Business Organizations Code, is not a change of ownership if a controlling person is not added to the license holder.

§15.118. Reporting Changes in Application Information.

If certain information provided on an initial or renewal application changes after DADS issues the license, a center must report the change to DADS by following the instructions on the DADS website for reporting a change. For requirements on reporting a change regarding:

(1) the administrator, chief financial officer, and controlling person, a center must comply with §15.119 of this division (relating to Notification Procedures for a Change in Administration and Management) and §15.302 of this chapter (relating to Organizational Structure and Lines of Authority);

(2) the center's contact information, a center must comply with §15.120 of this subchapter (relating to Notification Procedures for a Change in Contact Information);

(3) the center's operating hours, a center must comply with §15.121 of this subchapter (relating to Notification Procedures for a Change in Operating Hours);

(4) name (legal entity or doing business as), a center must comply with §15.122 of this subchapter (relating to Notification Procedures for a Name Change).

§15.119. Notification Procedures for a Change in Administration and Management.

(a) If a change occurs in the following management staff, a center must submit written notice to DADS no later than seven days after the date of a change in:

(1) administrator;

(2) chief financial officer; or

(3) controlling person, as defined in §15.5 of this chapter (relating to Definitions), including:

(A) a change of five percent or more of the controlling interest of a limited partner in a limited partnership or the addition of a controlling person to the limited partnership; or

(B) a change of five percent or more of the controlling interest in a for-profit corporation or limited liability company.

(b) A change in the management staff listed in subsection (a) of this section requires DADS evaluation and approval. DADS reviews the required documents and information submitted. DADS provides notification to a center if a person listed in subsection (a)(1) - (6) of this section does not meet the required qualifications.

§15.120. Notification Procedures for a Change of Contact Information.

A center must submit written notice to DADS no later than seven days after a change in the center's:

(1) telephone number; or

(2) mailing address, if different from the physical location.

§15.121. Notification Procedures for a Change in Operating Hours.

A center must submit written notice to DADS no later than seven days after a change in the center's operating hours.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. GENERAL PROVISIONS
DIVISION 1. OPERATIONS AND SAFETY PROVISIONS

40 TAC §§15.201 - 15.211

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive com-

missioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.205. Safety Provisions.

(a) A center must ensure that the local fire marshal's office inspects the center annually. The center must keep a copy of the annual fire inspection report on file at the center for two years after the date of inspection.

(b) A center must prepare a fire drill plan and conduct a fire drill at least once every month.

(1) The center's administrator and nursing director must participate in the monthly fire drill.

(2) The center must conduct fire drills at various times of the day.

(3) The center must document a drill on a DADS Fire Drill Report Form.

(c) The center's administrator and nursing director must:

(1) review the center's fire drill plan;

(2) evaluate the effectiveness of the plan after each fire drill;

(3) review any problems that occurred during each drill and take corrective action, if necessary; and

(4) maintain documentation to support the requirements of this subsection.

(d) A center must have a working telephone available at all times at the center. Coin operated telephones or cellular telephones are not acceptable for this purpose. If the center has multiple buildings, a working telephone must be located in each of the buildings.

(e) A center must post at or near the immediate vicinity of all telephones:

(1) emergency telephone numbers including:

(A) the DADS abuse, neglect, and exploitation hotline;

(B) poison control;

(C) 911 or the local fire department, ambulance, and police in communities where a 911 management system is unavailable; and

(D) an emergency medical facility; and

(2) the center's address.

(f) A center must adopt and enforce written policies and procedures for a minor's medical emergency. The policy must include:

(1) a requirement that each minor has an emergency plan, developed in collaboration with a minor's parent, that:

(A) includes instructions from a minor's prescribing physician, as applicable;

(B) includes coordination with other health care providers, including hospice; and

(C) is updated and reviewed at least yearly or more often as necessary to meet the needs of a minor;

(2) a requirement that staff receive training for medical emergencies;

(3) a requirement that staff receive training in the use of emergency equipment; and

(4) procedures that staff follow when a minor's parent cannot be contacted in an emergency.

(g) If a minor must be transported to an emergency medical facility while at the center, the staff must immediately notify a minor's parent and hospice provider, if applicable. If a parent cannot be contacted, the center must ensure that an individual authorized by the parent or center staff meets a minor at the emergency facility.

(h) The center must prepare a medical emergency transfer form to give to the emergency transportation provider when transporting a minor to an emergency medical facility. The transfer form must include:

(1) the minor's name and age;

(2) the minor's diagnoses, allergies, and medication;

(3) the minor's parent name and contact information;

(4) the minor's prescribing physician name and contact information;

(5) the center's name and contact information; and

(6) the name of the administrator or nursing director.

(i) A center must maintain a first aid kit with unexpired supplies and an automated external defibrillator for minors served at the center that is easily accessible but not within reach of minors.

(j) A center must adopt and enforce written policies and procedures for the verification and monitoring of visitors, including service providers at a center. The policies and procedures must include:

(1) verification of a visitor's identity;

(2) verification of a visitor's authorization to enter a center;

(3) the recording of a visitor's name, organization, purpose of the visit, and the date and time a visitor entered and exited a center;

(4) the center's awareness of a visitor while in a center; and

(5) documentation of the requirements in this subsection.

(k) A center must adopt and enforce written policies and procedures for the release of a minor. The policy must include:

(1) procedures to verify the identity of a person authorized to pick up a minor from the center; and

(2) procedures for the release of a minor when transported by the center in accordance with Subchapter D of this chapter (relating to Transportation).

(l) A center must adopt and enforce written policies and procedures to ensure that no minor is left unattended at the center. The policy must include procedures for:

(1) a minor who arrives at the center;

(2) a minor who remains at the center during operating hours;

(3) a minor who leaves the center; and

(4) staff to conduct daily visual checks at the center at the close of business.

(m) A center must maintain daily records and documentation of the visual check at the end of each day to ensure no minor is left at the center. The documentation must include:

(1) the date and time; and

(2) the signature of the staff member conducting the daily visual checks at the center at the close of business.

(n) Except as otherwise provided in this section, a center must meet the provisions applicable to the health care occupancy chapters of the 2000 edition of the LSC of the National Fire Protection Association (NFPA) and the requirements in Subchapter E of this chapter (relating to Building Requirements). Roller latches are prohibited on corridor doors.

(o) Notwithstanding any provisions of the 2000 edition of the Life Safety Code, NFPA 101, to the contrary, a center may place alcohol-based hand-rub dispensers at the center if:

(1) use of alcohol-based hand-rub dispensers does not conflict with any state or local codes that prohibit or otherwise restrict the placement of such dispensers in health care facilities;

(2) the dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(3) the dispensers are installed in a manner or location out of reach of a minor; and

(4) the dispensers are installed in accordance with Chapter 18.3.2.7 or Chapter 19.3.2.7 of the 2000 edition of the LSC, as amended by NFPA Temporary Interim Amendment 00-1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004.

(p) A center's environment must be free of health and safety hazards to reduce risks to minors. The center must:

(1) use childproof electrical outlets or childproof covers on unused electrical outlets in all rooms to which minors have access at the center;

(2) use safety precautions for strings and cords, including those used on window coverings, and keep them out of the reach of minors;

(3) use safety precautions for all furnishings including cabinets, shelves, and other furniture items that are not permanently attached to the center; and

(4) use play material and equipment that is safe and free from sharp or rough edges and toxic paints.

(q) A center must adopt and enforce a written policy describing whether a center is a weapons-free location. A center must:

(1) provide a copy of the policy to staff, individuals providing services on behalf of a center, an adult minor, and a minor's parent; and

(2) provide a copy of the policy to any person who requests it.

(r) If a center is weapons-free, a center must post a visible and readable sign at the entrance of the center indicating the center is a weapons-free location.

(s) A center must adopt and enforce a written policy prohibiting the use of tobacco in any form, the use of alcohol, and the possession of illegal substances and potentially toxic substances at a center.

§15.206. Person-Centered Direction and Guidance.

(a) A center must adopt and enforce written policies and procedures for the use of person-centered direction and guidance by individuals providing services to minors at the center. The policy must include:

(1) the implementation of a system-wide, person-centered direction and guidance program for minors that includes:

(A) the teaching of successful behavior and coping skills;

(B) proactive strategies to identify and manage a minor's behaviors before they escalate; and

(C) the monitoring and evaluation of the effectiveness of direction and guidance used with a minor by a committee as described in this section;

(2) procedures for ensuring consistent language, practices, and application of direction and guidance by individuals providing services at a center; and

(3) procedures for documenting and providing to a minor's parent a daily report of the minor's behavior.

(b) A center must ensure that only person-centered strategies and techniques that encourage self-esteem, self-control, and self-direction are used for the purposes of direction and guidance of a minor at a center. A center must not use a restraint as part of person-centered direction and guidance.

(c) Person-centered direction and guidance must be:

(1) individualized and consistent for each minor;

(2) differentiated in both nature and intensity based on a minor's level of behavior;

(3) appropriate to the minor's level of understanding and functional or educational development; and

(4) directed toward teaching the minor successful behavior, awareness of behavior triggers and self-control, including:

(A) encouraging a minor to develop positive behavior in accordance with a minor's individualized psychosocial program;

(B) redirecting behavior using positive statements; and

(C) teaching the minor to use effective behavior management techniques.

(d) A center must ensure that quiet time, if used, is:

(1) in accordance with the minor's psychosocial program and plan of care;

(2) brief and under continuous face-to-face observation by center staff;

(3) appropriate for the minor's age and development;

(4) limited to no more than one minute per year of the minor's developmental age; and

(5) does not place a minor alone in a room.

(e) A center must ensure the protection of minors at the center from harsh, cruel, or unusual treatment. Negative discipline is considered punishment and abuse and is prohibited at a center, including:

(1) corporal punishment or threats of corporal punishment;

(2) punishment associated with food, naps, or toilet training;

(3) pinching, shaking, or biting a minor;

(4) hitting a minor with a hand or object;

(5) putting anything in or on a minor's mouth;

(6) humiliating, ridiculing, rejecting, or yelling at a minor;

(7) subjecting a minor to harsh, abusive, or profane language;

(8) placing a minor alone in a locked or darkened room, bathroom, or closet without windows; and

(9) requiring a minor to remain silent or inactive for inappropriately long periods of time for the minor's developmental age.

(f) The center must establish a person-centered direction and guidance committee to review the techniques and strategies used at a center to:

(1) determine whether the individualized direction and guidance used as established in a plan of care is consistently applied for each minor in accordance with center policy;

(2) evaluate the frequency and outcomes of strategies and techniques used with a minor to:

(A) determine the impact of the direction and guidance on a minor's ability to achieve progress in goals;

(B) determine effectiveness of the minor's program; and

(C) recommend the use of new strategies and techniques when current strategies and techniques are determined to be ineffective.

(g) The committee must include:

(1) the center's administrator;

(2) the center's nursing director or designee;

(3) an individual providing psychosocial treatment and services on behalf of a center; and

(4) a parent or an individual from a parent council or support group for minors receiving services at the center.

(h) The center is not required to include a parent or individual from a parent council or support group if, after a good faith effort, the center is unable to include a parent or individual in a committee meeting. The center must document, for DADS review, a good faith effort to include a parent or individual from a parent council or support group at each meeting.

(i) The center must adopt and enforce written policies and procedures for the frequency, format and documentation of committee meetings.

(j) A center must provide its written person-centered direction and guidance policy to all parents, employees, volunteers and contractors. The center must maintain documentation of acknowledgment of the written policy from all employees, volunteers and contractors.

§15.207. Protective Devices and Restraints.

(a) Protective Devices. A center must ensure that a protective device is used only as ordered by a minor's physician, as agreed to by an adult minor or a minor's parent, and in accordance with the minor's plan of care.

(1) A center may use a protective device only in the following circumstances:

(A) as part of a therapeutic regimen of basic services for a minor's physical health and development;

(B) during medical, nursing, diagnostic, and dental procedures as prescribed by a physician's order and to protect the health and safety of a minor; or

(C) in a medical emergency to protect the health and safety of a minor.

(2) A center must adopt and enforce written policies and procedures requiring a protective device to be used as described in this subsection and in accordance with a minor's plan of care.

(3) A center must not implement a physician's order for the use of a protective device on a pro re nata (PRN) or as-needed basis.

(4) A center must ensure a physician's order is obtained before using a protective device at the center. The physician's order must include:

(A) the circumstances under which a protective device may be used at the center;

(B) instructions on how long a protective device may be used at the center; and

(C) any individualized, less restrictive interventions described in the minor's plan of care that must be used before using a protective device.

(5) A center must ensure that in implementing a physician's order for a protective device that an RN, with input from an adult minor, a minor's parent, and the IDT:

(A) conducts an assessment of a minor's current and ongoing need for a protective device at a center;

(B) reviews the physician's order for a protective device, as described in paragraph (4) of this subsection; and

(C) obtains and documents in a minor's medical record the written consent of an adult minor or a minor's parent to use a protective device at the center.

(6) Before using a protective device for the first time with a minor, the center must ensure an RN provides oral and written notification to the adult minor or the minor's parent of the right at any time to withdraw consent and discontinue use of a protective device at the center.

(7) The center must ensure that a staff member who will apply a protective device has been properly trained in the use of a protective device, as ordered in the minor's plan of care, in accordance with this subsection, and in accordance with §15.415(b)(8)(F) of this subchapter (relating to Staffing Policies for Staff Orientation, Development, and Training).

(8) If a protective device is used for a minor, the center must ensure:

(A) the minor is assessed by an RN, in accordance with the physician's order but no less than once every hour to determine if the protective device must be repositioned or discontinued;

(B) except for sedation, the protective device is removed to conduct the RN assessment described in subparagraph (A) of this paragraph and removed more frequently as determined necessary by the RN's assessment;

(C) center staff replaces the protective device, if necessary, after the assessment, in accordance with the physician's order;

(D) a minor's physician is notified immediately if an assessment determines a change in the minor's condition or a negative reaction to the protective device has occurred, including notification of:

(i) the minor's psychosocial condition;

(ii) the minor's reaction to the protective device;

(iii) the minor's medical condition; and

(iv) the need to continue or discontinue the use of the protective device;

(E) the type and frequency of use of the protective device is documented in the minor's medical record;

(F) the effects of a protective device on the minor's health and welfare are evaluated and documented in the medical record; and

(G) an RN, an adult minor, a minor's parent, and the IDT, at least every 180 days, or as the minor's needs change, review, with input and direction from the minor's prescribing physician, the use of a protective device to determine its effectiveness and the need to continue the use of the protective device.

(b) Restraints. A center may use a restraint only in a behavioral emergency when the immediate health and safety of the minor or another minor are at risk. A center must not use a chemical or mechanical restraint. A center may use only the following restraints:

(1) The center must adopt and enforce a written policy and procedures regarding the use of restraints in a behavioral emergency, including whether a center is a restraint-free environment.

(2) A center must ensure that the use of a restraint at a center must not be in a manner that:

(A) obstructs a minor's airway, including the placement of anything in, on, or over the minor's mouth or nose;

(B) impairs the minor's breathing by putting pressure on the minor's torso;

(C) interferes with the minor's ability to communicate;

(D) extends muscle groups away from each other;

(E) uses hyperextension of joints; or

(F) uses pressure points or pain.

(3) A center must ensure that a restraint is not used for:

(A) controlling a minor's behavior in a non-emergency;

(B) negative discipline as described in §15.206 of this division (relating to Person-Centered Direction and Guidance);

(C) convenience;

(D) coercion or retaliation; or

(E) as part of a behavior component of a minor's psychosocial program.

(4) A center must not implement a physician's order for the use of a restraint on a pro re nata (PRN) or as-needed basis.

(5) A center must ensure that a staff member whose job responsibilities will include the use or application of a restraint during a behavioral emergency has been properly trained in the use of a restraint for minors served at the center, in accordance with this section, and in accordance with §15.415(b)(8)(G) of this subchapter (relating to Staffing Policies for Staff Orientation, Development, and Training).

(6) If a center restrains a minor due to a behavioral emergency, the center must ensure:

(A) all less restrictive options available are exhausted before using a restraint;

(B) the restraint is limited to the use of such reasonable force as is necessary to address the emergency;

(C) the restraint is discontinued immediately at the point when the emergency no longer exists but no more than 15 minutes after the restraint was initiated;

(D) the restraint is implemented in such a way as to protect the health and safety of the minor and others;

(E) immediately after the restraint is discontinued, the minor is assessed by an RN;

(F) immediately following an RN assessment, medical attention is provided for the minor if determined necessary by the RN assessment;

(G) within three days after the use of the restraint, an assessment is conducted by an RN as described in §15.504 of this chapter (relating to Psychosocial Treatment and Services) to determine if the development and implementation of a psychosocial treatment and services program is needed for the minor to address the minor's behavior and reduce the occurrence of future behavioral emergencies; and

(H) within three days after the use of the restraint, an RN reviews and updates a minor's plan of care and psychosocial treatment and services program as determined appropriate.

(7) If a center restrains a minor due to a behavioral emergency, the center must ensure the following documentation and notifications occur:

(A) immediately after the restraint is discontinued, information about the restraint is documented, including:

(i) the name of the individual who administered the restraint;

(ii) the date and time the restraint began and ended;

(iii) the location of the restraint;

(iv) the nature of the restraint;

(v) a description of the setting and activity in which the minor was engaged immediately preceding the use of the restraint;

(vi) the behavior that prompted the restraint;

(vii) the efforts made to de-escalate the situation and the less restrictive alternatives attempted before the restraint; and

(viii) the minor's condition after the restraint was discontinued;

(B) within 24 hours after the use of the restraint, written documentation regarding the use of the restraint and the RN assessment conducted immediately after the use of the restraint is included in a minor's medical record;

(C) documentation of nursing director and administrator oral and written notifications as described in subparagraphs (E) and (I) of this paragraph, including nursing director and administrator signatures acknowledging receipt of notifications must be included in the minor's medical record;

(D) documentation of parent oral and written notifications as described in subparagraphs (F) and (J) of this paragraph, including a parent signature acknowledging receipt of notifications must be included in the minor's medical record;

(E) immediately after the restraint is used, the administrator and director of nursing are notified orally that the restraint occurred;

(F) on the day the restraint is used, the minor's parent is notified orally that the restraint occurred;

(G) on the day the restraint is used, the center's staff responsible for psychosocial treatment and services is notified orally that the restraint occurred;

(H) immediately after the RN assessment is conducted in accordance with paragraph (6)(E) of this subsection, if the assessment determines a change in the minor's condition or a negative reaction to the restraint has occurred, the minor's physician is notified of the restraint and the minor's condition, including:

(i) the minor's medical condition;

(ii) the minor's reaction to the restraint; and

(iii) the minor's psychosocial condition;

(I) within one hour after the use of the restraint, the administrator and director of nursing are notified in writing of the restraint, including the information in subparagraph (A) of this paragraph; and

(J) within one day after the use of the restraint, the minor's parent is notified in writing, in a language and format the parent understands, of the restraint, including the information in subparagraph (A) of this paragraph;

(8) The IDT must review, on an annual basis or more frequently as needed, all behavioral emergencies that occurred at the center during the time period being reviewed to determine the appropriateness of the center's response and to identify strategies for reducing behavioral emergencies at the center.

(9) A center must maintain documentation of compliance with this section.

§15.209. Emergency Preparedness Planning and Implementation.

(a) A center must have a written emergency preparedness and response plan that comprehensively describes its approach to an emergency situation, including a public health disaster that could affect the need for its services or its ability to provide those services.

(b) Administration. A center must:

(1) develop and implement a written plan as described in subsection (c) of this section;

(2) maintain a current written copy of the plan in a central location that is accessible to all staff at all times and at a work station of each staff who has responsibilities under the plan;

(3) evaluate the plan to determine if information in the plan must change:

(A) no later than 30 days after an emergency situation;

(B) as soon as possible after the remodeling or construction of an addition to the center; and

(C) at least annually;

(4) revise the plan no later than 30 days after information in the plan changes; and

(5) maintain documentation of compliance with this section.

(c) Emergency Preparedness and Response Plan. A center's plan must:

(1) include a risk assessment of all potential external and internal emergency situations that pose a risk for harm to minors or property and are relevant to the provision of services at a center and the center's geographical area, such as fire, earthquake, hurricane, tornado, flood, extreme snow and ice conditions for the area, wildfire, terrorism, hazardous materials accident, thunderstorm, wind storm, wave action, oil spill or other water contamination, epidemic, air contamination, infestation, explosion, riot, hostile military or paramilitary action, energy emergency, water outage, failure of heating and cooling systems, power outage, bomb threat, and explosion;

(2) include a description of minors served at the center;

(3) include a description of the services and assistance needed by minors served at the center in an emergency situation;

(4) include a section for each core function of emergency management, as described in subsection (d) of this section, that is based on the center's decision to either temporarily shelter-in-place or evacuate during an emergency situation; and

(5) include a section for a fire safety plan that complies with §15.205 of this division (relating to Safety Provisions).

(d) Plan Requirements Regarding Eight Core Functions of Emergency Management.

(1) Direction and control. A center's plan must contain a section for direction and control that:

(A) designates by name or title the emergency preparedness coordinator (EPC) who is the staff person with the authority to manage the center's response to an emergency situation in accordance with the plan, and includes the EPC's current phone number;

(B) designates by name or title the alternate EPC who is the staff person with the authority to act as the EPC if the EPC is unable to serve in that capacity, and includes the alternate EPC's current phone number;

(C) documents the name and contact information for the local emergency management coordinator (EMC) for the area where the center is located, as identified by the office of the local mayor or county judge;

(D) includes procedures for notifying the local EMC of the execution of the plan;

(E) includes a plan for coordinating a staffing response to an emergency situation; and

(F) includes a plan for relocating minors to a safe location that is based on the type of emergency situation occurring and a center's decision to either temporarily shelter-in-place or evacuate during an emergency situation.

(2) Warning. A center's plan must contain a section for warning that:

(A) describes how the EPC will be notified of an emergency situation;

(B) identifies who the EPC will notify of an emergency situation and when the notification will occur, including during off hours, weekends, and holidays; and

(C) addresses monitoring local news and weather reports regarding a disaster or potential disaster, taking into consideration factors such as geographic-specific natural disasters, whether a disaster is likely to be addressed or forecast in the reports, and the conditions, natural or otherwise, that would cause staff to monitor news and weather reports for a disaster.

(3) Communication. A center's plan must contain a section for communication that:

(A) identifies the center's primary mode of communication to be used during an emergency situation and the center's alternate mode of communication to be used in the event of power failure or the loss of the center's primary mode of communication in an emergency situation;

(B) requires posting of the emergency contact number for the local fire department, ambulance, and police at or near each telephone at the center in communities where a 911 emergency management system is unavailable;

(C) includes procedures for maintaining a current list of telephone numbers for:

(i) minors' parents;

(ii) safe locations; and

(iii) center staff;

(D) identifies the location of the lists described in subparagraph (C) of this paragraph;

(E) includes procedures to notify:

(i) center staff about an emergency situation;

(ii) a contact person at a safe location about an impending or actual evacuation of minors; and

(iii) a minor's parent about an impending or actual evacuation;

(F) provides a method for staff to obtain a minor's emergency information during an emergency situation;

(G) includes procedures for the center to maintain communication with:

(i) center staff during an emergency situation;

(ii) a contact person at a safe location; and

(iii) the authorized driver of a vehicle transporting minors, medication, medical records, food, water, equipment, or supplies during an evacuation; and

(H) includes procedures for reporting to DADS an emergency situation that caused the death or serious injury of a minor as follows:

(i) by telephone at 1-800-458-9858 or by using the DADS website, no later than 24 hours after the death or serious injury of a minor; and

(ii) in writing on the DADS Provider Investigation Report Form no later than five days after the center makes the report.

(4) Shelter-in-place. A center's plan must contain a section that includes procedures to temporarily shelter minors in place during an emergency situation.

(5) Evacuation. A center's plan must contain a section for evacuation that:

(A) requires posting center evacuation routes conspicuously throughout the center;

(B) identifies evacuation destinations and routes for an authorized driver, and includes a map that shows the destinations and routes;

(C) includes procedures for implementing a decision to evacuate minors to a safe location;

(D) includes a current copy of an agreement with a prearranged safe location, outlining arrangements for receiving minors in the event of an evacuation, if the evacuation destination identified in accordance with subparagraph (B) of this paragraph is a prearranged safe location that is not owned by the same entity as the evacuating center;

(E) includes procedures for:

(i) ensuring that staff accompany evacuating minors;

(ii) ensuring that minors and staff present at the center have been evacuated;

(iii) ensuring that visitors, including parents and service providers, evacuate the center;

(iv) accounting for minors and staff after they have been evacuated;

(v) accounting for minors absent from the center at the time of the evacuation;

(vi) releasing minor information in an emergency situation to promote continuity of a minor's care, in accordance with state law;

(vii) includes procedures for notifying the local EMC regarding an evacuation of the center, if required by the local EMC guidelines;

(viii) contacting the local EMC, if required by the local EMC guidelines, to find out if it is safe to return to the geographical area after an evacuation; and

(ix) determining if it is safe to re-enter and occupy the center after an evacuation;

(x) includes procedures for notifying DADS by telephone, at 1-800-458-9858, no later than 24 hours after an evacuation that minors have been evacuated; and

(xi) includes procedures for notifying DADS Regulatory Services by telephone immediately after the EPC makes a decision to evacuate all minors from the center.

(6) Transportation. A center's plan must contain a section for transportation that:

(A) arranges for a sufficient number of vehicles to safely evacuate all minors;

(B) identifies staff or contractors designated to drive a center owned, leased, or rented vehicle during an evacuation;

(C) includes procedures for safely transporting minors and staff involved in an evacuation; and

(D) includes procedures for safely transporting and having timely access to oxygen, medications, medical records, food, water, equipment, and supplies needed during an evacuation.

(7) Health and Medical Needs. A center's plan must contain a section for health and special needs that:

(A) identifies the types of services and medical equipment used by minors, including oxygen, respirator care, or hospice services; and

(B) ensures that a minor's needs identified in subparagraph (A) of this paragraph are met during an emergency situation.

(8) Resource Management. A center's plan must contain a section for resource management that:

(A) includes a plan for identifying medications, medical records, food, water, equipment, and supplies needed during an emergency situation;

(B) identifies staff who are assigned to locate the items in subparagraph (A) of this paragraph and who must ensure the transportation of the items during an emergency situation; and

(C) includes procedures to ensure that medications are secure and maintained at the proper temperature during an emergency situation.

(e) Training. A center must:

(1) train staff on their responsibilities under the plan no later than 30 days from their hire date;

(2) train staff on the staff responsibilities under the plan at least annually and when the staff member's responsibilities under the plan change; and

(3) conduct one unannounced annual drill with staff for severe weather and other emergency situations identified by a center as likely to occur, based on the results of the risk assessment required by subsection (c) of this section.

(f) Fire Emergency Response Plan.

(1) The center must have a comprehensive written fire emergency response plan. Copies of the plan must be available to all staff. The center must periodically instruct and inform staff about the duties of their positions under the plan. The written fire emergency response plan must provide for the following:

(A) use of alarms;

(B) transmission of an alarm to a fire department;

(C) response to alarms;

(D) isolation of fire;

(E) evacuation of the immediate area;

(F) preparation of floors and building for evacuation; and

(G) fire extinguishment;

(2) The fire emergency response plan must include procedures to contact DADS by telephone, at 1-800-458-9858, no later than 24 hours after activation of its Fire Emergency Response Plan.

(3) The staff must conduct emergency egress and relocation drills as follows:

(A) perform a monthly fire drill with all occupants of the building at expected and unexpected times and under varying conditions;

(B) relocate, during the monthly drill, all occupants of the building to a predetermined location where occupants must remain until a recall or dismissal is given; and

(C) complete the DADS Fire Drill Report Form for each required drill.

(4) The EPC or a designee must conduct fire prevention inspections on a monthly basis and prepare a report of the inspection results. The center must maintain copies of the fire prevention inspection report prepared by the center within the last 12 months. The center must post a copy of the most recent fire prevention inspection report in a conspicuous place at the center.

§15.210. Sanitation, Housekeeping, and Linens.

(a) A center must ensure a sanitary environment by following accepted standards of practice and maintain a safe physical environment free of hazards for minors, staff, and visitors.

(b) A center must ensure that the following conditions are met.

(1) Wastewater and sewage must be discharged into a state-approved municipal sewage system. An on-site sewage facility must be approved by the Texas Commission on Environmental Quality (TCEQ) or authorized agent.

(2) The water supply must be from a system approved by the Public Drinking Water Section of the TCEQ, or from a system regulated by an entity responsible for water quality in the jurisdiction where the center is located as approved by the Public Drinking Water Section of the TCEQ.

(3) Waste, trash, and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations are not permitted. Outside containers must have tight-fitting lids left in closed position. Containers must be maintained in a clean and serviceable condition.

(4) Center grounds must be well kept and the exterior of the building, including sidewalks, steps, porches, ramps, and fences, must be in good repair.

(5) The interior of the center's buildings including walls, ceilings, floors, windows, window coverings, doors, plumbing and electrical fixtures must be in good repair.

(6) Pest control must be provided by a licensed structural pest control applicator with a license category for pests. The center must maintain documented evidence of routine efforts to remove rodents and insects.

(7) The center must be kept free of offensive odors, accumulations of dirt, rubbish, dust, and hazards. Storage areas, attics, and cellars must be free of refuse and extraneous materials.

(c) A center must adopt and enforce a written work plan for housekeeping operations, with categorization of cleaning assignments as daily, weekly, monthly, or annually within each area of the center.

(d) A center must ensure the provision of housekeeping and maintenance of the interior, exterior and grounds of the center in a safe, clean, orderly and attractive manner. The center must provide housekeeping and maintenance staff with equipment and supplies if needed. A center must designate staff to be responsible for overseeing the housekeeping services.

(e) A center must develop procedures for the selection, use, and disposal of housekeeping and cleaning products and equipment. The center must ensure:

(1) the use of EPA approved cleaning products appropriate for the application and materials to be sanitized;

(2) the following of manufacturer instructions for use and disposal of cleaning products;

(3) all bleaches, detergents, disinfectants, insecticides, and other poisonous substances are kept in a safe place accessible only to staff; and

(4) all products are labeled.

(f) A center must ensure a sufficient supply of clean linens is available to meet the needs of minors. Clean laundry must be provided in-house by the center, through a contract with another health care center, or with an outside commercial laundry service.

(g) A center must ensure:

(1) linens are handled, stored, and processed so as to control the spread of infection;

(2) linens are maintained in good repair;

(3) linens are washed, dried, stored, and transported in a manner which will produce hygienically clean linen;

(4) the washing process has a mechanism for removing soil and killing bacteria;

(5) clean linens are stored in a clean linen area easily accessible to the staff;

(6) soiled linens and clothing are stored separately from clean linen and clothing;

(7) soiled linens and clothing are stored in well ventilated areas, and are not permitted to accumulate at the center;

(8) soiled linens and clothing are transported in accordance with procedures consistent with universal precautions;

(9) soiled linens are not sorted, laundered, rinsed, or stored in bathrooms, corridors, food preparation area, or food storage areas;

(10) a minor's clothing stored at the center is cleaned after each use; and

(11) staff wash their hands both after handling soiled linen and before handling clean linen.

§15.211. Infection Prevention and Control Program and Vaccinations Requirements.

(a) A center must establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment by preventing the development and transmission of disease and infection. Under the IPCP, the center must:

(1) investigate, prevent, and control infections at the center;

(2) decide what procedures, such as isolation, should be applied to an individual minor;

(3) address vaccine preventable diseases in accordance with THSC, Chapter 224;

(4) address hepatitis B vaccinations in accordance with Occupational Safety and Health Administration;

(5) address tuberculosis requirements; and

(6) maintain a record of incidents and corrective actions relating to infections.

(b) A center must provide IPCP information to employees, contractors, volunteers, parents, health care providers, other service providers, and visitors.

(c) A center's IPCP must include written policies and procedures for admissions and attendance of minors who are at risk for infections or present a significant risk to other minors. The policy must include that a minor is accepted only:

(1) as authorized by a minor's prescribing physician:

(2) as determined by the center's medical director's assessment of the risk;

(3) as determined by the medical and nursing director review, on a case-by-case basis, to determine appropriateness of admission to or attendance at the center; and

(4) in accordance with Centers for Disease Control (CDC) guidelines.

(d) The center's IPCP must include written policies and procedures for preventing the spread of infection.

(1) If the center determines, in accordance with its IPCP, that a minor must be isolated to prevent the spread of infection, the center must isolate a minor.

(A) The center must maintain an isolation room with a glass window for observation of a minor. The isolation room must be equipped with emergency outlets and equipment as necessary to provide care to a minor. The isolation room must have a dedicated bathroom not accessible to the center's other rooms if appropriate to control the spread of infectious disease.

(B) The center must ensure that all equipment is thoroughly cleaned and disinfected before being placed in the isolation room and before being removed from the room.

(C) The center's procedures must address:

(i) notification to a minor's parent of the minor's condition and the center's recommendation of isolation or removal based on the minor's risk assessment;

(ii) the arrangement of transportation if the minor must be removed from the center; and

(iii) the return of a minor to the center, as determined by a reassessment conducted by a nurse that the minor no longer poses a risk to other minors.

(2) The center must prohibit employees, volunteers, and contractors with an infectious disease or infected skin lesions from direct contact with minors or food, if direct contact will transmit the disease.

(3) The center's infection control policy must provide that staff, volunteers, and contractors wash their hands between each treatment and care interaction with a minor.

(4) The center must immediately report the name of any minor with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of Communicable Diseases) to the city health officer, county health officer, or health unit director having jurisdiction, and implement appropriate infection control procedures as directed by the local health authority or the Department of State Health Services.

(e) The center must assign a crib, bed, or sleep mat for a minor's exclusive use each day. A center must label cribs, beds, and sleep mats with the minor's name.

(f) A center must place liquid soap, disposable paper towels, and trash containers at each sink.

(g) The center must adopt and enforce written policies and procedures for the control of communicable diseases for employees, contractors, volunteers, parents, health care providers, other service providers, and visitors and must maintain evidence of compliance.

(h) The center must adopt and enforce written policies and procedures for the control of an identified public health disaster.

(1) If a center determines or suspects that an employee, volunteer, or contractor providing services has been exposed to, or has a positive screening for, a communicable disease, the center must respond according to current CDC guidelines and keep documentation of the action taken.

(2) If the center determines that an employee, volunteer or contractor providing services has been exposed to a communicable disease, the center must conduct and document a reassessment of the risk classification. The center must conduct and document subsequent screenings based upon the reassessed risk classification.

(3) If the center determines that an employee, volunteer, or a contractor providing services at the center is suspected of having a communicable disease, the individual must not return to the center until the individual no longer poses a risk of transmission as documented by a written physician's statement.

(i) The center must conduct and document an annual review that assesses the center's current risk classification according to the current CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings and 25 TAC Chapter 97, Subchapter A.

(1) The center must have a system in place to screen all individuals providing services at the center.

(2) The center must require employees, volunteers, and contractors providing services to provide evidence of current tuberculosis screening before providing services at the center. The center must maintain evidence of compliance.

(3) Any employee, volunteer, or contractor providing services at a center with positive results must be referred to the person's personal physician, and if active tuberculosis is suspected or diagnosed, the person must be excluded from work until the physician provides written approval to return to work.

(j) A center must adopt and enforce written policies and procedures to protect a minor from vaccine preventable diseases, in accordance with THSC, Chapter 224.

(1) The policy must:

(A) require an employee, volunteer, or contractor providing direct care to receive vaccines for the vaccine preventable diseases specified by the center based on the level of risk the employee, volunteer, or contractor, presents to minors by the employee's, volunteer's, or contractor's routine and direct exposure to minors;

(B) specify the vaccines an employee, volunteer, or contractor who provides direct care is required to receive in accordance with subsection (i) of this section;

(C) include procedures for the center to verify that an employee, volunteer, or contractor who provides direct care has complied with the policy;

(D) include procedures for the center to exempt an employee, volunteer, or contractor who provides direct care from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC;

(E) include procedures, including using protective equipment such as gloves and masks, to protect minors from exposure to vaccine preventable diseases, based on the level of risk the employee, volunteer, or contractor presents to minors by the employee's, volunteer's, or contractor's routine and direct exposure to minors;

(F) prohibit discrimination or retaliatory action against an employee, volunteer, or contractor who provides direct care and who is exempt from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC, except that required use of protective medical equipment, such as gloves and masks, will not be considered retaliatory action;

(G) require the center to maintain a written or electronic record of each employee's, volunteer's or contractor's compliance with or exemption from the policy; and

(H) include disciplinary actions the center may take against an employee, volunteer, or contractor providing direct care who fails to comply with the policy.

(2) The center must have a written policy describing whether it will exempt an employee, volunteer, or contractor providing direct care:

(A) from the required vaccines based on reasons of conscience, including a religious belief; and

(B) prohibit an employee, volunteer, or contractor providing direct care who is exempt from the required vaccines from having contact with minors during a public health disaster.

(k) The center must adopt and enforce written policies and procedures to identify employees, volunteers, or contractors at risk of directly contacting blood or potentially infectious materials in accordance with Occupational Safety and Health Administration (OSHA), 29 Code of Federal Regulations Part 1910.1030 and Appendix A relating to Bloodborne Pathogens.

(l) A center must ensure that its employees, volunteers, and contractors comply with:

(1) the center's IPCP;

(2) the Communicable Disease Prevention and Control Act, THSC Chapter 81; and

(3) THSC Chapter 85, Subchapter I, concerning the prevention of the transmission of human immunodeficiency virus and hepatitis B virus.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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DIVISION 2. ADMINISTRATION AND MANAGEMENT

40 TAC §§15.301 - 15.311

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commis-

sioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.301. License Holder's Responsibilities.

(a) The license holder is responsible for the conduct of the center and for the adoption, implementation, and enforcement of the written policies required throughout this chapter. The license holder is also responsible for ensuring that these policies comply with THSC Chapter 248A and the applicable provisions of this chapter and are administered to provide safe, professional, and quality health care.

(b) The persons described in §15.101(f) of this chapter (relating to Criteria and Eligibility for a License) must not have been convicted of an offense described in §99.2 of this title (relating to Convictions Barring Licensure), during the time frames described in that chapter.

(c) The license holder must ensure that all documents submitted to DADS or maintained by the center as required by this chapter are accurate and do not misrepresent or conceal a material fact.

(d) The license holder must comply with an order of the DADS commissioner or other enforcement orders that may be imposed on the center in accordance with THSC Chapter 248A and this chapter.

(e) The license holder of the center must have full legal authority and responsibility for the operation of the center.

(f) A license holder must designate in writing an individual who meets the qualifications and conditions set out in §15.303 of this subchapter (relating to Administrator and Alternate Administrator Qualifications and Conditions) to serve as the administrator of the center.

(g) A license holder must designate in writing an alternate administrator who meets the qualifications and conditions of an administrator set out in §15.303 of this subchapter to act in the absence of the administrator or when the administrator is unavailable to the staff during the center's operating hours.

(h) A license holder must ensure the position and designation of an administrator or alternate administrator is filled with a qualified staff.

(i) A license holder must ensure maintenance of documentation of efforts to ensure a vacancy in the position of an administrator or alternate administrator does not last more than 30 days.

(j) A license holder must ensure all written notices to DADS required by this chapter, unless specified, are submitted as described in the instructions provided on the DADS website.

§15.309. Nursing Director and Alternate Nursing Director Qualifications and Conditions.

(a) A center must designate a nursing director and alternate nursing director who meet the qualifications and conditions set out in this section and who have completed the DADS pre-licensing program training titled "Overview of Prescribed Pediatric Extended Care Center Licensing Standards in Texas."

(b) The nursing director and alternate nursing director must have the following qualifications:

(1) a baccalaureate degree in nursing;

(2) a valid RN license under Texas Occupations Code, Chapter 301, with no disciplinary action;

(3) a valid certification in Cardio Pulmonary Resuscitation or Basic Cardiac Life Support; and

(4) a minimum of two years of supervision and management in employment in a pediatric setting caring for a medically or technologically dependent minor or at least two years of supervision in one of the following specialty settings:

(A) pediatric intensive care;

(B) neonatal intensive care;

(C) pediatric emergency care;

(D) center;

(E) home health or hospice agency specializing in pediatric care;

(F) ambulatory surgical center specializing in pediatric care; or G) have comparable pediatric unit experience in a hospital for two consecutive years before the person applies for the position of nursing director.

(c) The nursing director and alternate nursing director must meet the requirements of this subsection.

(1) The nursing director must be a full time employee of the center.

(2) The nursing director or alternate nursing director may serve as the administrator or alternate administrator of the center if the nursing director or alternate nursing director meets the administrator qualifications as described in §15.303 of this division (relating to Administrator and Alternate Administrator Qualifications and Conditions).

(3) A center must designate an alternate nursing director who meets the qualifications as specified in this section who will assume the responsibilities of the nursing director when the nursing director is unavailable during the center's operating hours.

(4) The nursing director must not be included in the center's staffing ratio when the center's actual census is four or more minors.

(5) The nursing director must not be included in the center's staffing ratio when the center's actual census is less than four minors and the nursing director is also functioning as the administrator.

(6) The designated alternate nursing director must not be included in the center's staffing ratio when functioning as the nursing director, administrator or alternate administrator.

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DIVISION 3. NURSING AND STAFFING REQUIREMENTS

40 TAC §§15.401 - 15.419

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.402. Registered Nurse Qualifications.

(a) A RN providing services on behalf of a center must have at least the following qualifications and experience:

(1) a valid RN license under Texas Occupations Code, Chapter 301, with no disciplinary action;

(2) valid certifications in Cardio Pulmonary Resuscitation and Basic First Aid; and

(3) one of the following:

(A) one year of pediatric specialty experience with emphasis on medically and technologically dependent minors, obtained within the previous five years; or

(B) sufficient skills to meet the competency and training requirements described in subsection (b) of this section.

(b) A center must adopt and enforce a written policy regarding an RN who qualifies to provide services at the center under subsection (a)(3)(B) of this section. The policy must:

(1) require an RN qualified under subsection (a)(3)(B) of this section to complete a training program that is determined appropriate by the Director of Nursing and conducted by an RN on the RN responsibilities described in §15.403 of this division (relating to Registered Nurse Responsibilities) and that includes hands-on training;

(2) require, before performing the RN responsibilities described in §15.403 of this division, an RN qualified under subsection (a)(3)(B) of this section to demonstrate competency in performing the responsibilities described in §15.403 of this division, as determined by an RN;

(3) describe procedures for increased supervision of an RN qualified under subsection (a)(3)(B) of this section during the training program, competency evaluation, and for three months after completion of the competency evaluation to ensure the health and safety of minors; and

(4) prohibit an RN qualified under subsection (a)(3)(B) of this section from performing the responsibilities in §15.403 of this division or being included in the nursing services staffing ratio as an RN, as described in §15.410 of this division (relating to Nursing Services Staffing Ratio), until the RN completes the training program described in paragraph (1) of this subsection and demonstrates competency as described in paragraph (2) of this subsection.

(c) An RN qualified under subsection (a)(3)(B) of this section must meet the requirements in §15.415 of this division (relating to Staffing Policies for Staff Orientation, Development, and Training) and §15.416 of this division (relating to Staff Development Program).

§15.404. Licensed Vocational Nurse Qualifications.

(a) An LVN providing services on behalf of a center must have at least the following qualifications and experience:

(1) a valid LVN license under Texas Occupations Code, Chapter 301, with no disciplinary action;

(2) valid certifications in Cardio Pulmonary Resuscitation and Basic First Aid; and

(3) one of the following:

(A) one year of pediatric specialty experience with emphasis on medically and technologically dependent minors obtained within the last consecutive five years; or

(B) sufficient skills to meet the competency and training requirements described in subsection (b) of this section;

(b) A center must adopt and enforce a written policy regarding an LVN who qualifies to provide services at the center under subsection (a)(3)(B) of this section. The policy must:

(1) require an LVN qualified under subsection (a)(3)(B) of this section to complete a training program that is determined appropriate by the Director of Nursing and conducted by an RN on the LVN responsibilities described in §15.405 of this division (relating to Licensed Vocational Nurse Responsibilities) and that includes hands-on training;

(2) require, before performing the LVN responsibilities described in §15.405 of this division, an LVN qualified under subsection (a)(3)(B) of this section to demonstrate competency in performing the responsibilities described in §15.405 of this division, as determined by an RN;

(3) describe procedures for increased supervision of an LVN qualified under subsection (a)(3)(B) of this section during the training program, competency evaluation, and for three months after completion of the competency evaluation to ensure the health and safety of minors; and

(4) prohibit an LVN qualified under subsection (a)(3)(B) of this section from performing the responsibilities in §15.405 of this division or being included in the nursing services staffing ratio as an LVN, as described in §15.410 of this division (relating to Nursing Services Staffing Ratio), until the LVN completes the training program described in paragraph (1) of this subsection and demonstrates competency as described in paragraph (2) of this subsection.

(c) An LVN must meet the requirements in §15.415 of this division (relating to Staffing Policies for Staff Orientation, Development, and Training) and §15.416 of this division (relating to Staff Development Program).

§15.406. Student Nurses.

(a) If a center has an agreement with an accredited school of nursing to use the center for a portion of a student nurse's clinical experience, the student nurse may provide care under the following conditions:

(1) the agreement ensures that criminal history checks are conducted for a student nurse in accordance with §15.418 of this division (relating to Criminal History Checks, Nurse Aide Registry (NAR), and Employee Misconduct Registry (EMR) Requirements) before a student nurse provides direct care;

(2) a student nurse is not counted in the staffing ratio required in this chapter; and

(3) one of the following:

(A) an instructor from the school is onsite, provides class supervision, and assumes responsibility for all student nursing activities at the center; or

(B) the center:

(i) assumes responsibility for supervision of all student nurses and for all student nursing activities at the center; and

(ii) meets the requirements described in subsection (b) of this section.

(b) The center must adopt and enforce written policy and procedures describing whether the center will assume responsibility for supervision of all student nurses and for all student nursing activities at the center. If a center assumes responsibility for student nurse activity, the center must:

(1) determine the appropriate level of student nurse interaction with a minor, based on the qualifications and experience of the student nurse;

(2) assign an RN to supervise a student nurse;

(3) limit RN supervision to no more than three student nurses at one time; and

(4) based on the outcomes of paragraph (1) of this subsection, determine if it is appropriate to exclude from the staffing ratio the RN assigned to supervise the student nurse activities to ensure the health and safety of minors.

§15.409. Direct Care Staff Qualifications.

(a) Direct care staff providing services on behalf of a center, must have the following qualifications:

(1) be 18 years of age or older;

(2) a high school diploma or a general equivalency degree;

(3) one of the following:

(A) one year of experience employed in a health care setting providing direct care to minors who are medically or technologically dependent;

(B) two years of experience employed in a health care, childcare, or school setting providing direct care to minors who are medically or technologically dependent;

(C) two years of experience employed in a health care setting providing direct care to adults; or

(D) sufficient skills to meet the competency and training requirements described in subsection (b) of this section; and

(4) maintain current certification in Pediatric Cardio Pulmonary Resuscitation and basic First Aid.

(b) The center must adopt and enforce written policy and procedures describing whether direct care staff who qualify to provide services under subsection (a)(3)(D) of this section. The policy must:

(1) require direct care staff who qualify under subsection (a)(3)(D) of this section to complete a training program regarding the provision of direct care to minors that:

(A) is determined appropriate by the nursing director;

(B) is conducted by an RN or LVN; and

(C) includes hands-on training;

(2) require, before providing services to a minor, direct care staff who qualify under subsection (a)(3)(D) of this section to demonstrate competency in the provision of direct care to minors as determined by an RN;

(3) describe procedures for increased supervision of direct care staff who qualify under subsection (a)(3)(D) of this section during the training program and the competency evaluation, and for six months after completion of the competency evaluation, to ensure the health and safety of minors; and

(4) prohibit direct care staff who qualify under subsection (a)(3)(D) of this section from being assigned to a minor or being included in the nursing services staffing ratio as described in §15.410 of this division (relating to Nursing Services Staffing Ratio) until the direct care staff completes the training program described in paragraph (1) of this subsection and demonstrates competency as described in paragraph (2) of this subsection.

(c) Direct care staff must meet the requirements in §15.415 of this division (relating to Staffing Policies for Staff Orientation, Development, and Training) and §15.416 of this division (relating to Staff Development Program).

§15.410. Nursing Services Staffing Ratio.

(a) A center's total staffing for nursing services must be maintained, at a minimum, in the following ratios but at no time must there be less than one staff member on duty per three minors receiving nursing services from a center. If only one staff member is on duty, that member must be an RN.

(b) The staffing ratio is based on the number of minors on the center's actual census that are receiving nursing services from the center.

(c) A center must not include direct care staff who qualify under subsection (b) of §15.409 of this division (relating to Direct Care Staff Qualifications) in the staffing ratio until the staff complete the training program and demonstrate competency as described in subsection (b)(3) of §15.409 of this division.

(d) A center must maintain documentation to support compliance with this section and §15.803 of this chapter (relating to Census). Documentation must include:

(1) each change in the number of minors on the center's actual census that are receiving nursing services from the center; and

(2) the increase or decrease in the number of RNs, LVNs, and direct care staff in accordance with this section as changes in the number of minors on the center's actual census that are receiving nursing services from the center occurs.

Figure: 40 TAC §15.410(d)(2)

§15.415. Staffing Policies for Staff Orientation, Development, and Training.

(a) A center must adopt and enforce written staffing policies and procedures that govern all staff providing services on behalf of the center, including employees, volunteers, and contractors.

(b) A center's written staffing policies must include:

(1) requirements for orientation to the policies, procedures, and objectives of the center;

(2) requirements and procedures for processing criminal history checks;

(3) requirements that staff are current on immunizations;

(4) requirements that an applicant for employment provide written documentation to rule out communicable diseases, including but not limited to tuberculosis;

(5) requirements for direct care staff to demonstrate the necessary skills and competency to meet the direct care needs of a minor to which he or she is assigned and as described in their job description;

(6) requirements for staff to participate in appropriate employee development programs quarterly;

(7) requirements for participation by all staff in job-specific training;

(8) staff training policies that ensure:

(A) staff are properly oriented to tasks performed;

(B) demonstration of competency for tasks when competency cannot be determined through education, license, certification, or experience;

(C) quarterly continuing systemic training for all staff who provide services, including training on infection prevention and control;

(D) staff are informed of changes in techniques, philosophies, organization, minor's rights, ethics and confidentiality, medical record requirements, information relating to minor's development, goals, and products relating to a minor's care;

(E) staff are properly oriented and trained in the proper use of person-centered direction and guidance as outlined in center policy and in accordance with §15.206 of this subchapter (relating to Person-Centered Direction and Guidance);

(F) staff are properly oriented and trained in the proper use and application of protective devices; and

(G) staff are properly oriented and trained in the proper use and application of restraints in accordance with the following requirements:

(i) all center staff whose job responsibilities include the use of restraint during a behavioral emergency must be trained before assuming direct care responsibilities for a minor;

(ii) all center staff must receive training and demonstrate competency in the following areas:

(I) using any restraint techniques or procedures that are expected or anticipated to be employed;

(II) identifying the underlying causes or functions of threatening behaviors;

(III) understanding how the behavior of staff members affects the behavior of minors;

(IV) using de-escalation, mediation, self-protection, and other techniques, such as quiet time, to prevent or reduce the use of restraint;

(V) applying principles of trauma informed care; and

(VI) recognizing and responding to signs of distress in a minor who is being restrained; and

(iii) all center staff must complete training and demonstrate competence in the use of restraint in a behavioral emergency at least every 12 months following initial training; and

(H) job-specific training is documented with the following information:

(i) the name and qualifications of the trainer;

(ii) the training topics and length; and

(iii) a list of staff who completed the training and demonstrated competence;

(9) a requirement to have a written job description that is a statement of the functions and responsibilities, and job qualifications, including the specific education and training requirements for each position at the center;

(10) procedures for searching the nurse aide registry and the employee misconduct registry for staff in accordance with §15.418 of this division (relating to Criminal History Checks, Nurse Aid Registry (NAR) and Employee Misconduct Registry (EMR) Requirements);

(11) a requirement to have annual evaluation of employee and volunteer performance;

(12) a description of employee and volunteer disciplinary action and procedures;

(13) a policy regarding the use of volunteers that is in compliance with §15.414 of this division (relating to Volunteers); and

(14) a requirement that all staff providing services on behalf of a center sign a statement that the staff have read, understand, and will comply with all applicable center policies.

(c) A center must adopt and enforce written policies and procedures for parent orientation and training programs in accordance with §15.509 of this subchapter (relating to Parent Training). The policy must:

(1) require orientation be provided to each parent of each minor admitted to the center; and

(2) ensure that orientation includes:

(A) the philosophy of the center;

(B) the basic services as defined in this chapter;

(C) on-going parent training needs as determined by the individual needs of the minor;

(D) a minor's parent agreement and disclosure form;

(E) the center attendance policy for minors; and

(F) information about a minor's rights while receiving services at the center.

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DIVISION 4. GENERAL SERVICES

40 TAC §§15.501 - 15.511

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.502. Medical Services.

(a) A center must ensure the provision of medical services based on the needs of a minor, in accordance with a minor's plan of care and as ordered by a minor's prescribing physician.

(b) A center must ensure that a minor's prescribing physician maintains responsibility for the overall medical therapeutic plan of a minor and consults and collaborates with the staff providing services in a center.

(c) A center's nursing director or designee must communicate with each minor's prescribing physician at least every 90 days or more frequently when there is a health status or physical status change in a minor's condition.

(d) A center must adopt and enforce a written policy requiring that therapists who provide services to a minor at the center consult with a minor's prescribing physician directly or coordinate with the clinical staff at least every 180 days or more frequently when there is a health status or physical status change in a minor's condition.

§15.507. Functional Developmental Services.

(a) A center must ensure the provision of functional developmental services based on the needs of a minor, in accordance with the minor's plan of care and as ordered by a minor's prescribing physician.

(b) A center must refer a minor to Early Childhood Intervention, within seven days after identification of a developmental delay or risk of developmental delay in accordance with Code of Federal Regulations, Title 34, §303.303 (relating to Referral Procedures).

(c) A center must ensure that each minor has a functional assessment incorporated into the comprehensive assessment to include developmentally appropriate areas.

(d) A minor's functional assessment must include:

(1) measurable goals that enhance independent functioning in daily activities and to promote socialization;

(2) a description of a minor's strengths and present performance level with respect to each goal;

(3) skills areas in priority order; and

(4) planning for specific areas identified as needing development.

§15.508. Educational Developmental Services.

(a) The center must adopt and enforce written policies and procedures to facilitate each minor's access to available early intervention and educational services and programs delivered by an education provider, including a local education agency, as defined in United States Code, Title 20, §1401(15), (LEA), early childhood intervention agency, or private school, in the least restrictive environment in the community where a minor resides and where the center is located. The center's educational policy must:

(1) be person-centered and parent driven;

(2) be collaborative with the education provider;

(3) ensure that the center does not act as the primary education provider for a minor or accept a delegation of responsibility for the provision of a minor's education from an education provider; and

(4) support a minor's education program as agreed to by a parent and education provider.

(b) The center must not coerce or provide an incentive to an individual or education provider that would result in a minor's removal from a less restrictive educational environment.

(c) The center must not be the primary location for the education provider to deliver services to a minor unless it is determined by the education provider, including the LEA's Admission, Review, and Dismissal (ARD) committee or committee required by Section 504 of the Rehabilitation Act of 1973, in collaboration with a minor's parent and a minor's prescribing physician that the center is the least restrictive environment for a minor to receive educational services.

(d) For a minor who is not receiving services from an education provider, the center must provide a minor and a minor's parent contact information for the LEA where a minor resides.

(e) For a minor receiving services from an education provider, the center must:

(1) not duplicate or provide services that conflict with a minor's education program;

(2) for a minor receiving services from an LEA, not interfere with the compulsory attendance requirements of Texas Education Code §25.085 and §25.086;

(3) when requested by a parent, make available a minor's records to support the minor's education program;

(4) request copies of a minor's education program records to support center care planning activities;

(5) if requested by a parent, participate in planning activities for a minor conducted by the education provider, including an LEA's ARD committee or committee required by Section 504 of the Rehabilitation Act of 1973;

(6) request that a minor's teacher, or other education provider representative, participate as part of the IDT to ensure coordination of a minor's services with the scheduled education component of activities; and

(7) support a minor's education program activities at the center, if needed, by:

(A) providing a well-lighted room, private space or other adequate workspace;

(B) providing functional assistance to a minor;

(C) coordinating with a minor and a minor's parent to ensure special and general supplies and equipment available for a minor if needed; and

(D) providing an area to post education program calendars and information bulletins provided to the center for minors and parents to view.

§15.511. Dietary Services.

(a) A center must adopt and enforce written policy and procedures to ensure that a minor, while at the center, receives:

(1) a nourishing, well-balanced diet as recommended by the American Academy of Pediatrics or Food and Nutrition Board of the National Research Council, National Academy of Sciences; or

(2) a diet ordered by a minor's prescribing physician.

(b) If a minor's meals and snacks are supplied by an adult minor or a minor's parent, the center's written policy and procedures must:

(1) include a written signed agreement between the center and the adult minor or minor's parent that includes:

(A) a statement that the adult minor or minor's parent is responsible for providing the appropriate meals and snacks for the minor in accordance with this section;

(B) the responsibilities of the center and the responsibilities of the adult minor or minor's parent concerning the provision of meals and snacks; and

(C) actions that may be taken by the center if the adult minor or minor's parent fails to provide meals and snacks for the minor as agreed;

(2) describe the actions that will occur if an adult minor or minor's parent fails to provide the minor's meals and snacks or fails to provide meals and snacks in accordance with the minor's prescribed diet, which must include that the center ensures that the minor receives the meals and snacks as required in this section while at the center; and

(3) ensure an adult minor or minor's parent receives nutritional counseling as described in §15.5101 of this division (relating to Nutritional Counseling).

(c) If the center provides meals and snacks directly or under contract, the center must employ or contract with a dietitian as described in §15.411(b) of this subchapter (relating to Rehabilitative and Ancillary Professional Staff and Qualifications).

(1) The dietitian is responsible for the overall operation of the dietary service.

(2) The dietitian must participate in regular conferences with the administrator and nursing director to provide information about approaches to identified nutritional problems.

(3) The dietitian must participate in the development of dietary support staff policies.

(4) The center must employ sufficient dietary support staff who meet the qualifications to carry out the functions of the dietary service.

(5) The dietitian must ensure that a minor has a diet:

(A) that meets the daily nutritional and special dietary needs of a minor, based upon the acuity and clinical needs of a minor; or

(B) as prescribed by a minor's prescribing physician.

(6) The dietitian is required to review a minor's plan of care for any known food allergy and special diet ordered by a minor's prescribing physician as often as necessary for changes to a minor's dietary needs.

(d) If a center provides meals and snacks directly or under contract:

(1) a dietitian must develop a menu that:

(A) is prepared at least one week in advance;

(B) is written for each type of diet; and

(C) varies from week to week, taking the general age-group of minors into consideration;

(2) the center must post the current week's menu in a conspicuous location so an adult minor and a minor's parent may see it; and

(3) the center must retain menus for 30 days.

(e) If a center provides meals and snacks directly, the center must retain records of menus served and food purchased for 30 days. The center must keep a list of minors receiving special diets and a record of the diets in the minors' medical records for at least 30 days.

(f) The center must:

(1) provide tables that allow minors to eat together when possible;

(2) provide assistance to minors, as needed;

(3) serve food on appropriate tableware; and

(4) ensure clean napkins, bibs, dishes, and utensils are available for each use.

(g) A center must coordinate with an adult minor or a minor's parent to ensure special eating equipment and utensils are available for a minor at the center if needed.

(h) An identification system, such as tray cards, must be available to ensure that all food is served in accordance with a minor's diet.

(i) A center must monitor and record food intake of all minors as follows.

(1) Deviations from normal food and fluid intake must be recorded in a minor's medical record.

(2) In-between meal snacks, and supplementary feedings, either as a part of the overall plan of care or as ordered by a minor's prescribing physician, including special diets, must be documented using professional practice standards.

(j) The center must serve a minor meals and snacks as specified in this section and as outlined in a minor's plan of care.

(1) If breakfast is served, a morning snack is not required.

(2) Notwithstanding the provisions of this section, a minor must not go more than three hours without a meal or snack being offered, unless a minor is sleeping.

(3) The center must offer at least one snack to a minor who is served at the center for less than four hours.

(4) The center must offer one meal, or one meal and one snack, equal to one third of a minor's daily food needs to a minor who is served at the center for four to seven hours.

(5) The center must offer two meals and one snack, or two snacks and one meal, equal to one half of a minor's daily food needs to a minor who is served at the center for more than seven hours.

(6) The center must ensure that a supply of drinking water is always available to each minor and is served at every snack, mealtime, and after active play.

(k) The center must:

(1) purchase food from sources approved or considered satisfactory by federal, state, and local authorities;

(2) store, prepare, and serve food under sanitary conditions, as required by the Department of State Health Services food service sanitation requirements; and

(3) dispose of garbage and refuse properly.

(l) The center must provide safe and proper storage and service of a minor's meals and snacks provided by an adult minor and minor's parent.

(m) Dietary service staff must be in good health and practice hygienic food-handling techniques. Staff with symptoms of communicable diseases or open, infected wounds may not work at the center until the center receives written documentation from a health care professional that the staff member is released to return to work or, the signs and symptoms which relate to the communicable disease are no longer evident.

(n) Dietary service staff must wear clean, washable garments, wear hair coverings or clean caps, and have clean hands and fingernails.

(o) Routine health examinations must meet all local, state, and federal codes for food service staff.

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DIVISION 5. ADMISSION CRITERIA, CONFERENCE, ASSESSMENT, INTERDISCIPLINARY PLAN OF CARE, AND DISCHARGE OR TRANSFER

40 TAC §§15.601 - 15.608

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.607. Initial and Updated Plan of Care.

(a) A center must develop an individualized written plan of care for a minor. The plan of care must include:

(1) the minor's and the minor's parent's goals and interventions based on the issues identified in the pre-admission conference and the initial and updated comprehensive assessments; and

(2) measurable goals with interventions based on the minor's care needs and means of achieving each goal and must address, as appropriate, rehabilitative and restorative measures, preventive intervention and training, and teaching of personal care by the minor's parent.

(b) An RN must address in the written interdisciplinary plan of care:

(1) the services needed to address the medical, nursing, psychosocial, therapeutic, dietary, functional, educational, and developmental needs of the minor and the training needs of the minor's parent;

(2) the minor's functional assessment;

(3) the specific goals of care;

(4) the time frame for achieving the goals and the schedule for evaluation of progress;

(5) the orders for treatment, services, medications, medical equipment, diet, and restraints, if applicable;

(6) specific criteria for transitioning from or discontinuing participation at the center; and

(7) the minor's scheduled days of attendance.

(c) In collaboration with the interdisciplinary team, an RN, a minor's parent, the minor, and an individual requested by the adult minor or the minor's parent must develop a plan of care based on the comprehensive assessment.

(d) The RN, a minor's parent and the minor, if the minor is an adult minor, must sign the plan of care within five days after initiation of the plan.

(e) A minor's prescribing physician must review and sign the plan of care within 30 days after initiation of the plan.

(f) The center must incorporate the plan of care into a minor's medical record no later than 10 days after receiving the signed plan from a minor's prescribing physician.

(g) Copies of the plan of care must be given, in a language and format the recipient understands, to a minor's parent, an adult minor, the minor's prescribing physician, the center's staff and other health care providers and providers of basic services as appropriate.

(h) The center's IDT and an RN must review and update a minor's plan of care at least every 180 days, or more often, if there is a change in a minor's medical condition or changes in a minor's needs.

(i) A minor's parent and the minor, if the minor is an adult minor, must review and sign the updated plan of care within five days before changes to the plan of care are implemented.

(j) A minor's prescribing physician must review and sign the updated plan of care within 30 days after initiation of the updated plan.

(k) The center must incorporate the updated plan of care into a minor's medical record no later than 10 days after receiving the signed plan from a minor's prescribing physician.

(l) The center must adopt and enforce written policies and procedures regarding the communication and coordination of a minor's care with a minor's prescribing physician in accordance with the plan of care.

(m) The policy described in subsection (l) of this section must ensure the communication between the center's staff and the minor's prescribing physician is conveyed to the minor's parent and the minor in a language and format that an adult minor and minor's parent understand.

(n) The center's nursing director or designee must:

(1) document communication with the minor's prescribing physician;

(2) maintain the documentation in the minor's medical record; and

(3) ensure that the communication is conveyed to the minor's parent and the adult minor in a language and format the adult minor and minor's parent understand.

(o) The center staff must ensure the provision of services and treatments in accordance with the plan of care and as ordered by the minor's prescribing physician.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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DIVISION 6. PHYSICIAN, PHARMACY, MEDICATION, AND LABORATORY SERVICES

40 TAC §§15.701 - 15.708

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

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DIVISION 7. CARE POLICIES, COORDINATION OF SERVICES, AND CENSUS

40 TAC §§15.801 - 15.803

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

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DIVISION 8. RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES, ABUSE, NEGLECT, AND EXPLOITATION, INVESTIGATIONS, DEATH REPORTING, AND INSPECTION RESULTS

40 TAC §§15.901 - 15.906

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall

adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.901. Rights and Responsibilities.

(a) A center must adopt and enforce written policies to ensure a minor's legal rights are observed and protected and to ensure compliance with this section. The policies must comply with relevant law and ensure that the center considers a minor's age and legal status, including whether a guardian has been appointed or the disabilities of minority have been removed, to determine a minor's or other individual's authority to make decisions for the minor.

(b) Before providing services to a minor, a center must provide an adult minor and a minor's parent with oral and written notification of the requirements of this section in a language and format that the minor and parent understand. The center must obtain the signature of the adult minor and minor's parent to confirm that the individual received the notice.

(c) A center must:

(1) ensure that a minor is free from abuse, neglect, and exploitation at the center, as described in §15.903 of this division (relating to Abuse, Neglect, or Exploitation Reportable to DADS);

(2) inform a minor and a minor's parent of the center's policy for reporting abuse, neglect, or exploitation of a minor;

(3) ensure that a minor and the minor's property is treated with respect;

(4) at the time of admission, inform an adult minor and a minor's parent, orally and in a written statement, that a complaint or question about the center may be directed to the Department of Aging and Disability Services, DADS Consumer Rights and Services Division, P.O. Box 149030, Austin, Texas 78714-9030, toll free 1-800-458-9858;

(5) at the time of admission, inform an adult minor and a minor's parent, orally and in a written statement, that:

(A) states that complaints about services at the center may be directed to the administrator who will address them promptly;

(B) provides the time frame in which a center must review and resolve the complaint as described in §15.904 of this division (relating to Investigations of a Complaint and Grievance); and

(C) does not include a statement that a complaint must be made to the center administrator before directing a complaint to DADS;

(6) ensure that a minor is not subjected to unlawful discrimination or retaliation;

(7) ensure that a minor is treated appropriate to his or her age and developmental status;

(8) ensure that a minor is allowed to interact with other minors, including through planned and spontaneous active play, respective to a minor's condition and physician orders;

(9) ensure that an adult minor and a minor's parent are informed in advance about the services to be provided, including:

(A) staff who will provide the services and the proposed frequency of each service;

(B) any change in the plan of care before the change is made, except when a delay based on notification would compromise the health and safety of a minor;

(10) ensure that an adult minor and a minor's parent are informed of the expected outcomes of services and any specific limitations or barriers to services;

(11) ensure that an adult minor and a minor's parent are allowed and encouraged to participate in planning services and in planning changes to services and that the adult minor and the minor's parent consented to the changes before the changes are made, except when a delay based on participation in planning or obtaining consent would compromise the immediate health and safety of a minor;

(12) ensure that an adult minor and a minor's parent are informed of the center's policies on implementing an advance directive in accordance with §15.902 of this division (relating to Advance Directives) and to receive information about executing an advance directive;

(13) ensure that an adult minor and a minor's parent are allowed to refuse services;

(14) ensure that minor's medical record is kept confidential and an adult minor and a minor's parent are informed of the center's policies and procedures regarding disclosure of medical records;

(15) ensure that an adult minor and a minor's parent are informed, before care is provided, of the:

(A) extent to which payment for the center's services may be expected from Medicaid, or any other federally funded or aided program known to the center, or any other third-party payment source;

(B) charges for services not covered by a third-party payment source; and

(C) charges that the adult minor or minor's parent may have to pay;

(16) inform an adult minor and a minor's parent of any changes in the information provided in accordance with paragraph (15) of this subsection as soon as possible after changes occur, but no later than 30 days after the date the center becomes aware of the change;

(17) inform an adult minor and a minor's parent of the availability of other programs, including day care, early intervention programs, or school; and

(18) ensure that an adult minor and a minor's parent are allowed to convene or participate in a council or support group for individuals receiving services at the center.

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DIVISION 9. MEDICAL RECORDS, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT, DISSOLUTION AND RETENTION OF RECORDS

40 TAC §§15.1001 - 15.1004

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

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SUBCHAPTER D. TRANSPORTATION

40 TAC §15.1101, §15.1102

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.1101. Transportation Services.

(a) A center must ensure transportation services are provided for a minor, as authorized by an adult minor, the minor's parent, and the minor's prescribing physician:

(1) from the minor's home to the center;

(2) from the center to the minor's home; and

(3) to and from the center for services coordinated by the center.

(b) A center must ensure that vehicles are accessible for a minor with disabilities and equipped to meet the needs of a minor during transport.

(c) A minor's parent may decline a center's transportation services.

(d) A center must adopt and enforce written policies and procedures describing the staff and equipment that will accompany a minor during transportation. The staff must include a driver and a nurse.

(e) A center must ensure that:

(1) a person transporting a minor on behalf of a center has a valid and appropriate Texas driver's license, a copy of which the center must keep on file;

(2) a vehicle used to transport a minor has a current Texas safety inspection sticker and vehicle registration decal properly affixed to a vehicle;

(3) the center maintains commercial insurance for the operation of a center's vehicles, including coverage for minors and staff in a center's vehicle in the event of accident or injury;

(4) documentation of the insurance is maintained and includes:

(A) the name of the insurance company;

(B) the insurance policy number;

(C) the period of coverage; and

(D) an explanation of the coverage;

(5) the center provides a driver and the center's nurse with an up-to-date master transportation list that includes a minor's name, pick up and drop off locations, and authorized persons to whom a minor may be released;

(6) the master transportation list is on file at the center;

(7) the driver and the center's nurse riding in the vehicle maintain a daily attendance record for each trip that includes the driver's name, the date, names of all passengers in the vehicle, the name of the person to whom a minor was released, and the time of release; and

(8) the number of people in a vehicle used to transport minors does not exceed the manufacturer's recommended capacity for the vehicle.

§15.1102. Transportation Safety Provisions.

(a) A center must adopt and enforce written policies and procedures to ensure the care and safety of minors during transport.

(b) A center must appropriately train staff on the needs of a minor being transported.

(c) A center must properly restrain or secure a minor when the minor is transported by the center in a motor vehicle, in accordance with applicable federal motor vehicle safety standards, state law, THSC Chapter 248A, and this chapter.

(d) A center must ensure that:

(1) a minor boards and leaves the vehicle from the curbside of the street and is safely accompanied to the minor's destination;

(2) there is a first aid kit with unexpired supplies, including oxygen, a pulse oximeter, and suction equipment, in each center vehicle;

(3) the center prohibits the use of tobacco in any form, electronic cigarettes, alcohol and possession of illegal substances or unauthorized potentially toxic substances, firearms, pellet or BB guns, including loaded or unloaded BB guns, in any vehicle;

(4) the driver does not use a hand-held wireless communication device while operating a center vehicle;

(5) a center's nurse accompanies all minors during transport;

(6) at least one direct care staff member, or more depending on the acuity of the minors, accompanies every seven minors;

(7) the driver or center's nurse does not leave a minor unattended in the vehicle at any time;

(8) the driver or the center's nurse riding in the vehicle inspects the vehicle at the completion of each trip to ensure that no minor is left in the vehicle; and

(9) the center maintains documentation that includes the signature of the individual conducting the inspection described in paragraph (8) of this subsection and the time of inspection.

(e) A center must post near the emergency exit of each vehicle that transports a minor the following information in an easily readable font:

(1) the name of the administrator;

(2) the center's name;

(3) the center's telephone number; and

(4) the center's address.

(f) The center must adopt and enforce a policy on emergencies while transporting a minor. The policy must include:

(1) procedures for mechanical break downs;

(2) procedures for vehicle accidents; and

(3) procedures for a minor's emergency.

(g) If a center conducts a field trip, the center must ensure that the driver or center's nurse riding in the vehicle must inspect the vehicle and account for each minor upon arrival and departure from each destination to ensure that no minor is left in the vehicle after reaching the vehicle's final destination.

(1) A center must ensure that the driver or center's nurse riding in the vehicle maintains a field trip record for each trip. The record must include the driver's name, the nurse's name, the time and date, the vehicle's destinations, and names of all passengers in the vehicle.

(2) A center must maintain documentation that includes the signature of the person conducting the inspection and the time of each inspection during the field trip.

(3) Appropriate staff must be present when a minor is delivered to the center.

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SUBCHAPTER E. BUILDING REQUIREMENTS

40 TAC §§15.1201 - 15.1224

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

§15.1207. Interior Spaces.

(a) A center must consist of a building suitable for the purpose intended, and have a minimum of 50 square feet of space per minor exclusive of kitchen, toilet facilities, storage areas, hallways, stairways, basements, and attics.

(b) If a center uses a room exclusively for dining or sleeping, the center must not count that space as part of the licensed capacity.

(c) A center must have sufficient rooms to accommodate and segregate the different age groups of minors being served at the center.

(d) A center must provide staff area and staff toilets.

(e) A center must provide a reception area.

(f) A center must provide an administrative office.

(g) A center must provide quiet rooms based on the needs of minors.

(h) A center's quiet room must contain a minimum of 100 square feet.

(i) A center must provide indoor recreational exercise play area.

(j) A center must provide a treatment room with a medication preparation area. The medication preparation area must contain a work counter, refrigerator, sink with hot and cold water, and locked storage for biologicals and drugs.

(k) A center must develop isolation procedures to prevent cross-infection and provide an isolation room with at least one large glass area for observation of a minor in accordance with §15.211 of this chapter (relating to Infection Prevention and Control Program and Vaccination Requirements). The isolation room must contain a minimum of 100 square feet.

(l) The center must make privacy accommodations available to attend to the personal care needs of a minor.

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SUBCHAPTER F. INSPECTIONS AND VISITS

40 TAC §§15.1301 - 15.1305

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

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SUBCHAPTER G. ENFORCEMENT

40 TAC §§15.1401 - 15.1409

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Health and Safety Code, Chapter 248A, which provides that the HHSC executive commissioner shall adopt rules that are necessary to implement the chapter and to establish minimum standards for prescribed pediatric extended care centers.

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CHAPTER 30. MEDICAID HOSPICE PROGRAM

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§30.4, 30.30, 30.34, 30.36, 30.60, and 30.62, concerning definitions; general contracting requirements, voluntary termination of hospice contract; submission of written information; Medicaid hospice payments and limitations; Medicaid hospice claims requirements; and the repeal of §30.32, 30.70, 30.80, 30.82, and 30.84, concerning disclosure requirements; procedural requirements, enforcement generally, sanctions, and referral to the attorney general, in Chapter 30, Medicaid Hospice Program, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3113).

The amendments and repeals are adopted to update and delete rules in Chapter 30 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including hospice services. Therefore, the rules are being amended and repealed to remove provisions addressed in the new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose. DADS received no comments regarding adoption of the amendments and repeals.

SUBCHAPTER A. INTRODUCTION

40 TAC §30.4

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. CONTRACTING AND DISCLOSURE REQUIREMENTS

40 TAC §§30.30, 30.34, 30.36

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §30.32

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER F. REIMBURSEMENT

40 TAC §30.60, §30.62

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER G. INSPECTIONS, SURVEYS, AND VISITS

40 TAC §30.70

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services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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Department of Aging and Disability Services
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SUBCHAPTER H. ENFORCEMENT

40 TAC §§30.80, 30.82, 30.84

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 41. CONSUMER DIRECTED SERVICES OPTION

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts new §41.108, concerning services available through the CDS option; §41.233, concerning training and management of service providers; §41.238, concerning service delivery requirements; and §41.404, concerning ensuring development, approval, and review of service backup plans; the repeals of §41.201, concerning employer responsibilities; and §41.233, concerning management of service providers; and amendments to §41.207, concerning initial orientation of an employer; §41.217, concerning employer responsibilities regarding service backup plan; §41.301, concerning contracting as a financial management services agency; and §41.339, concerning records, in Chapter 41, Consumer Directed Services Option. New §41.108 and §41.233, and amendments to §41.207 and §41.301, are adopted with changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3120). The amendments to §41.217 and §41.339, new §41.238 and §41.404, and repeals of §41.201 and §41.233 are adopted without changes to the proposed text.

The adopted rules address the assurances set forth in the §1915(c) waiver applications about health and safety and qualified providers as those assurances relate to the consumer directed services (CDS) option. Specifically, to address the assurance regarding health and safety, the adopted rules add a requirement for case managers or service coordinators to review service backup plans annually. The adopted rules also require CDS employers to revise a service backup plan if the case manager or service coordinator determines that the plan is ineffective. To address the assurance regarding qualified providers, the adopted rules clarify an employer's responsibility to document training of employees. The employer is required to send the documentation to the financial management services agency (FMSA).

The adopted rules also delete requirements in Chapter 41 that are addressed in Chapter 49, Contracting for Community Services, as adopted elsewhere in this issue of the Texas Register.

The adopted rules describe DADS already existing service delivery expectations of a CDS employer. Specifically, an employer is required to (1) ensure that services provided are included on the service plan, are budgeted in the employer budget, and are provided only to the individual; and (2) obtain an acknowledgement of nursing requirements from a nurse hired by the employer.

The adopted rules require the CDS employer to enter into an agreement with the FMSA that contains all of the requirements specific to the individual's program regarding service delivery, documentation, and provider qualifications to help ensure that the employer understands and complies with program requirements.

The adopted rules also state that the case manager or service coordinator, instead of the service planning team, must approve a service backup plan. This change is made because the individual or legally authorized representative (LAR), as the employer, develops the plan and in some waiver programs the service planning team consists of only the individual or LAR and the service coordinator.

The adopted rules list, for clarification, the waiver programs and services in which the CDS option is available and provide a list

of the services in each waiver program that an individual may receive through the CDS option. The adopted rules also describe existing policy that prohibits individuals in the Community Living Assistance and Support Services (CLASS) Program, Deaf Blind with Multiple Disabilities (DBMD) Program, and Home and Community- Based Services (HCS) Program from receiving services through the CDS option if the individuals live in certain residential settings.

The adopted rules also update terminology and make minor editorial and organizational changes for clarity and consistency.

Changes were made in §41.108(a)(1)(A) to add "if the individual does not receive in the CLASS Program family support services or continued family services." Changes were made in §45.108(a)(1)(B) to add "if the individual receives in the DBMD Program, licensed assisted living or licensed home health assisted living." Changes were made in §45.108(a)(1)(C) to add "if the individual receives in the HCS Program, residential support, supervised living, or host home/companion care." Changes were made in §41.108(b) to add "Except for an individual who receives any of the services described in subsection (a)(1)(A) - (C) of this section." The agency made these changes to implement already existing requirements in the CLASS Program, DBMD Program, and HCS Program, consistent with the respective waiver applications, that allow an individual in these programs to participate in the CDS option only if the individual is not receiving certain types of residential services. The agency also removed "cognitive rehabilitation therapy" and "employment assistance" from the list of CLASS services in §41.108(b)(1) and re-lettered the CLASS services. This change was made because the effective date of the CLASS waiver renewal application, which allows for the provision of these two new services, has not yet been determined by the Centers for Medicare and Medicaid Services.

Minor editorial changes were made in §41.233(a). The agency made the changes to improve the readability and formatting of the rule and to correct the title of DADS Form 1732.

Changes were made in §41.233(a)(1) to replace "training activities" with "initial and on- going training of a service provider." The agency made these changes to more accurately describe the CDS employer's responsibility to document training of a service provider.

Changes were made in §41.233(a)(2) to replace "on-going management activities" with "the activities regarding on-going management of a service provider" and to add "the Service Provision Requirements Addendum to." The agency made these changes to more accurately describe the CDS employer's responsibility to document management of a service provider and to clarify that the management responsibilities are addressed in the Service Provision Requirements Addendum to DADS Form 1735.

Changes were made in §41.233(b) to replace "mail or fax" with "send" and to replace "or" with "and" between paragraphs (1) and (2). The agency made these changes to clarify that an employer or designated representative (DR) must send a copy of Form 1732 after hiring a service provider and after each annual evaluation and may send the copy electronically.

A change was made in §41.301(b)(2) to delete "to the same individual" and to replace the term "Client" with "Consumer." The agency made these changes to clarify the rule by deleting unnecessary language and to update the name of the Consumer Managed Personal Attendant Services program.

Changes were made in §41.301(c) to reorganize and format the rule to state that an individual receiving FMS services, the individual's LAR, or DR, must not be (1) the individual's FMSA; or (2) a controlling person, as defined in §49.102 of this title, of the individual's FMSA. The agency made these changes to improve the clarity of the rule.

DADS received written comments from one individual representing an FMSA. A summary of the comments and responses follows.

Comment: The commenter cited §41.207 and stated that the rule will require the original forms to stay with the employer and for the FMSA to retain copies. The commenter stated that it is the employer's responsibility to ensure that the FMSA receives a copy of the forms within five calendar days. The commenter asked what happens if the employer fails to give the FMSA a copy within five calendar days, what happens if the paperwork is lost before the FMSA receives a copy, and whether the FMSA may take the paperwork to the office after an orientation, make copies, and mail them back to the employer.

Response: The agency responds that, in accordance with §41.307(d), services provided through the CDS option may not be initiated by the employer until the FMSA receives, from the employer, a completed Form 1735 with required attachments signed and dated by the employer. To make §41.207 consistent with §41.307(d), the agency added a new §41.207(6) to require the employer and the DR to "ensure services are not initiated until after the FMSA receives the completed forms." In response to the question of whether the FMSA may take the completed forms to make copies, if allowed by the individual and the DR, §41.207 does not prohibit the FMSA from taking the completed forms to make copies and returning the originals or copies to the employer and the DR. To allow the employer or DR more flexibility in providing required documentation to the FMSA, the agency made changes in §41.207(5) to state that an employer or DR must "send the original completed forms or a copy of the forms" to the FMSA and made changes to the rule to state that an employer and the DR must "retain the original completed forms or a copy of the forms."

Comment: The commenter, citing §41.233, stated that DADS Form 1732 must also be completed at each annual evaluation and that the employer must provide the FMSA with a copy of the updated form annually within 30 days of the hire date. The commenter also asked if the FMSA needs to do a corrective action plan (CAP) with an employer or DR if the employer or DR does not comply with §41.233 and what happens if the employer or DR refuses to complete the CAP?

Response: The agency agrees that the instructions for DADS Form 1732 require the employer to document an evaluation of the employee's performance at least annually. Therefore, in response to the comment, the agency added new language in §41.233(a)(3) to state that an employer or DR must also use DADS Form 1732 to document "an evaluation of the service provider's performance at least annually after the date of hire." In response to the question about compliance with §41.233 by an employer or DR, the FMSA may require an employer or DR to develop a corrective action plan in accordance with §41.319, Corrective Action Plans, if an employer or DR does not comply with §41.233. In response to the question about the employer or DR refusing to complete the CAP, the FMSA, after providing any training to the employer or DR to correct the non-compliance, may recommend to the case manager or service coordinator ter-

mination of the individual's participation in the CDS option in accordance with §41.407.

SUBCHAPTER A. INTRODUCTION

40 TAC §41.108

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§41.108. Services Available Through the CDS Option.

(a) The CDS option is available in the following programs and services:

(1) Medicaid waiver programs as follows:

(A) the Community Living Assistance and Support Services (CLASS) Program, if the individual does not receive in the CLASS Program:

(i) family support services; or

(ii) continued family services;

(B) the Deaf Blind with Multiple Disabilities (DBMD) Program, if the individual does not receive in the DBMD Program:

(i) licensed assisted living; or

(ii) licensed home health assisted living;

(C) the Home and Community-Based Services (HCS) Program, if the individual does not receive in the HCS Program:

(i) residential support;

(ii) supervised living; or

(iii) host home/companion care;

(D) the Medically Dependent Children (MDCP) Program; and

(E) the Texas Home Living (TxHmL) Program;

(2) primary home care/community attendant services (Medicaid state plan services); and

(3) services under Title XX, Subtitle A of the Social Security Act as follows:

(A) family care; and

(B) consumer managed personal attendant services.

(b) Except for an individual who receives any of the services described in subsection (a)(1)(A) - (C) of this section, for each waiver program listed in subsection (a)(1) of this section, an individual may choose to receive any of the following services through the CDS option:

(1) the CLASS Program:

(A) habilitation;

(B) in-home respite;

(C) nursing;

(D) occupational therapy;

(E) out-of-home respite;

(F) physical therapy;

(G) speech therapy;

(H) supported employment; and

(I) any other service provided through the CDS option as listed on DADS website;

(2) the DBMD Program:

(A) employment assistance;

(B) intervener;

(C) residential habilitation;

(D) respite;

(E) supported employment; and

(F) any other service provided through the CDS option as listed on DADS website;

(3) the HCS Program:

(A) cognitive rehabilitation therapy;

(B) employment assistance;

(C) nursing;

(D) supported employment;

(E) supported home living;

(F) respite; and

(G) any other service provided through the CDS option as listed on DADS website;

(4) the MDCP Program:

(A) employment assistance;

(B) flexible family support services;

(C) respite;

(D) supported employment; and

(E) any other service provided through the CDS option as listed on DADS website; and

(5) the TxHmL Program:

(A) adaptive aids;

(B) audiology services;

(C) behavioral support;

(D) community support;

(E) day habilitation;

(F) dental treatment;

(G) dietary services;

(H) employment assistance;

(I) nursing;

(J) minor home modifications;

(K) occupational therapy;

(L) physical therapy;

(M) respite;

(N) speech/language pathology services;

(O) supported employment; and

(P) any other service provided through the CDS option as listed on DADS website.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. RESPONSIBILITIES OF EMPLOYERS AND DESIGNATED REPRESENTATIVES

40 TAC §41.201, §41.233

The repealed sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §§41.207, 41.217, 41.233, 41.238

The amendments and new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§41.207. Initial Orientation of an Employer.

An employer and the DR must:

(1) complete the initial orientation conducted by the FMSA in the residence of the individual in accordance with §41.307 of this chapter (relating to Initial Orientation of an Employer);

(2) complete:

(A) DADS Form 1736, Documentation of Employer Orientation, upon completion of the orientation; and

(B) if applicable, one of the following:

(i) DADS Form 1733, Employer and Employee Exemption from Nursing License for Certain Services; or

(ii) DADS Form 1585, Statement of Responsibilities for Consumer Directed Services;

(3) enter into an agreement with the FMSA by signing and dating:

(A) DADS Form 1735, Employer and Financial Management Services Agency (FMSA) Agreement; and

(B) the Service Provision Requirements Addendum to DADS Form 1735;

(4) complete DADS Form 1726, Relationship Definitions in Consumer Directed Services;

(5) send the original completed forms or a copy of the forms described in this section to the FMSA within five calendar days after the date of the initial orientation; and

(6) ensure services are not initiated until after the FMSA receives the completed forms; and

(7) retain the original completed forms or a copy of the forms described in paragraphs (2) - (4) of this section.

§41.233. Training and Management of Service Providers.

(a) An employer or DR must use DADS Form 1732, Management and Training of Service Provider, to document:

(1) the activities regarding initial and on-going training of a service provider required by the Service Provision Requirements Addendum to DADS Form 1735, Employer and Financial Management Services Agency (FMSA) Agreement;

(2) the activities regarding on-going management of a service provider required by the Service Provision Requirements Addendum to DADS Form 1735; and

(3) an evaluation of the service provider's performance at least annually after the date of hire.

(b) An employer or DR must send a copy of completed DADS Form 1732 to the FMSA within 30 calendar days after:

(1) hiring a service provider; and

(2) each annual evaluation of the service provider.

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SUBCHAPTER C. ENROLLMENT AND RESPONSIBILITIES OF FINANCIAL MANAGEMENT SERVICES AGENCIES (FMSAS)

40 TAC §41.301, §41.339

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§41.301. Contracting as a Financial Management Services Agency.

(a) An FMSA must:

(1) comply with Chapter 49 of this title (relating to Contracting for Community Services);

(2) have at least one eligible employee or contractor to provide support consultation services as defined in Subchapter F of this chapter (relating to Support Consultation Services and Support Advisor Responsibilities);

(3) operate as a Vendor Fiscal/Employer Agent (VF/EA) in accordance with §3504 of the Internal Revenue Service (IRS) Code; and

(4) participate in all mandatory training provided or authorized by DADS.

(b) An FMSA must not:

(1) use a third party to file and report payroll taxes to the IRS on behalf of a CDS employer;

(2) provide FMS to an individual who is receiving case management services or service coordination from the FMSA or a controlling person, as defined in §49.102 of this title (relating to Definitions) of the FMSA, except in the Consumer Managed Personal Attendant Services program.

(c) An individual receiving FMS, the individual's LAR, or DR, must not be:

(1) the individual's FMSA; or

(2) a controlling person, as defined in §49.102 of this title, of the individual's FMSA.

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SUBCHAPTER D. ENROLLMENT, TRANSFER, SUSPENSION, AND TERMINATION

40 TAC §41.404

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 42. DEAF BLIND WITH MULTIPLE DISABILITIES (DBMD) PROGRAM

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§42.103, 42.104, 42.201, 42.212, 42.214, 42.215, 42.216, 42.217, 42.223, 42.242, 42.301, 42.401, 42.402, 42.403, 42.404, 42.405, 42.406, 42.615, 42.620, 42.625, 42.626, 42.628, 42.630, and 42.631, concerning definitions, description of deaf blind with multiple disabilities (DBMD) waiver program, eligibility criteria, process for enrollment of an individual, development of enrollment individual plan of care (IPC), development of enrollment individual program plan (IPP), DADS review of request for enrollment, consumer directed services (CDS) option, periodic review and update of IPC and IPP, suspension of DBMD program services with advance notice, program providers, protection of individual, staff qualifications, training, service delivery, recordkeeping requirements, quality assurance, specifications for a minor home modification, individual satisfaction with minor home modification, employment services, habilitation, nursing, residential services, and respite; new §§42.407 - 42.409, concerning service backup plans, protective devices, and restraints; and the repeal of §42.407, concerning e-mail notification, in Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program. The amendments to §§42.103, 42.104, 42.212, 42.223, 42.402, 42.625 and new §42.408 and §42.409 are adopted with changes to the proposed text published in the May 16, 2014, issue of the *Texas Register* (39 TexReg 3813). The amendments to §§42.201, 42.214, 42.215, 42.216, 42.217, 42.242, 42.301, 42.401, 42.403, 42.404, 42.405, 42.406, 42.615, 42.620, 42.626, 42.628, 42.630, 42.631; new §42.407 and the repeal of §42.407 are adopted without changes to the proposed text.

The amendments, new sections, and repeal, in part, are adopted to implement the assurance set forth in the DBMD Program waiver application to provide safeguards concerning the use of restrictive interventions. To address the assurance, the adopted rules establish the requirements a program provider must meet if using a protective device or a restraint, and add definitions for terms associated with restrictive interventions. The adopted rules also emphasize the current policy of DADS that a program provider must not use seclusion. The adopted rules add a requirement for an annual nursing assessment by a registered nurse (RN) and require the RN to use a DADS form for the initial and annual nursing assessment of an individual. The adopted rules also prohibit a program provider from terminating or otherwise retaliating against specified persons for filing a complaint, presenting a grievance, or otherwise providing good faith information relating to the program provider's misuse of restraint or use of seclusion.

The adopted rules change the definitions, service provider qualifications, and requirements for providing employment assistance and supported employment, based on a waiver amendment. The changes to the definition of supported employment allow an individual to receive this service and be self-employed or work from home. This change provides a standardized policy across waiver programs and enhances an individual's opportunities to have a desired job or career. The changes to the qualifications for service providers of employment assistance and supported employment help ensure that service providers have sufficient expertise to provide these services. The changes to the requirements for providing these services remove the prohibition of a service provider being an individual's employer or an employee of the individual's employer and describe what each service consists of. The adopted rules include certain requirements the program provider must comply with to receive payment for employment assistance and supported employment, such as not using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training and not providing employment assistance or supported employment to an individual with the individual present at the same time that certain other services are provided.

The adopted rules replace deleted requirements (including those for recordkeeping, complaint processes, and DBMD Program email notifications) with references to requirements that apply to DBMD program providers in new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.*

The adopted rules add a requirement for a program provider to develop a service backup plan for residential habilitation, nursing, and specialized nursing services if identified by the service planning team (SPT) on the IPC and IPP as critical to meeting the individual's health and safety, and to revise the service backup plan if the program provider determines that plan is ineffective. The adopted rules require a case manager, during a quarterly review of an individual whose IPC includes residential habilitation, nursing, or specialized nursing, to consider if an individual without a service backup plan needs such a plan, and to review the effectiveness of a service backup plan of an individual who has a plan. The adopted rules require the case manager to document on the IPP quarterly review form for an individual who has a service backup plan whether the plan was implemented, effective, or revised by the SPT to address any problems or concerns regarding the plan. The adopted rules require a case manager to convene an SPT meeting within five business days after the date of a quarterly review meeting if the case manager determines that an individual may need a service backup plan for residential habilitation, nursing, or specialized nursing or if a service backup plan was ineffective. The adopted rules require the program provider to provide the individual or legally authorized representative (LAR) with a copy of the service backup plan or revised service backup plan.

The adopted rules reorganize and update the requirements for a case manager to develop a revision IPC and a revision IPP; add the Provider Agency Model Service Backup Plan form to the list of forms that may need to be submitted to DADS; specify that DADS, during review of an IPC, may request additional assessments and supporting documentation related to the individual's diagnosis; and give the case manager 10 calendar days after the date of the request to submit the information. The adopted rules delete the requirement for a program provider to give an individual or LAR a copy of the initial, annual, and revised IPCs and IPPs within 10 days after an SPT meeting and replace it with a requirement for a case manager to provide those documents after DADS authorizes services on a revision IPC; and clarifies that it is during the annual SPT meeting that a case manager

must orally explain and provide the written information required during the annual review to the individual or LAR.

The adopted rules update the title and references to Chapter 41, Consumer Directed Services Option. The adopted rules require a program provider to ensure an individual's case manager informs the individual or LAR of the consumer directed services (CDS) option, and of the specific DBMD Program services provided through the CDS option, as specified in Chapter 41.

The adopted rules provide better protection of the health and welfare of individuals receiving licensed assisted living and licensed home health assisted living by clarifying and changing the safety requirements. The adopted rules require installation of a working carbon monoxide detector in each individual's bedroom in a residence in which these residential services are provided. The adopted rules require a program provider of licensed home health assisted living to conduct and document the results of a home inspection to ensure that the residence meets the safety requirements specified in the adopted rules, and to ensure correction of any noncompliance found during the home inspection and document the correction. The adopted rules clarify the requirements for a program provider in licensed home health assisted living to conduct a fire drill with all individuals in the residence at least once every 90 calendar days, to ensure that an individual participates in a fire drill after moving into the residence and that an individual participates in a fire drill if the individual's ability to successfully evacuate the residence may have changed. The adopted rules delete that a program provider for licensed assisted living must comply with applicable provisions in Chapter 92 because the definition for licensed assisted living includes that this service is provided in a residence licensed in accordance with Chapter 92. The adopted rules also delete that a program provider for licensed home health assisted living must comply with applicable provisions in Chapter 97 because the definition for licensed home health assisted living includes that this service is provided by a program provider licensed in accordance with Chapter 97.

The adopted rules address the DBMD Program waiver renewal by requiring an IPP to include documentation that the type, frequency, and amount of each DBMD Program service included in the IPP and the IPC does not replace existing natural supports or non-waiver resources for which the individual may be eligible. The adopted rules also require an IPP to include a description of (1) the needs and preferences identified by the individual, LAR, or both; (2) the services and supports the individual requires to continue living in a community-based setting; (3) the individual's current natural supports and non-waiver services that will be or are available; (4) the outcomes to be achieved through the DBMD Program services and justification for each service included in the IPC; and (5) actions and methods to be used to reach identified service outcomes. The adopted rules require an IPP to include a statement of whether the individual needs a service backup plan for residential habilitation, nursing, or specialized nursing services critical to the individual's health and safety.

The adopted rules also clarify (1) that a program provider of licensed assisted living and licensed home health assisted living may bill for 18 hours but must not bill for 24 hours if an individual is away from the home for 6 or more hours, regardless of where the individual was at the time; (2) the program provider of licensed assisted living or licensed home health assisted living may, at the request of an individual or the individual's LAR, hold an individual's bed during a suspension due to admission to a facility and charge the individual for room and board for each day the program provider holds the bed for up to 180 consecutive calendar days; and (3) that a program provider must provide or ensure the provision of each DBMD Program service and provide the assisted living service as either licensed assisted living or licensed home health assisted living. The adopted rules clarify current training requirements, add training in managing challenging behaviors, reference the training requirements for protective devices and restraints, and delete delegated tasks from the training requirements because that topic is not included in DADS Service Provider Training curriculum.

The adopted rules clarify the documentation requirements for an individual's progress or lack of progress in achieving the outcomes for day or residential habilitation and for residential services. The adopted rules delete the requirement that, if requested by DADS, a program provider must be able to demonstrate the outcomes for day or residential habilitation and for residential services because DADS does not request that information.

The adopted rules clarify that an individual is eligible for DBMD Program services if the individual has an IPC with a cost for DBMD Program services at or below $114,736.07, rather than 200 percent of the estimated annualized per capita cost of providing services in an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). This change is consistent with current policy and the DBMD Program waiver application.

The adopted rules implement DADS current policy that provides an exemption from the recordkeeping requirements in an individual's record for non-delegated tasks that are provided by unlicensed staff and documented on the IPP. The adopted rules update the list of forms that a program provider must submit to DADS at enrollment and at a review of the IPC or IPP.

The adopted rules move the requirement for a program provider to report the death of an individual to DADS in writing within 24 hours after learning of the death to a new section where it applies to all individuals, not just individuals receiving residential services. This change is consistent with current policy and the DBMD Program waiver application.

The adopted rules clarify the terms "business day," "intervener," "IPC," "nursing," and "service provider;" revise the definitions for "CDSA," "CDS option," "competitive employment," "employment assistance," "FMS," "physician," "program provider," and "supported employment;" standardize the use of "ALF" for an assisted living facility, "LVN" for licensed vocational nurse, "RN" for registered nurse, and "TAS" for transition assistance services; add definitions for "behavioral emergency," "calendar day," "contract," "FMSA," and "seclusion;" and delete definitions for "ICF/MR," "ICF/MR Program," "integrated employment," "mental retardation," and "provider agreement." The adopted rules replace outdated terminology with person first respectful language and correct cross-references in the chapter.

A change was made in proposed §42.103(9) to replace "maladaptive" with "challenging." The agency made this change to use the terminology currently used for these behaviors.

Changes were made to amend in §42.103(18), rather than delete as proposed in §42.103(16), the definition for "competitive employment" to define it as "employment that pays an individual at least minimum wage if the individual is not self-employed." The agency made these changes so that the definitions and rules on

"employment assistance" and "supported employment" conform to the DBMD waiver application.

Changes were made in proposed §42.103(18), now (19), to state that the term "contract" includes a provisional contract that DADS enters into in accordance with 40 TAC §49.208, Provisional Contract Application Approval, that has a stated expiration date or a standard contract that DADS enters into in accordance with 40 TAC §49.209, Standard Contract, that does not have a stated expiration date. The agency made these changes to provide program providers with information and references to new Chapter 49 on the two types of contracts with DADS.

Changes were made in proposed §42.103(29), now (30), in the definition for "employment assistance" and in proposed §42.103(85), now (86), in the definition for "supported employment" to change "paid employment" to "competitive employment." The agency made these change so that the definitions conform to the DBMD waiver application.

Changes were made in proposed §42.103(63), now (64), to add that a physical restraint is "used to control an individual's behavior." The agency made this change to correct the omission of this language when the definition was proposed.

A minor editorial change was made in proposed §42.103(80) to replace "Texas Health and Safety Code" with "THSC." The agency made this change because of the use of "THSC" in §42.103(7).

A minor editorial change was made in proposed §42.104(b) to delete "the Texas Health and Human Services Commission (HHSC)" and replace it with "HHSC." The agency made this change because in §42.103, HHSC is defined as the Texas Health and Human Services Commission.

A minor editorial change was made in proposed §42.104(c) to delete "the Centers for Medicare and Medicaid Services." The agency made this change because in §42.103, CMS is defined as Centers for Medicare and Medicaid Services.

A minor editorial change was made in proposed §42.212(c)(1)(L) to change a period to a semicolon. The agency made this change to correct the punctuation needed for the formatting of the subsection.

A minor editorial change was made in proposed §42.212(e)(1) to delete "and" at the end of the paragraph. The agency made the change to correct the formatting of the rule.

A minor editorial change was made in proposed §42.223(a)(4)(A) to delete "and" at the end of the subparagraph. The agency made the change to correct the formatting of the rule.

A minor editorial change was made in proposed §42.223(a)(5)(B)(iii) to add "and" at the end of the clause. The agency made the change to correct the formatting of the rule.

A minor editorial change was made in proposed §42.223(b)(3)(G) to delete "and" at the end of the subparagraph. The agency made the change to correct the formatting of the rule.

Changes were made in proposed §42.402 by adding a new subsection (k), which provides that a service provider must not be the parent of an individual if the individual is under 18 years of age or the spouse of an individual; must not, if an individual is an adult, be a relative or guardian of the individual to whom the service provider is providing assisted living, case management, behavioral support, dental treatment, dietary services, FMS, occupational therapy, orientation and mobility, physical therapy, speech, language, audiology therapy, support consultation, or TAS; and may, if an individual is an adult, be a relative or guardian of the individual to whom the service provider is providing adaptive aids, chore services, day habilitation, employment assistance, intervener, minor home modifications, nursing, residential habilitation, respite, or supported employment. The agency made these changes to ensure program providers comply with the waiver application that specifies whether DBMD services may be provided by a legally authorized representative (parent of a child or spouse), relative, or guardian. A change was made to proposed §42.402(k) to reformat it as §42.402(l) because of the addition of a new subsection (k).

A minor editorial change was made in proposed §42.404(i)(1) to correct a grammatical error.

Minor changes were made in proposed §42.404(j)(1)(B) and (j)(2) to correct the terminology used in the chapter for a service planning team.

Changes were made in proposed §42.408(c)(6) to delete "that is signed by a physician for the use of a protective device" and replace it with "signed by a physician" in a different part of this rule. The agency made these changes to improve the readability of the rule. The agency made grammatical changes in proposed §42.408(c)(6)(D) and (E), in proposed §42.408(c)(7) - (9), and in proposed §42.408(d)(2)(A) and (C), now (B). The agency made these changes to improve the readability of these adopted rules. Changes were made in proposed §42.408(d)(2)(A) - (C) to delete (d)(2)(B) and replace it by adding "and documents in the individual's case record" in proposed §42.408(d)(2)(A). Because of the deletion of proposed §42.408(d)(2)(B), changes were made to reformat (d)(2)(C) as (d)(2)(B). Changes were made to reformat proposed §42.408(d)(2)(D) as (d)(3). Changes were made in reformatted §42.408(d)(3) to delete "if necessary based on the evaluation and review described in subparagraphs (A) and (C) of this paragraph" and replace it with "when the individual's service planning team and physician determine that a protective device is not effective or needed" and to make necessary grammatical changes. The agency made these changes to improve the readability of the rule and to include the physician in determining that a protective device is not effective or needed.

Changes were made in proposed §42.409(d)(1) to change and reformat in §42.409(d)(1)(A) - (C) the list of reasons restraints must not be used. The changes prohibit restraints from being used in §42.409(d)(1)(A) "for disciplinary purposes, retaliation, coercion, or retribution; in §42.409(d)(1)(B) "for the convenience of a service provider or other persons;" and in §42.409(d)(1)(C) "as a substitute for an effective, less restrictive method." The changes delete "for the purpose of behavioral management." The agency decided this language is confusing because the definitions in §42.103 for mechanical, physical, and psychoactive medication restraints include they are used to "control an individual's behavior." The agency changed "discipline" to "for disciplinary purposes" for grammatical reasons. The agency replaced "convenience" with "for the convenience of a service provider or other persons" to clarify the meaning. The agency added "coercion," "retaliation," and "as a substitute for an effective, less restrictive method" so that the rule also prohibits the use of restraints for these reasons.

A minor editorial change was made in proposed §42.625(c) to delete an unnecessary "the." A change was made in proposed §42.625(c)(1)(D) to change "paid" employment to "competi-

tive" employment. The agency made this change to the rule to conform to the DBMD waiver application. Minor editorial changes were made in proposed §42.625(c)(4) and (e)(4)(B) to delete unnecessary commas. Changes were made in proposed §42.625(d) to add "ensure and maintain documentation in the individual's record" to replace the deletion of "determine" and "maintain documentation of the determination in the individual's record." The agency made these changes because a program provider does not determine if supported employment is available under a program funded by the Individuals with Disabilities Education Act; and because the changes are consistent with the amendments proposed in §42.625(b) for employment assistance. A change was made in proposed §42.625(e)(1)(A) to change "disability" to "assessed needs." The agency made this change to conform to the terms used in the DBMD waiver application.

DADS received written comments from the Texas Association for Home Care and Hospice. A summary of the comments and responses follows.

Comment: The commenter stated that as a safety precaution necessary for individuals, restrictive intervention definitions and/or protective device definitions must not be classified as restraints or restrictive devices. The commenter stated that protective devices can be safety devices that are physician ordered and prescribed, custom made and appropriate for safety and are not a restraint or a restrictive device. The commenter provided language to add in §42.408(b) for the rule to state that a program provider must not use a protective device to modify or control an individual's behavior, for disciplinary purposes, for convenience, or as a substitute for an effective, less restrictive method "outside of the prescribed protective device's intentional use."

Response: A protective device is not defined as a restraint. A protective device is defined as a type of restrictive intervention that can only be used as described in §42.408 and, therefore, the agency did not make the suggested change to §42.408(b).

Comment: The commenter stated concern that requiring a program provider to attempt a less restrictive method before using a protective device will encourage the use of unsafe methods. The commenter recommended the deletion of §42.408(c)(1) and (2) for this reason.

Response: The agency agrees that attempting a less restrictive method before using a protective device may not be possible for every individual. However, a less restrictive method should be considered, and attempted, if it would accomplish the purpose of the protective device. In response to this comment, the agency made changes in §42.408(c)(1) - (3) to require a program provider to (1) have an RN conduct an assessment of the individual's needs; (2) consider less restrictive methods that, if effective, would accomplish the purpose of the protective device; and (3) document in the individual's case record the reasons why less restrictive methods would not be effective.

SUBCHAPTER A. INTRODUCTION

40 TAC §42.103, §42.104

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§42.103. Definitions.

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

(1) Actively involved--Significant, ongoing, and supportive involvement with an individual by a person, as determined by the individual's service planning team, based on the person's:

(A) interactions with the individual;

(B) availability to the individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the individual's needs, preferences, values, and beliefs.

(2) Activities of daily living (ADL)--Activities that are essential to daily self care, including bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer and ambulation, positioning, and assistance with self-administered medications.

(3) Adaptive aid--An item or service (including a medically necessary supply or device) that enables an individual to retain or increase the ability to:

(A) perform activities of daily living; or

(B) perceive, control, or communicate with the environment in which the individual lives.

(4) Adaptive behavior--The effectiveness with or degree to which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group as assessed by a standardized measure.

(5) Adaptive behavior level--The categorization of an individual's functioning level based on a standardized measure of adaptive behavior. Four levels are used ranging from mild limitations in adaptive skills (I) through profound limitations in adaptive skills (IV).

(6) Adaptive behavior screening assessment--A standardized assessment used to determine an individual's adaptive behavior level, and conducted using one of the following assessment instruments:

(A) American Association of Intellectual and Developmental Disabilities (AAIDD) Adaptive Behavior Scales (ABS);

(B) Inventory for Client and Agency Planning (ICAP);

(C) Scales of Independent Behavior--Revised (SIB-R); or

(D) Vineland Adaptive Behavior Scales, Second Edition (Vineland-II).

(7) ALF--Assisted living facility. An entity required to be licensed under the Texas Health and Safety Code, (THSC), Chapter 247, Assisted Living Facilities.

(8) Behavioral emergency--A situation in which an individual is acting in an aggressive, destructive, violent, or self-injurious manner that poses a risk of death or serious bodily harm to the individual or others.

(9) Behavioral support--Formerly referred to as "behavior communication," a service that provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify challenging or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life, with a particular emphasis on communication as it affects behavior.

(10) Business day-- Any day except a Saturday, a Sunday, or a national or state holiday listed in Texas Government Code §662.003(a) or (b).

(11) Calendar day--Any day, including weekends and holidays.

(12) Case management--Services that assist an individual to gain access to needed waiver and other state plan services, as well as needed medical, social, education, and other services, regardless of the funding source for the services.

(13) Case manager--A service provider who is responsible for the overall coordination and monitoring of DBMD Program services provided to an individual.

(14) CDS option--Consumer directed services option. A service delivery option as defined in §41.103 of this title (relating to Definitions).

(15) CDSA--FMSA.

(16) Chore services--Services needed to maintain a clean, sanitary, and safe environment in an individual's home.

(17) CMS--The Centers for Medicare and Medicaid Services.

(18) Competitive employment--Employment that pays an individual at least minimum wage if the individual is not self-employed.

(19) Contract--A written agreement between DADS and a program provider for the program provider to provide DBMD Program services. A contract is a provisional contract that DADS enters into in accordance with §49.208 of this chapter (relating to Provisional Contract Application Approval) that has a stated expiration date or a standard contract that DADS enters into in accordance with §49.209 of this chapter (relating to Standard Contract) that does not have a stated expiration date.

(20) DADS--The Department of Aging and Disability Services.

(21) DAHS--Day Activity and Health Services. Day activity and health services as defined in §98.2 of this title (relating to Definitions).

(22) DBMD Program--The Deaf Blind with Multiple Disabilities Waiver Program.

(23) DBMD Program specialist--Employee in DADS' state office who is the primary contact for the DBMD Program.

(24) Deafblindness--A chronic condition in which a person:

(A) has deafness, which is a hearing impairment severe enough that most speech cannot be understood with amplification; and

(B) has legal blindness, which results from a central visual acuity of 20/200 or less in the person's better eye, with correction, or a visual field of 20 degrees or less.

(25) Denial--A DADS' action that disallows:

(A) an individual's request for enrollment in the DBMD Program;

(B) a service requested on an IPC that was not authorized on the prior IPC; or

(C) a portion of the amount or level of a service requested on an IPC that was not authorized on the prior IPC.

(26) Dental treatment--A service that provides the following services, as described in Appendix C of the DBMD Program waiver application (found on the DBMD Program page of DADS website at www.dads.state.tx.us):

(A) therapeutic, orthodontic, routine preventive, and emergency treatment; and

(B) sedation.

(27) Developmental disability--As defined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, Section 102(8), a severe, chronic disability of an individual five years of age or older that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the individual attains 22 years of age;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;

(ii) receptive and expressive language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(vii) economic self-sufficiency.

(28) DFPS--Department of Family and Protective Services.

(29) Dietary services--A therapy service that:

(A) assists an individual to meet basic or special therapeutic nutritional needs through the development of individual meal plans; and

(B) is provided by a person licensed in accordance with Texas Occupations Code, Chapter 701, Dieticians.

(30) Employment assistance--Assistance provided to an individual to help the individual locate competitive employment in the community.

(31) FMS--Financial management services. Services, as defined in §41.103 of this title provided to an individual who chooses to participate in the CDS option.

(32) FMSA--Financial management services agency. An entity, as defined in §41.103 of this title, that provides FMS to an individual participating in the CDS option.

(33) Functions as a person with deafblindness--Situation in which a person is determined:

(A) to have a progressive medical condition, manifested before 22 years of age, that will result in the person having deafblindness; or

(B) before attaining 22 years of age, to have limited hearing or vision due to protracted inadequate use of either or both of these senses.

(34) Habilitation--Services that assist an individual in acquiring, retaining, and improving socialization and adaptive skills related to activities of daily living to enable the individual to live successfully in the community and participate in home and community life, including day habilitation and residential habilitation.

(35) HCSSA (Home and community support services agency) --An entity required to be licensed under THSC, Chapter 142, Home and Community Support Services.

(36) HHSC--Texas Health and Human Services Commission.

(37) ICF/IID--A facility in which ICF/IID Program services are provided.

(38) ICF/IID Program--The Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program that provides Medicaid-funded residential services to individuals with an intellectual disability or related conditions.

(39) ID/RC Assessment (Intellectual Disability/Related Condition Assessment)--An assessment conducted to determine if an individual meets the diagnostic eligibility criteria for the DBMD Program.

(40) Impairment to independent functioning--An adaptive behavior level of II, III, or IV.

(41) Individual--A person seeking to enroll or who is enrolled in the DBMD Program.

(42) Institutional services--Services provided in an ICF/IID or a nursing facility.

(43) Intellectual disability--Significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period.

(44) Intervener--A service provider with specialized training and skills in deafblindness who, working with one individual at a time, serves as a facilitator to involve an individual in home and community services and activities, and who is classified as an "Intervener", "Intervener I", "Intervener II", or "Intervener III" in accordance with Texas Government Code, §531.0973.

(45) IPC--Individual Plan of Care. A DADS form that documents the plan developed by an individual's service planning team using person-directed planning that describes the type, amount, and estimated cost of each DBMD Program service to be provided to an individual.

(46) IPP--Individual Program Plan. A written plan completed by an individual's case manager that describes goals and objectives for each DBMD Program service included on the individual's IPC.

(47) IPC period--The effective period of an IPC as follows:

(A) for an enrollment IPC, the period of time from the effective date of service approved by DADS until the first calendar day of the same month of the effective date of service in the following year; and

(B) for a renewal IPC, a 12-month period of time starting on the effective date of a renewal IPC.

(48) LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(49) Licensed assisted living--A service provided in a residence licensed in accordance with Chapter 92 of this title (relating to Licensing Standards for Assisted Living Facilities) for four to six individuals.

(50) Licensed home health assisted living--A service provided by a program provider licensed in accordance with Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies) in a residence for no more than three individuals, at least one of whom owns or leases the residence.

(51) LVN--Licensed vocational nurse. A person licensed to provide vocational nursing in accordance with Texas Occupations Code, Chapter 301, Nurses.

(52) Mechanical restraint--A mechanical device, material, or equipment used to control an individual's behavior by restricting the ability of the individual to freely move part or all of the individual's body. The term does not include a protective device.

(53) Medicaid--A program funded jointly by the states and the federal government that provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance.

(54) Medicaid waiver program--A service delivery model authorized under §1915(c) of the Social Security Act in which certain Medicaid statutory provisions are waived by CMS.

(55) Minor home modifications--Physical adaptation to an individual's residence necessary to address the individual's specific needs and enable the individual to function with greater independence or control the residence's environment.

(56) MR/RC Assessment (Mental Retardation/Related Condition Assessment)--ID/RC Assessment.

(57) Natural supports--Assistance to help sustain an individual's living in the community from persons, including family members and friends, that occurs naturally within the individual's environment.

(58) Nursing--Treatments and health care procedures provided by an RN or LVN that are:

(A) ordered by a physician; and

(B) provided in compliance with:

(i) Texas Occupations Code, Chapter 301, Nurses; and

(ii) rules at Texas Board of Nursing at Texas Administrative Code (TAC), Title 22, Part 11, Texas Board of Nursing.

(59) Occupational therapy--Services that:

(A) address physical, cognitive, psychosocial, sensory, and other aspects of performance to support an individual's engagement

in everyday life activities that affect health, wellbeing, and quality of life; and

(B) are provided by a person licensed in accordance with Texas Occupations Code, Chapter 454, Occupational Therapists.

(60) Orientation and mobility--Service that assists an individual to acquire independent travel skills that enable the individual to negotiate safely and efficiently between locations at home, school, work, and in the community.

(61) Person-directed planning--A process that empowers the individual (and the LAR on the individual's behalf) to direct the development of a plan for supports and services that meet the individual's outcomes. The process:

(A) identifies existing supports and services necessary to achieve the individual's outcomes;

(B) identifies natural supports available to the individual and negotiates needed services and supports;

(C) occurs with the support of a group of people chosen by the individual (and the LAR on the individual's behalf); and

(D) accommodates the individual's style of interaction and preferences regarding time and setting.

(62) Personal funds--The funds that belong to an individual, including earned income, social security benefits, gifts, and inheritances.

(63) Personal leave day--A continuous 24-hour period, measured from midnight to midnight, when an individual who resides in a residence in which licensed assisted living or licensed home health assisted living is provided is absent from the residence for personal reasons.

(64) Physical restraint--Any manual method used to control an individual's behavior, except for physical guidance or prompting of brief duration that an individual does not resist, that restricts:

(A) the free movement or normal functioning of all or a part of the individual's body; or

(B) normal access by an individual to a portion of the individual's body.

(65) Physical therapy--Services that:

(A) prevent, identify, correct, or alleviate acute or prolonged movement dysfunction or pain of anatomic or physiologic origin; and

(B) are provided by a person licensed in accordance with Texas Occupations Code, Chapter 453, Physical Therapists.

(66) Physician--As defined in §97.2 of this title (relating to Definitions), a person who is:

(A) licensed in Texas to practice medicine or osteopathy in accordance with Texas Occupations Code, Chapter 155;

(B) licensed in Arkansas, Louisiana, New Mexico, or Oklahoma to practice medicine, who is the treating physician of a client and orders home health or hospice services for the client, in accordance with the Texas Occupations Code, §151.056(b)(4); or

(C) a commissioned or contract physician or surgeon who serves in the United States uniformed services or Public Health Service if the person is not engaged in private practice, in accordance with the Texas Occupations Code, §151.052(a)(8).

(67) Program provider--An entity that provides DBMD Program services under a contract.

(68) Protective device--An item or device, such as a safety vest, lap belt, bed rail, safety padding, adaptation to furniture, or helmet, if:

(A) used only:

(i) to protect an individual from injury; or

(ii) for body positioning of the individual to ensure health and safety; and

(B) not used to modify or control behavior.

(69) Psychoactive medication restraint--A medication used to control an individual's behavior or to restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychological condition.

(70) Reduction--A DADS action taken as a result of a review of a revision or renewal IPC that decreases the amount or level of a service authorized by DADS on the prior IPC.

(71) Related condition--As defined in the Code of Federal Regulations (CFR), Title 42, §435.1010, a severe and chronic disability that:

(A) is attributed to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability, and requires treatment or services similar to those required for individuals with an intellectual disability;

(B) is manifested before the individual reaches 22 years of age;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in at least three of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

(72) Request date--The date an individual or LAR requests the individual's name be added to the DBMD Program interest list.

(73) Respite--Services provided on a short-term basis to an individual because of the absence or need for relief of an individual's unpaid caregiver.

(74) Restraint--Any of the following:

(A) a physical restraint;

(B) a mechanical restraint; or

(C) a psychoactive medication restraint.

(75) Restrictive intervention--An action or procedure that limits an individual's movement, access to other individuals, locations

or activities, or restricts an individual's rights, including a restraint, a protective device, and seclusion.

(76) RN--Registered nurse. A person licensed to provide professional nursing in accordance with Texas Occupations Code, Chapter 301, Nurses.

(77) Seclusion--A restrictive intervention that is the involuntary separation of an individual away from other individuals in an area that the individual is prevented from leaving.

(78) Service planning team--A team comprising persons convened and facilitated by a DBMD Program case manager for the purpose of developing, reviewing, and revising an individual's IPC. The team includes:

(A) the individual;

(B) if applicable, the individual's LAR or an actively involved person;

(C) other persons whose inclusion is requested by the individual, LAR, or actively involved person;

(D) the program director or a RN designated by the program provider; and

(E) other persons selected by the program provider who are:

(i) professionally qualified by certification or licensure and have special training and experience in the diagnosis and habilitation of persons with the individual's related condition; or

(ii) directly involved in the delivery of services and supports to the individual.

(79) Service provider--A person who provides a DBMD Program service directly to an individual and who is an employee or contractor of:

(A) the program provider; or

(B) the individual or LAR, if the individual has chosen the CDS option.

(80) Significantly subaverage general intellectual functioning--Consistent with THSC, §591.003, measured intelligence on standardized general intelligence tests of two or more standard deviations (not including standard error of measurement adjustments) below the age- group mean for the tests used.

(81) Speech, language, audiology therapy--Services that:

(A) address the development and disorders of communication, including speech, voice, language, oral pharyngeal function, or cognitive processes; and

(B) are provided by a person licensed in accordance with Texas Occupations Code, Chapter 401, Speech-Language Pathologists and Audiologists.

(82) Specialized nursing--Nursing provided to an individual who has a tracheostomy or is dependent on a ventilator.

(83) SSA--Social Security Administration.

(84) SSI--Supplemental Security Income.

(85) Support consultation--A service, as defined in §41.103 of this title, that may be chosen by an individual who chooses to participate in the CDS option.

(86) Supported employment--Assistance provided, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed.

(87) TAC--Texas Administrative Code.

(88) TAS--Transition Assistance Services. Services provided to a Medicaid-eligible person receiving institutional services in Texas to assist with setting up a household when transitioning from institutional services into the DBMD Program.

(89) TMHP--Texas Medicaid & Healthcare Partnership. The Texas Medicaid program claims administrator.

(90) Transfer--The movement of an individual from a DBMD Program provider or a FMSA to a different DBMD Program provider or FMSA.

(91) Trust fund account--An account at a financial institution that contains an individual's personal funds and is under the program provider's control.

§42.104. Description of Deaf Blind with Multiple Disabilities (DBMD) Waiver Program.

(a) The Deaf Blind with Multiple Disabilities (DBMD) Program is a Medicaid waiver program. It provides community-based services and supports to an eligible individual as an alternative to the ICF/IID Program.

(b) DADS operates the DBMD Program under the authority of HHSC.

(c) DADS limits the enrollment in the DBMD Program to the number of individuals approved by CMS and funded by the State of Texas.

(d) The DBMD Program offers the following services approved by CMS:

(1) adaptive aids;

(2) assisted living:

(A) licensed assisted living; and

(B) licensed home health assisted living;

(3) behavioral support;

(4) case management;

(5) chore services;

(6) day habilitation;

(7) dental treatment;

(8) dietary services;

(9) employment assistance;

(10) FMS, if the individual is participating in the CDS option;

(11) intervener;

(12) minor home modifications;

(13) nursing;

(14) occupational therapy;

(15) orientation and mobility;

(16) physical therapy;

(17) residential habilitation;

(18) respite;

(19) speech, language, audiology therapy;

(20) support consultation, if the individual is participating in the CDS option;

(21) supported employment; and

(22) TAS.

(e) A program provider with a contract enrollment date on or after September 1, 2009, must serve all counties within a DADS region.

(f) A program provider with a contract enrollment date before September 1, 2009, may continue to serve only the counties specified in its contract. If such a program provider chooses to provide services in additional counties, the program provider does not have to serve all the counties within the DADS region.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW

DIVISION 1. ELIGIBILITY

40 TAC §42.201

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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DIVISION 2. ENROLLMENT PROCESS

40 TAC §§42.212, 42.214 - 42.217

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§42.212. Process for Enrollment of an Individual.

(a) A program provider, upon notification by DADS that an individual designated the program provider on a completed Documentation of Provider Choice form, must assign a case manager to the individual.

(b) The program provider must ensure that the assigned case manager contacts the individual or LAR within five business days after the program provider receives the DADS notification. During the initial contact, the case manager must:

(1) verify that the individual resides in a county for which the program provider has a contract;

(2) determine if the individual is currently enrolled in Medicaid;

(3) determine if the individual is currently enrolled in a Medicaid waiver program other than the DBMD Program, or another DADS-operated program described in the DBMD Program Manual other than DAHS; and

(4) arrange with the individual and LAR for an initial face-to-face, in-home visit to occur as soon as possible but no later than 30 calendar days after the program provider receives the DADS notification.

(c) During the initial face-to-face, in-home visit, the case manager must:

(1) explain to the individual or LAR:

(A) the DBMD Program services and supports;

(B) the application and enrollment process described in this chapter;

(C) the individual's rights and responsibilities, including the right to request a Medicaid Fair Hearing as described in §42.251 of this chapter (relating to Individual's Right to a Fair Hearing);

(D) the mandatory participation requirements as described in §42.252 of this chapter (relating to Mandatory Participation Requirements of an Individual);

(E) if the individual is enrolled in a Medicaid waiver program other than the DBMD Program or another DADS-operated program described in the DBMD Program Manual other than DAHS, that the individual or LAR must choose between the DBMD Program and the other program;

(F) the procedures for an individual or LAR to file a complaint regarding a DBMD Program provider;

(G) the CDS option as described in §42.217 of this chapter (relating to Consumer Directed Services (CDS) Option);

(H) if the individual is Medicaid-eligible and receiving institutional services, TAS as described in Chapter 62 of this title (relating to Contracting to Provide Transition Assistance Services);

(I) the voter registration process, if the individual is 18 years of age or older; and

(J) how to contact the program provider, the case manager, and the RN;

(K) that the individual or LAR may request the provision of residential habilitation, case management, nursing, out-of-home respite in a camp, adaptive aids, or intervener services while the individual is temporarily staying at a location outside the contracted service delivery area but within the state of Texas during a period of no more than 60 consecutive days; and

(L) orally and in writing, procedures for reporting an allegation of abuse, neglect, and exploitation;

(2) if possible:

(A) complete an adaptive behavior screening assessment or ensure an appropriate professional completes the adaptive behavior screening assessment; and

(B) ensure an RN completes a nursing assessment using the DADS DBMD Nursing Assessment form;

(3) complete the ID/RC Assessment form; and

(4) obtain the signature of the individual or LAR on:

(A) the Verification of Freedom of Choice form designating the individual's choice of DBMD Program services over enrollment in the ICF/IID Program; and

(B) DADS Release of Information Consent form or a similar form developed by the program provider.

(d) If one or both of the assessments described in subsection (c)(2) of this section is not completed during the initial face-to-face, in-home visit, the case manager must ensure that the assessment is completed within 10 business days after the date of the initial face-to-face, in-home visit.

(e) If the individual is Medicaid eligible, is receiving institutional services, and anticipates needing TAS, the case manager must:

(1) provide the individual or LAR with a list of TAS provider agencies;

(2) using the TAS Assessment and Authorization form, assist the individual or LAR to:

(A) identify the individual's essential needs for TAS; and

(B) provide estimated amounts for TAS items and services; and

(3) retain the completed TAS Assessment and Authorization form in the individual's record for inclusion on the enrollment IPC as described §42.214 of this chapter (relating to Development of Enrollment Individual Plan of Care (IPC)).

(f) The program provider must:

(1) gather and maintain the information necessary to process the individual's request for enrollment in the DBMD Program using forms prescribed by DADS in the DBMD Program Manual;

(2) assist the individual who does not have Medicaid financial eligibility or the individual's LAR to:

(A) complete an application for Medicaid financial eligibility; and

(B) submit the completed application to HHSC within 30 calendar days after the case manager's initial face-to-face, in-home visit;

(3) document in the individual's record any problems or barriers the individual or LAR encounters that may inhibit progress towards completing:

(A) the application for Medicaid financial eligibility; and

(B) enrollment in DBMD Program services; and

(4) assist the individual or LAR to overcome problems or barriers documented as described in paragraph (3) of this subsection.

(g) If an individual or LAR does not submit a completed Medicaid application to HHSC as described in subsection (f)(2)(B) of this section as a result of problems or barriers documented in subsection (f)(3) of this section but is making progress in collecting the documentation necessary for an application, the program provider may grant one or more 30 calendar day extensions.

(1) The program provider must ensure the case manager documents the rationale for an extension in the individual's record.

(2) The program provider must not issue an extension that will cause the period of Medicaid application preparation to exceed 12 months after the date of the case manager's initial face-to-face, in-home visit.

(3) The program provider must notify DADS DBMD program specialist in writing if the individual or LAR:

(A) fails to submit a completed Medicaid application to HHSC within 12 months after the date of the case manager's initial face-to-face, in-home visit; or

(B) does not cooperate with the case manager in completing the enrollment process described in this section.

(h) A program provider must ensure:

(1) the related conditions documented on the ID/RC Assessment form for the individual are on DADS Approved Diagnostic Codes for Persons with Related Conditions list contained in the DBMD Program Manual;

(2) the ID/RC Assessment is submitted to a physician for review; and

(3) the DADS Prior Authorization for Dental Services form is sent to a dentist as described in the DBMD Program Manual if the

individual or LAR requests dental services other than an initial dental exam.

(i) After receiving the signed and dated ID/RC Assessment from the physician establishing that the individual meets the eligibility criteria described in §42.201(3) and (4) of this chapter (relating to Eligibility Criteria), the case manager must:

(1) convene a service planning team meeting within 10 business days after receipt of the signed and dated ID/RC Assessment; and

(2) if a DADS Prior Authorization for Dental Services form was submitted to a dentist as described in subsection (h)(3) of this section, ensure that the signed and completed form is available for the service planning team to review.

(j) During the service planning team meeting, the case manager must ensure:

(1) if the individual or LAR is requesting dental services other than an initial dental exam, the DADS Prior Authorization for Dental Services form has been signed by the dentist as described in §42.624(b) of this chapter (relating to Dental Treatment);

(2) an enrollment IPC is developed as described in §42.214 of this chapter; and

(3) if the enrollment IPC includes residential habilitation, nursing, or specialized nursing:

(A) the service planning team determines whether the individual requires a service backup plan in accordance with §42.407 of this chapter (relating to Service Backup Plans); and

(B) that a service backup plan is developed if needed.

(k) Within ten business days after the service planning team meeting, the case manager must:

(1) complete an enrollment Individual Program Plan (IPP) as described in §42.215 of this chapter (relating to Development of Enrollment Individual Program Plan (IPP));

(2) submit a request for enrollment to DADS for review as described in §42.216 of this chapter (relating to DADS Review of Request for Enrollment) that includes the following:

(A) a copy of the completed enrollment IPC;

(B) a copy of the ID/RC Assessment form signed by a physician;

(C) a copy of the completed enrollment IPP;

(D) a copy of the adaptive behavior screening assessment;

(E) a copy of the Related Conditions Eligibility Screening Instrument form;

(F) a copy of the DBMD Summary of Services Delivered form (for pre-assessment services) with supporting documentation;

(G) a copy of the Verification of Freedom of Choice, Waiver Program form;

(H) a copy of the Non-Waiver Services form;

(I) a copy of the Documentation of Provider Choice form;

(J) a copy of the DADS DBMD Nursing Assessment form; and

(K) if applicable:

(i) Prior Authorization for Dental Services form;

(ii) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(iii) Provider Agency Model Service Backup Plan form;

(iv) Specialized Nursing Certification form;

(v) copies of letters of denial from non-waiver resources; and

(vi) TAS Assessment and Authorization; and

(3) keep the original ID/RC Assessment, signed by a physician, in the individual's record.

(l) Within five business days after receiving a written notice from DADS approving or denying the individual's request for enrollment, the program provider must notify the individual or LAR of DADS decision. If DADS:

(1) approves the request for enrollment, the program provider must initiate DBMD Program services as described on the IPC; or

(2) denies the request for enrollment, the program provider must send the individual or LAR a copy of DADS written notice of denial.

(m) The program provider must not provide DBMD Program services to an individual until notified by DADS that the individual's request for enrollment is approved. If a program provider provides DBMD Program services to an individual before the effective date of service approved by DADS, DADS does not reimburse the program provider for those services.

(n) Within ten business days after receiving a written notice from DADS approving the individual's request for enrollment, the program provider must provide to the individual or LAR a copy of the approved enrollment IPC and IPP, and if a service backup plan is needed, a copy of the service backup plan.

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DIVISION 3. REVIEW

40 TAC §42.223

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall

study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§42.223. Periodic Review and Update of IPC and IPP.

(a) Case manager's quarterly review.

(1) At least every 90 calendar days after the effective date of service of an individual's IPC as determined in accordance with §42.216(i) of this subchapter (relating to DADS Review of Request for Enrollment), the case manager must meet face-to-face with the individual or LAR at a time and place acceptable to the individual or LAR to:

(A) review whether the DBMD Program services are being provided as outlined in the IPC and IPP;

(B) review the individual's progress toward achieving the goals and objectives described in the IPP for each DBMD Program service;

(C) determine if the services are meeting the individual's needs;

(D) determine if the individual's needs have changed;

(E) review assessments, evaluations, and progress notes prepared by service providers since the previous quarterly review;

(F) if the individual's IPC includes residential habilitation, nursing, or specialized nursing, and none of these services are identified as critical to meeting the individual's health and safety, discuss with the individual or LAR whether any of these services may now be critical to the individual's health and safety and needs a service backup plan; and

(G) if a service backup plan for residential habilitation, nursing, or specialized nursing services has been implemented, discuss the implementation of the service backup plan with the individual or LAR to determine if the plan was effective.

(2) The case manager must:

(A) document the results of the quarterly review in the individual's record using the IPP quarterly review form;

(B) document on the IPP quarterly review form for an individual who has a service backup plan if the service backup plan was:

(i) implemented;

(ii) effective; and

(iii) revised by the service planning team to address any problems or concerns regarding implementation of the service backup plan; and

(C) provide a copy of the completed IPP quarterly review form to the individual or LAR within 10 business days after the date of the quarterly review.

(3) The case manager must convene a service planning team meeting within five business days after the date of the quarterly review meeting if the case manager:

(A) identifies needed changes in the individual's services; or

(B) determines that a residential habilitation, nursing, or specialized nursing service may now be critical to the individual's health and safety, as described in paragraph (1)(F) of this subsection, or that the service backup plan was ineffective, as described in paragraph (1)(G) of this subsection.

(4) During a service planning team meeting described in paragraph (3) of this subsection, the case manager must:

(A) develop a revision IPC that meets the requirements described in §42.214(d)(1) - (6) of this subchapter (relating to Development of Enrollment Individual Plan of Care (IPC));

(B) develop a revision IPP that meets the requirements described in §42.215(2)(A) - (D) and (3)(A) - (G) of this subchapter (relating to Development and Enrollment Individual Program Plan (IPP)); and

(C) if the revision IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter (relating to Service Backup Plans).

(5) The case manager must:

(A) ensure the revision IPC is signed and dated by each member of the service planning team; and

(B) within 10 business days after the date of the service planning meeting, submit to DADS:

(i) a copy of the completed revision IPC;

(ii) a copy of the revision IPP;

(iii) a copy of the most recent IPC approved by DADS; and

(iv) if applicable:

(I) Specifications for Minor Home Modifications form;

(II) Prior Authorization for Dental Services form;

(III) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(IV) Provider Agency Model Service Backup Plan form;

(V) Specialized Nursing Certification form; and

(VI) an adaptive behavior screening assessment.

(6) DADS reviews the revision IPC in accordance with §42.221 of this division (relating to Utilization Review of IPC by DADS) and may request additional assessments and supporting documentation related to the individual's diagnosis.

(7) If DADS requests the information described in paragraph (6) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(8) Within 10 business days after receiving a written notice from DADS authorizing services on the revision IPC, the case manager must provide to the individual or LAR a copy of the revision IPC and revision IPP, and any new or revised service backup plan.

(9) The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) to

verify that the services on the revision IPC have been authorized by DADS.

(b) Annual review by the service planning team.

(1) Within 90 calendar days before the end of the IPC period:

(A) an individual's case manager must convene a service planning team meeting to review the IPC and IPP; and

(B) an RN must complete an annual nursing assessment of the individual using the DADS DBMD Nursing Assessment form.

(2) During the service planning team meeting:

(A) the service planning team must:

(i) develop a renewal IPC in accordance with §42.214(d)(1) - (6) of this subchapter and renewal IPP in accordance with §42.215(2)(A) - (D) and (3)(A) - (G) of this subchapter;

(ii) complete a renewal ID/RC Assessment in accordance with the DBMD Program Manual;

(iii) if the renewal IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter; and

(iv) ensure the renewal IPC is signed and dated by each member of the service planning team; and

(B) the case manager must:

(i) orally and in writing explain all DBMD Program services to the individual or LAR;

(ii) explain to the individual, orally and in writing, the mandatory participation requirements of an individual as described in §42.252 of this subchapter (relating to Mandatory Participation Requirements of an Individual);

(iii) orally explain to the individual or LAR that the individual may transfer to a different program provider;

(iv) give the individual or LAR the Documentation of Provider Choice form for the DADS region in which the individual resides;

(v) orally explain to the individual or LAR that the individual or LAR may request the provision of residential habilitation, nursing, case management, out-of-home respite in a camp, adaptive aids, or intervener services while the individual is temporarily staying at a location outside the program provider's contracted service delivery area but within the state of Texas during a period of no more than 60 consecutive days;

(vi) orally explain to the individual or LAR the individual's rights and responsibilities, including the right to request a Medicaid Fair Hearing as described in §42.251 of this chapter (relating to Individual's Right to a Fair Hearing);

(vii) orally explain to the individual or LAR the procedures for an individual or LAR to file a complaint regarding a DBMD Program provider;

(viii) orally explain the CDS option to the individual or LAR as described in §42.217 of this subchapter (relating to Consumer Directed Services (CDS) Option);

(ix) explain orally and in writing to the individual or LAR procedures for reporting an allegation of abuse, neglect, and exploitation;

(x) orally explain to the individual or LAR that the individual may request a service planning team meeting to discuss the reason the provider declined the request to provide services outside the program provider's contracted service delivery area; and

(xi) have documentation that the oral explanations and information required under clauses (i) - (x) of this subparagraph were provided.

(3) The case manager must, within 10 business days after the date of the service planning meeting but at least 30 calendar days before the end of the current IPC period, submit to DADS:

(A) a copy of the completed renewal IPC;

(B) a copy of the most recent IPC approved by DADS;

(C) a copy of the ID/RC Assessment;

(D) a copy of the renewal IPP;

(E) a copy of the Related Conditions Eligibility Screening Instrument;

(F) a copy of the Non-Waiver Services form;

(G) a copy of the Documentation of Provider Choice form;

(H) a copy of the DADS DBMD Nursing Assessment form; and

(I) if applicable:

(i) an adaptive behavior screening assessment if the last assessment occurred five years prior or if significant changes have occurred;

(ii) Specifications for Minor Home Modifications form;

(iii) Prior Authorization for Dental Services form;

(iv) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(v) Provider Agency Model Service Backup Plan form; and

(vi) Specialized Nursing Certification form.

(4) DADS:

(A) reviews:

(i) the renewal IPC in accordance with §42.221 of this division; and

(ii) the renewal ID/RC Assessment in accordance with §42.222 of this division (relating to Annual Review and Reinstatement of Lapsed Diagnostic Eligibility); and

(B) may request additional assessments and supporting documentation related to the individual's diagnosis.

(5) If DADS requests the information described in paragraph (4)(B) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(6) Within 10 business days after receiving a written notice from DADS authorizing services on the renewal IPC, the case manager must provide to the individual or LAR a copy of the renewal IPC and renewal IPP, and any new or revised service backup plan.

(7) The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) to

verify that the services on the renewal IPC have been authorized by DADS.

(c) Review and revision in an emergency.

(1) If a program provider delivers a DBMD Program service to an individual in an emergency to ensure the individual's health and welfare and the service is not on the IPC and IPP or exceeds the amount on the IPP, the case manager must:

(A) within five business days after providing the service, convene a service planning team meeting to review and revise the IPC in accordance with §42.214(d)(1) - (6) of this subchapter and a revision IPP in accordance with §42.215(2)(A) - (D) and (3)(A) - (G) of this subchapter and include on the revision IPP, documentation of how the requested services addressed the emergency;

(B) if the revision IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter;

(C) ensure the revision IPC is signed and dated by each member of the service planning team; and

(D) within 10 business days after the service planning meeting, submit to DADS:

(i) a copy of the completed revision IPC;

(ii) a copy of the revision IPP;

(iii) a copy of the most recent IPC approved by DADS; and

(iv) if applicable:

(I) Specifications for Minor Home Modifications form;

(II) Prior Authorization for Dental Services form;

(III) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(IV) Provider Agency Model Service Backup Plan form;

(V) Specialized Nursing Certification form; and

(VI) an adaptive behavior screening assessment.

(2) DADS:

(A) reviews the revision IPC in accordance with §42.221 of this division; and

(B) may request additional assessments and supporting documentation related to the individual's diagnosis.

(3) If DADS requests the information described in paragraph (2)(B) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(4) Within ten business days after receiving a written notice from DADS authorizing services on the revision IPC, the case manager must provide to the individual or LAR a copy of the revision IPC and revision IPP, and any new or revised service backup plan.

(5) The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) to verify that the services on the revision IPC have been authorized by DADS.

(d) Review and change other than quarterly, annually, or in an emergency.

(1) If a program provider becomes aware at any time during an individual's IPC period that changes to the individual's services may be necessary, the individual's case manager must:

(A) within five business days after becoming aware that changes to the individual's services may be necessary, convene a service planning team meeting to review and, if determined necessary, revise the IPC in accordance with §42.214(d)(1) - (6) of this subchapter and IPP in accordance with §42.215(2)(A) - (D) and (3)(A) - (G) of this subchapter;

(B) if the revision IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter;

(C) ensure the revised IPC is signed and dated by each member of the service planning team; and

(D) within 10 business days after the date of the service planning meeting, submit the following to DADS:

(i) a copy of the completed revision IPC;

(ii) a copy of the revision IPP;

(iii) a copy of the most recent IPC approved by DADS; and

(iv) if applicable:

(I) Specifications for Minor Home Modifications form;

(II) Prior Authorization for Dental Services form;

(III) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(IV) Provider Agency Model Service Backup Plan form;

(V) Specialized Nursing Certification form; and

(VI) an adaptive behavior screening assessment.

(2) DADS:

(A) reviews the revision IPC in accordance with §42.221 of this division; and

(B) may request additional assessments and supporting documentation related to the individual's diagnosis.

(3) If DADS requests the information described in paragraph (2)(B) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(4) Within 10 business days after receiving a written notice from DADS authorizing services on the revision IPC, the case manager must provide to the individual or LAR a copy of the revision IPC and revision IPP, and any new or revised service backup plan.

(5) The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) to verify that the services on the revision IPC have been authorized by DADS.

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DIVISION 5. DENIAL, SUSPENSION, REDUCTION, AND TERMINATION

40 TAC §42.242

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER C. PROGRAM PROVIDER ENROLLMENT

40 TAC §42.301

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER D. ADDITIONAL PROGRAM PROVIDER PROVISIONS

40 TAC §§42.401 - 42.407

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§42.402. Staff Qualifications.

(a) A program provider must employ a program director who is responsible for the program provider's day-to-day operations. The program director must:

(1) have a minimum of one year of paid experience in community programs planning and providing direct services to individuals with deafness, blindness, or multiple disabilities and have a master's degree in a health and human services related field;

(2) have a minimum of two years of paid experience in community programs planning and providing direct services to individuals with deafness, blindness, or multiple disabilities, and have a bachelor's degree in a health and human services related field; or

(3) have been the program director for a DBMD Program provider on or before June 15, 2010.

(b) A program provider must ensure that a case manager:

(1) has:

(A) a bachelor's degree in a health and human services related field and a minimum of two years of experience in the delivery of direct services to individuals with disabilities;

(B) an associate's degree in a health and human services related field and a minimum of four years of experience providing direct services to individuals with disabilities; or

(C) a high school diploma or certificate recognized by a state as the equivalent of a high school diploma and a minimum of six years of experience providing direct services to individuals with disabilities; and

(2) either:

(A) is fluent in the communication methods used by an individual to whom the case manager is assigned (for example American sign language, tactile symbols, communication boards, pictures, and gestures); or

(B) within six months after being assigned to an individual, becomes fluent in the communication methods used by the individual.

(c) For purposes of subsection (d) of this section and consistent with Texas Government Code, §531.0973, "deafblind-related course work" means educational courses designed to improve a person's:

(1) knowledge of deafblindness and its effect on learning;

(2) knowledge of the role of intervention and ability to facilitate the intervention process;

(3) knowledge of areas of communication relevant to deafblindness, including methods, adaptations, and use of assistive technology, and ability to facilitate the development and use of communication skills for a person with deafblindness;

(4) knowledge of the effect that deafblindness has on a person's psychological, social, and emotional development and ability to facilitate the emotional well-being of a person with deafblindness;

(5) knowledge of and issues related to sensory systems and ability to facilitate the use of the senses;

(6) knowledge of motor skills, movement, orientation, and mobility strategies and ability to facilitate orientation and mobility skills;

(7) knowledge of the effect that additional disabilities have on a person with deafblindness and the ability to provide appropriate support; or

(8) professionalism and knowledge of ethical issues relevant to the role of an intervener.

(d) A program provider must ensure that:

(1) an intervener:

(A) is at least 18 years of age;

(B) is not the spouse of the individual to whom the intervener is assigned;

(C) holds a high school diploma or a high school equivalency certificate;

(D) has a minimum of two years of experience working with individuals with developmental disabilities; and

(E) has the ability to proficiently communicate in the functional language of the individual to whom the intervener is assigned;

(2) an intervener I:

(A) meets the requirements for an intervener as described in paragraph (1) of this subsection;

(B) has a minimum of six months of experience working with persons who have deafblindness or function as persons with deafblindness;

(C) has completed a minimum of eight semester credit hours in deafblind-related course work at a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education;

(D) a one-hour practicum in deafblind-related course work at a college or university accredited by a state agency or a non-governmental entity recognized by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education;

(3) an intervener II:

(A) meets the requirements of an intervener I as described in paragraph (2)(A), (C), and (D) of this subsection;

(B) has a minimum of nine months of experience working with persons who have deafblindness or function as persons with deafblindness; and

(C) has completed an additional 10 semester credit hours in deafblind-related course work at a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education; and

(4) an intervener III:

(A) meets the requirements of an intervener II as described in paragraph (3)(A) of this subsection;

(B) has a minimum of one year of experience working with persons with deafblindness; and

(C) holds an associate's or bachelor's degree in a course of study with a focus on deafblind-related course work from a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education;

(e) A program provider must ensure that a service provider who interacts directly with an individual is able to communicate with the individual.

(f) A program provider must ensure that a service provider of a therapy described in §42.632(a) of this chapter (relating to Therapies) is licensed by the State of Texas as described in §42.632(b) of this chapter.

(g) A service provider of employment assistance or a service provider of supported employment must be at least 18 years of age, not be the LAR of the individual receiving employment assistance or supported employment, and have:

(1) a bachelor's degree in rehabilitation, business, marketing, or a related human services field with six months of paid or unpaid experience providing services to people with disabilities;

(2) an associate's degree in rehabilitation, business, marketing, or a related human services field with one year of paid or unpaid experience providing services to people with disabilities; or

(3) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, with two years of paid or unpaid experience providing services to people with disabilities.

(h) Documentation of the experience required by subsection (g) of this section must include:

(1) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and

(2) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

(i) A program provider must ensure that a service provider not required to meet the other education or experience requirements described in this section:

(1) is 18 years of age or older;

(2) has:

(A) a high school diploma;

(B) a certificate recognized by a state as the equivalent of a high school diploma; or

(C) the following:

(i) documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment; and

(ii) at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual; and

(3) except for a service provider of chore services, either:

(A) is fluent in the communication methods used by the individual to whom the service provider is assigned (for example American sign language, tactile symbols, communication boards, pictures, and gestures); or

(B) has the ability to become fluent in the communication methods used by an individual within three months after being assigned to the individual.

(j) The program provider must ensure that:

(1) a vehicle in which a service provider transports an individual has a valid Vehicle Identification Certificate of Inspection, in accordance with state law; and

(2) a service provider who transports an individual in a vehicle has:

(A) a current Texas driver's license; and

(B) vehicle liability insurance, in accordance with state law.

(k) A service provider:

(1) must not be:

(A) the parent of an individual if the individual is under 18 years of age; or

(B) the spouse of an individual;

(2) must not, if an individual is an adult, be a relative or guardian of the individual to whom the service provider is providing:

(A) assisted living;

(B) case management;

(C) behavioral support;

(D) dental treatment;

(E) dietary services;

(F) FMS, if the individual is participating in the CDS option;

(G) occupational therapy;

(H) orientation and mobility;

(I) physical therapy;

(J) speech, language, audiology therapy;

(K) support consultation, if the individual is participating in the CDS option; or

(L) TAS; and

(3) may be, if an individual is an adult, a relative or guardian of the individual to whom the service provider is providing:

(A) adaptive aids;

(B) chore services;

(C) day habilitation;

(D) employment assistance;

(E) intervener;

(F) minor home modifications;

(G) nursing;

(H) residential habilitation;

(I) respite; or

(J) supported employment.

(l) The program provider must maintain documentation in a service provider's employment, contract, or personal service agreement file that the service provider meets the requirements of this section.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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40 TAC §42.407

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive com-

missioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §42.408, §42.409

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§42.408. Protective Devices.

(a) A protective device is a restrictive intervention that a program provider may use in accordance with this section.

(b) A program provider must not use a protective device to modify or control an individual's behavior, for disciplinary purposes, for convenience, or as a substitute for an effective, less restrictive method.

(c) Before a program provider uses a protective device, the program provider must:

(1) have an RN conduct an assessment of the individual's needs;

(2) consider less restrictive methods that, if effective, would accomplish the purpose of the protective device;

(3) document in the individual's case record the reasons why less restrictive methods would not be effective;

(4) obtain and retain in the individual's case record written consent of the individual or LAR to use a protective device;

(5) provide oral and written notification to the individual or LAR of the right at any time to withdraw consent for the use of the protective device;

(6) have an RN, with input from the individual, the individual's LAR, the individual's service planning team, and other professional personnel, develop a written service plan, which may be part of the individual's plan of care as defined in §97.2 of this title (relating to Definitions), signed by a physician, that describes:

(A) the type of device and the circumstances under which it may be used;

(B) how to use the protective device and any contraindications specific to the individual;

(C) how and when to document the use of the protective device;

(D) how to monitor the protective device; and

(E) when and whom the program staff must notify of the use of a protective device;

(7) ensure the service planning team reviews and approves the written service plan;

(8) ensure that each service provider who will use a protective device has been trained in the proper use of the protective device; and

(9) ensure the training is documented in the service provider's record.

(d) A program provider that uses a protective device must:

(1) document in the individual's case record any use of the protective device in accordance with the written service plan;

(2) ensure that an RN, with input from the individual's service planning team and other professional personnel, at least annually, and when the individual's needs change:

(A) evaluates and documents in the individual's case record the effects of the protective device on the individual's health and welfare; and

(B) reviews the use of a protective device to determine its effectiveness and the need to continue the protective device; and

(3) ensure that an RN, in accordance with subsection (c)(6) of this section, revises the service plan when the individual's service planning team and physician determine that a protective device is not effective or needed.

§42.409. Restraints.

(a) A restraint is a restrictive intervention that a program provider may use in accordance with this section.

(b) A program provider providing licensed assisted living must comply with §92.41(p) of this title (relating to Standards for Type A and Type B Assisted Living Facilities).

(c) A program provider must ensure that a six-bed ICF/IID providing respite complies with §90.42(e)(4) of this title (relating to Standards for Facilities Serving Individuals with an Intellectual Disability or Related Conditions).

(d) A program provider providing licensed home health assisted living:

(1) must not use restraints:

(A) for disciplinary purposes, retaliation, coercion, or retribution;

(B) for the convenience of a service provider or other persons; or

(C) as a substitute for an effective, less restrictive method;

(2) may use a restraint only:

(A) if the use is authorized in writing by a physician and specifies:

(i) the circumstances under which the restraint may be used; and

(ii) the duration for which the restraint may be used; or

(B) if the use is necessary in a behavioral emergency to protect the individual or others from injury;

(3) except in a behavioral emergency, must ensure:

(A) that a service provider who uses a restraint has been trained in the use of the restraint:

(i) before using the restraint;

(ii) annually; and

(iii) when the individual's needs change; and

(B) that the training is documented in the service provider's record;

(4) must not use a restraint under any circumstance if it:

(A) obstructs the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose;

(B) impairs the individual's breathing by putting pressure on the individual's torso;

(C) interferes with the individual's ability to communicate; or

(D) places the individual in a prone or supine position;

(5) must ensure that if a physical restraint is used in a behavioral emergency:

(A) it must be a restraint in which the individual's limbs are held close to the body to limit or prevent movement and that does not violate the provisions of paragraph (4) of this subsection;

(B) that as soon as possible but no later than one hour after the use of the restraint, the service provider notifies an RN of the restraint;

(C) that after the RN is notified of the use of the restraint, the service provider documents the RN's instructions to the service provider;

(D) that medical services are obtained for the individual as necessary;

(E) the program provider:

(i) with the individual's consent, makes an appointment with a physician no later than the end of the first working day after the use of restraint and document in the individual's record that the appointment was made; or

(ii) if the individual refuses to see a physician, documents the refusal in the individual's record; and

(F) that as soon as possible but no later than 24 hours after the use of restraint, the program provider notifies one of the following persons, if there is such a person, that the individual has been restrained:

(i) the individual's LAR; or

(ii) a person actively involved in the individual's care, unless the release of this information would violate other law;

(6) that uses a restraint must document in an individual's case record:

(A) the use of the restraint;

(B) time and date the restraint was used;

(C) name of person administering the restraint;

(D) type of restraint and duration used; and

(E) if used in a behavioral emergency:

(i) events preceding the use of the restraint;

(ii) actions taken after the use of the restraint; and

(iii) types of intervention attempted before the use of the restraint; and

(7) in order to decrease the frequency of the use of restraint, and to minimize the risk of harm to an individual, must ensure that a service provider is aware of and adheres to the findings of the nursing assessment required in §42.212(c)(2) of this chapter (relating to Process for Enrollment of an Individual) or in §42.223(b)(1) of this chapter (relating to Periodic Review and Update of IPC and IPP) for each individual.

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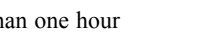

SUBCHAPTER F. SERVICE DESCRIPTIONS AND REQUIREMENTS

DIVISION 2. MINOR HOME MODIFICATIONS

40 TAC §42.615, §42.620

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall

study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §§42.625, 42.626, 42.628, 42.630, 42.631

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§42.625. Employment Services.

(a) A program provider must ensure that a service provider of employment assistance or a service provider of supported employment meets the qualifications described in §42.402(g) of this chapter (relating to Staff Qualifications).

(b) Before including employment assistance on an individual's IPC, a program provider must ensure and maintain documentation in the individual's record that employment assistance is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

(c) The program provider must ensure that employment assistance:

(1) consists of a service provider performing the following activities:

(A) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

(B) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements;

(C) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;

(D) transporting the individual to help the individual locate competitive employment in the community; and

(E) participating in service planning team meetings;

(2) is provided in accordance with the individual's IPC and with Appendix C of the DBMD waiver application approved by CMS and found at www.dads.state.tx.us;

(3) is not provided to an individual with the individual present at the same time that one of the following DBMD Program services is provided:

(A) day habilitation;

(B) residential habilitation;

(C) supported employment; or

(D) respite; and

(4) does not include using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(A) paying an employer:

(i) to encourage the employer to hire an individual; or

(ii) for supervision, training, support, or adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(B) paying the individual:

(i) as an incentive to participate in employment assistance activities; or

(ii) for expenses associated with the start-up costs or operating expenses of an individual's business.

(d) Before including supported employment on an individual's IPC, a program provider must ensure and maintain documentation in the individual's record that supported employment is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

(e) A program provider must ensure that supported employment:

(1) consists of a service provider performing the following activities:

(A) making employment adaptations, supervising, and providing training related to an individual's assessed needs;

(B) transporting the individual to support the individual to be self-employed, work from home, or perform in a work setting; and

(C) participating in service planning team meetings;

(2) is provided in accordance with the individual's IPC and with Appendix C of the DBMD waiver application approved by CMS and found at www.dads.state.tx.us;

(3) is not provided to an individual with the individual present at the same time that one of the following DBMD Program services is provided:

(A) day habilitation;

(B) residential habilitation;

(C) employment assistance; or

(D) respite; and

(4) does not include:

(A) sheltered work or other similar types of vocational services furnished in specialized facilities; or

(B) using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(i) paying an employer:

(I) to encourage the employer to hire an individual; or

(II) to supervise, train, support, or make adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(ii) paying the individual:

(I) as an incentive to participate in supported employment activities; or

(II) for expenses associated with the start-up costs or operating expenses of an individual's business.

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CHAPTER 43. SERVICE RESPONSIBILITY OPTION

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§43.4, 43.22, 43.41, and 43.71, concerning definitions; SRO provider responsibilities; support consultation services; and oversight, in Chapter 43, Service Responsibility Option, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3126).

The amendments are adopted to update rules in Chapter 43 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, some of which use the service responsibility option (SRO). Therefore, the rules are being amended to reflect current terminology and reference new Chapter 49 instead of program rules in describing the background check an SRO provider must conduct on potential service providers.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

DADS received no comments regarding adoption of the amendments.

SUBCHAPTER A. INTRODUCTION

40 TAC §43.4

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER C. RESPONSIBILITIES OF AN SRO PROVIDER

40 TAC §43.22

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall

adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER E. SUPPORT CONSULTATION

40 TAC §43.41

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER H. OVERSIGHT

40 TAC §43.71

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 44. CONSUMER MANAGED PERSONAL ATTENDANT SERVICES

SUBCHAPTER C. SERVICE DELIVERY IN ALL CMPAS OPTIONS

40 TAC §44.302

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts an amendment to §44.302, concerning provider qualifications and responsibilities in all CMPAS service delivery options, in Chapter 44, Consumer Managed Personal Attendant Services, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3130).

The purpose of the amendment is to correct the reference to Chapter 49 to reflect the title of new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register,* and to clarify that a CMPAS provider must comply with the provisions of Chapter 49 as described in that chapter.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

DADS received no comments regarding adoption of the amendment.

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that

operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 45. COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§45.503, 45.609, 45.619, 45.701, 45.703, 45.707, 45.801, and 45.902, concerning contracting requirements; requirements of DSA following provision of adaptive aid; satisfaction of minor home modification; compliance with laws, rules, regulations, and requirement for e-mail subscription; qualifications of CMA staff persons; CMA: quality management and complaint process; compliance with laws, rules, regulations, and requirement for e-mail subscription; and financial errors; and the repeal of §§45.501, 45.808, and 45.901, concerning purpose; DSA: complaint process; and administrative errors, in Chapter 45, Community Living Assistance and Support Services. The amendment to §45.801 is adopted with changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3131). The amendments to §§45.503, 45.609, 45.619, 45.701, 45.703, 45.707, and 45.902 and the repeals of §§45.501, 45.808, and 45.901 are adopted without changes to the proposed text and will not be republished.

The purpose of the amendments and repeal is to update and delete rules in Chapter 45 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including services provided through the Community Living Assistance and Support Services (CLASS) Program. Therefore, the rules are being amended and repealed to remove provisions addressed in new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

Changes were made to the text of §45.801 to delete the requirement in paragraph (3) for a direct service agency (DSA) to comply with Chapter 62, Contracting to Provide Transition Assistance Services. The agency made this change because a DSA contracting to provide CLASS services under Chapter 45 provides "direct services." "Direct services," as defined in §45.103, do not include transition assistance services.

DADS received no comments regarding adoption of the amendments and repeals.

SUBCHAPTER E. SUPPORT FAMILY SERVICES

DIVISION 1. INTRODUCTION

40 TAC §45.501

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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40 TAC §45.503

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER F. ADAPTIVE AIDS AND MINOR HOME MODIFICATIONS
DIVISION 1. ADAPTIVE AIDS

40 TAC §45.609

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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DIVISION 2. MINOR HOME MODIFICATIONS

40 TAC §45.619

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER G. ADDITIONAL CMA REQUIREMENTS

40 TAC §§45.701, 45.703, 45.707

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER H. ADDITIONAL DSA REQUIREMENTS
DIVISION 1. INTRODUCTION

40 TAC §45.801

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§45.801. DSA Compliance with Rules.

A DSA must comply with:

(1) this chapter;

(2) Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies); and

(3) Chapter 49 of this title (relating to Contracting for Community Services).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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40 TAC §45.808

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER I. FISCAL MONITORING
DIVISION 1. INTRODUCTION

40 TAC §45.901

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §45.902

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 46. CONTRACTING TO PROVIDE ASSISTED LIVING AND RESIDENTIAL CARE SERVICES

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§46.11, 46.19, 46.21, 46.23, and 46.33, concerning contracting requirements, recordkeeping, reimbursement, monitoring reviews, and staff training; and the repeal of §46.17 and §46.25, concerning termination of contract, and complaints; in Chapter 46, Contracting to Provide Assisted Living and Residential Care Services. The amendments to §46.21 and §46.23 are adopted with changes to the proposed text published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3137). The amendments to §§46.11, 46.19, and 46.33 and the repeals of §46.17 and §46.25 are adopted without changes to the proposed text and will not be republished.

The purpose of the amendments and repeals is to update and delete rules in Chapter 46 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including assisted living and residential care services. The rules are being amended and repealed to delete provisions addressed in the new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

A minor editorial change was made in §46.21(b) to correct the grammar and in §46.23(1) to spell out "DADS" the first time it is used.

DADS received no comments regarding adoption of the amendments and repeals.

SUBCHAPTER B. PROVIDER CONTRACTS

40 TAC §§46.11, 46.19, 46.21, 46.23

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§46.21. Reimbursement.

(a) A unit of service is one billable day of authorized service delivered to a client.

(b) The unit rate reimbursed by the Department of Aging and Disability Services (DADS) includes any copayment. The combined reimbursement from DADS and the client or the client's representative for the required services described in §46.41 of this chapter (relating to Required Services) must not exceed the unit rate plus room and board specified for each type of setting. The unit rate does not include charges for services described in §46.15 of this chapter (relating to Additional Services and Fees).

(c) The facility must deduct the copayment amount from reimbursement claims submitted to DADS.

(d) The facility must not bill DADS for the day of discharge, unless the discharge is due to the death of the client.

(e) The facility must bill the double occupancy (Residential Care Apartment) rate for clients in the single occupancy (Assisted Living Apartment) setting who request double occupancy.

(f) The facility must bill DADS for the balance of the bedhold charge for any clients whose daily copayment is less than the maximum bedhold charge allowed by DADS.

(1) The facility must determine the client's daily copayment amount by dividing the client's monthly copayment charge by the number of days in the month.

(2) The facility must deduct the client's daily copayment amount from the bedhold rate and submit the claim to DADS.

(3) This subsection does not apply to the Assisted Living (AL) services allowed in the Community Based Alternatives (CBA) Program.

(g) The facility may bill DADS for emergency care provided to clients for:

(1) up 60 days per authorization for eligible clients; or

(2) five days for a client ineligible for emergency care.

(h) The facility must not bill for services provided before or after the authorized effective dates for CBA AL or Community Care for Aged and Disabled (CCAD) Residential Care (RC) services, as those dates are determined by DADS.

(i) When the facility requests a level of care reset, the facility may bill DADS at the new payment rate effective the date of the new assessment. The facility may request only two level of care resets during each calendar year for each CBA client for the following time periods:

(1) January through June; and

(2) July through December.

(j) CCAD RC services will be reimbursed at the double occupancy rate, regardless of the actual occupancy.

§46.23. Financial Errors.

Financial errors include the errors described in this section.

(1) The facility is reimbursed for services, but the daily census documentation and the daily service delivery documentation are missing for the period for which services are reimbursed. The Department of Aging and Disability Services (DADS) applies the error to the total number of units reimbursed for the billing period for which forms are missing.

(2) The facility is reimbursed for units that exceed the units recorded on daily census documentation and daily service delivery documentation. DADS applies the error to the total number of units reimbursed in excess of units recorded.

(3) The facility is reimbursed for units of service and the client did not receive services. DADS applies the error to the total number of units reimbursed for the days the client did not receive services.

(4) The facility is reimbursed for units of service and the client was Medicaid ineligible. DADS applies the error to the total number of units reimbursed for the days the client was Medicaid ineligible. This does not apply to the Community Care for Aged and Disabled (CCAD) Residential Care (RC) program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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40 TAC §46.17, §46.25

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER C. PROVIDER REQUIREMENTS

40 TAC §46.33

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 47. CONTRACTING TO PROVIDE PRIMARY HOME CARE

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §47.11, concerning contracting requirements, and §47.89, concerning reimbursement; and the repeal of §47.75, concerning complaints, and §47.87, concerning record keeping, in Chapter 47, Contracting to Provide Primary Home Care, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3142).

The amendments and repeals are adopted to update and delete rules in Chapter 47 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including primary home care. Therefore, the rules are be-

ing amended and repealed to delete provisions addressed in the new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

DADS received no comments regarding adoption of the amendments and repeals.

SUBCHAPTER B. PROVIDER CONTRACTS

40 TAC §47.11

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER E. SERVICE REQUIREMENTS

40 TAC §47.75

STATUTORY AUTHORITY

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER F. CLAIMS PAYMENT AND DOCUMENTATION

40 TAC §47.87

STATUTORY AUTHORITY

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §47.89

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which

provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 11, 2014.

TRD-201403702
Lawrence Hornsby
General Counsel
Department of Aging and Disability Services
Effective date: September 1, 2014
Proposal publication date: April 18, 2014
For further information, please call: (512) 438-3734

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CHAPTER 48. COMMUNITY CARE FOR AGED AND DISABLED
SUBCHAPTER K. MINIMUM STANDARDS FOR ADULT FOSTER CARE

40 TAC §§48.8901, 48.8906, 48.8907

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§48.8901, 48.8906, and 48.8907, concerning minimum standards; enrollment and licensure requirements; and provider responsibilities, in Subchapter K, Minimum Standards for Adult Foster Care, in Chapter 48, Community Care for Aged and Disabled, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3144).

The amendments are adopted to update and delete rules regarding adult foster care homes in Chapter 48, Subchapter K, in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including adult foster care services. Therefore, the rules are being amended and repealed to remove provisions addressed in new Chapter 49 and to update the rules to reflect current practice.

DADS received a written comment from the Texas Academy of Physician Assistants. A summary of the comment and the response follows.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

Comment: Concerning §48.8907(f)(4) and (g)(6), the commenter requested that a physician assistant, in addition to a physician, be recognized as a health care provider who is authorized to prescribe special diets and medication.

Response: The agency did not make the requested revision to §48.8907(f)(4) and (g)(6) because the requested change is not related to the proposed amendments and the agency does not want to make the change at adoption without the benefit of public comment. However, the agency agrees to consider the suggestion when making future changes to the rule.

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Lawrence Hornsby
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Department of Aging and Disability Services
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For further information, please call: (512) 438-3734

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CHAPTER 49. CONTRACTING FOR COMMUNITY CARE SERVICES

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts the repeal of Chapter 49, Contracting for Community Care Services, Subchapter A, consisting of §49.1, concerning definitions; Subchapter B, consisting of §§49.11 - 49.18 and §49.20, concerning contractor requirements; Subchapter C, consisting of §§49.31 - 49.33, concerning records; Subchapter D, consisting of §49.41 and §49.42, concerning billings and payments; Subchapter E, consisting of §§49.51 - 49.54, concerning audits, monitoring, and reviews; Subchapter F, consisting of §§49.61 - 49.63, concerning sanctions and terminations; and Subchapter G, consisting of §§49.71 - 49.73, concerning personal attendants wages; and adopts new Chapter 49, Contracting for Community Services, Subchapter A, consisting of §49.101 and §49.102, concerning application and definitions; Subchapter B, consisting of §§49.201 - 49.211, concerning contractor enrollment; Subchapter C, consisting of §§49.301 - 49.312, concerning requirements of a contractor; Subchapter D, Division 1, consisting of §49.401, concerning applicability of Subchapter D; Division 2, consisting of §§49.411

- 49.414, concerning monitoring and investigation; Subchapter E, Division 1, consisting of §49.501, concerning applicability of Subchapter E; Division 2, consisting of §49.511, concerning immediate protection; Division 3, consisting of §§49.521 - 49.523, concerning actions; Division 4, consisting of §§49.531 - 49.534, concerning sanctions; Division 5, consisting of §49.541, appeals; Division 6, consisting of §49.551, concerning termination by contractor; Subchapter F, consisting of §49.601, concerning review by DADS of expiring or terminated contract; and Subchapter G, consisting of §49.701 and §49.702, concerning application denial period, in Chapter 49, Contracting for Community Care Services. New §§49.101, 49.102, 49.204, 49.205, 49.208, 49.304, 49.305, 49.308, 49.309, 49.310, 49.413, 49.522, and 49.551 are adopted with changes to the proposed text published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3148). New §§49.201 - 49.203, 49.206, 49.207, 49.209 - 49.211, 49.301 - 49.303, 49.306, 49.307, 49.311, 49.312, 49.401, 49.411, 49.412, 49.414, 49.501, 49.511, 49.521, 49.523, 49.531 - 49.534, 49.541, 49.601, 49.701 and 49.702 are adopted without changes to the proposed text.

This adoption repeals Chapter 49, Contracting for Community Care Services, and adopts a new Chapter 49, Contracting for Community Services. Generally, the new chapter provides the basis for contracting with DADS to provide community-based services. The new chapter clarifies and revises requirements for obtaining, maintaining, and terminating those contracts. Some significant provisions in the new chapter include requiring a comprehensive screening of potential contractors and controlling persons. The new chapter also requires a contractor to receive a provisional contract with a stated expiration date as an initial contract. At the end of the term of a provisional contract, a contractor may be considered for a standard contract with no expiration date. The new chapter also establishes standardized application denial periods, which are periods of time during which DADS will deny the application of a former contractor. The new chapter provides consistency in DADS recoupment process by allowing DADS to recoup funds if a contractor does not appeal the proposed recoupment or the contractor appeals the proposed recoupment and the final decision from the administrative hearing is favorable to DADS. DADS will not recoup funds while an administrative hearing is pending, which is the current practice in some programs. Subject to the exceptions stated in Chapter 49, the new chapter applies to the Home and Community-Based Services (HCS) Program and Texas Home Living (TxHmL) Program, which current Chapter 49 does not.

Other rules are amended or repealed in this issue of the *Texas Register* to conform to the changes resulting from the adopted new Chapter 49. Specifically, Chapter 9, Subchapter Q, governing enrollment of contractors in the HCS and TxHmL Programs, and Chapter 69, governing contract administration, are repealed. In addition, sections in Chapter 9, Subchapter D, governing the Home and Community-based Services Program, and Subchapter N, governing the Texas Home Living Program; Chapter 30, governing Medicaid hospice services; Chapter 41, governing consumer directed services option; Chapter 42, governing Deaf Blind with Multiple Disabilities (DBMD) Program; Chapter 43, governing the service responsibility option; Chapter 44, governing consumer-managed personal attendant services; Chapter 45, governing community living assistance and support services; Chapter 46, governing assisted living and residential care services; Chapter 47, governing primary home care services; Chapter 48, governing adult foster care; Chapter 51, governing Medically Dependent Children Program; Chapter 52, governing emergency response services; Chapter 55, governing home-delivered meals; Chapter 58, governing special services to persons with disabilities; Chapter 60, governing programs of all inclusive care for the elderly; Chapter 62, governing contracting to provide transition assistance services; and Chapter 98, governing day activity and health services, are amended and repealed to be consistent and avoid duplication with the new Chapter 49.

These rules apply to: (1) a contract application approved by DADS on or after the effective date of the rules; and (2) a contract in effect on or after the effective date of these rules, regardless of the effective date of the contract. Performance under a contract occurring before the effective date of these rules is governed by the rules in effect on the date of the performance, and the former rules continue in effect for that purpose. Performance under a contract occurring on or after the effective date of these rules is governed by these rules. A sanction proposed or an action taken by DADS before the effective date of these rules is governed by the rules in effect on the date the sanction is proposed or the action is taken, and the former rules continue in effect for that purpose. A sanction proposed or an action taken by DADS on or after the effective date of these rules is governed by these rules.

The agency made a change to §49.101(a)(3)(B) to correctly title the program "Emergency Response Services."

The agency made a change to §49.204 to make the rule consistent with current practice, which allows an applicant to forego the applicant training or competency examination if the applicant is applying for an HCS contract and has a contract for the HCS Program in another service area or is applying for a TxHmL contract and has a contract for the HCS or TxHmL Program in another service area. Because the applicant has a contract in another service area, the applicant would have completed the training and examination that was required when its contract was executed.

The agency made a change to §49.205(a)(1) to correct the license and permit requirements for a contractor of continued family services or support family services in the Community Living Assistance and Support Services Program.

The agency made a change to §49.208(b)(3) to clarify that, based on §49.302(b), some contractors may not be placed on a choice list until the contractor has completed training required by DADS.

The agency made a change to §49.305(i) and (j) to clarify that the rule applies to records maintained in accordance with its contract, this subchapter, and program rules.

The agency made a change to §49.305(i) to require a contractor that uses paper records to retain the original records.

The agency made a change to §49.305(j)(2)(A) to clarify that procedures governing the use of electronic signatures must ensure the authenticity of a signature.

The agency made a change to §49.305(j)(3) to require a contractor that uses electronic records to be able to retrieve information stored electronically as a paper record.

The agency made a change to §49.308 to limit the applicability of the section to subcontracts under which a subcontractor provides a service to an individual.

The agency made a change to §49.522(e)(3) and (4) to use "performing" instead of "completion of" and "accomplishing" for consistency with (e)(2).

The agency made a change to §49.551(c)(1)(A) to clarify that DADS may send notice of contract termination to individuals before a contractor's payments are on a vendor hold.

DADS received written comments from Disability Services of the Southwest, Meals on Wheels Association of Texas, Providers Alliance for Community Services of Texas, and Texas Association for Home Care. A summary of the comments and the responses follows.

Comment: Concerning §49.102, a commenter requested the addition of a definition for "businesses required to be registered with the Texas Secretary of State."

Response: The agency did not make the requested revision to §49.102. This information is provided by the Texas Secretary of State. The agency also notes that the requirement in §49.304 to check a potential subcontractor's status with the Secretary of State has been deleted.

Comment: Concerning §49.102, a commenter requested instructions for determining if a business is required to pay a franchise tax.

Response: The agency did not make the requested revision to §49.102. This information is provided by the Texas Comptroller of Public Accounts. The agency also notes that the requirement in §49.304 to check a potential subcontractor's franchise tax status has been deleted.

Comment: Concerning §49.102, a commenter requested the addition of a definition for the term "electronic records."

Response: The agency has revised §49.102 to add a definition of "electronic record." In addition, the agency revised the definition of "records" to clarify that, for purposes of this chapter, records are electronic or paper. A definition of "paper records" was also added to the section.

Comment: Concerning §49.102(6), the definition of "business day," a commenter stated that the definition includes the word "national" but national holidays have not historically been recognized as holidays in contracting rules. The commenter asked if the word "national" will be added to all the programs rules covered by the proposal.

Response: The agency did not make a change to §49.102(6). The word "national" is being added to the programs rules for HCS, TxHmL, CLASS, DBMD and MDCP, which are all covered by these rules, for consistency across the rules.

Comment: Concerning §49.102(20), the definition of "controlling person," a commenter stated that the breadth of the new definition could allow for potentially serious sanctions or contract termination to be levied due to the action of an employee without true operational authority, like a house manager, or that contractors could be cited for not providing the names of particular individuals listed in the definition as a "controlling person" who would not be perceived by the provider to have actual control over the contract. The commenter believes the definition for "controlling person" in Texas Health and Safety Code, §142.0012(a) is clearer than the proposed rule regarding the type of individuals that would be considered a controlling person. That section states, "A person is a controlling person if the person, acting alone or with others, has the ability to directly or indirectly influence, direct, or cause the direction of the management, expenditure of money, or policies of a home and community support services agency."

The commenter recommended the definition for "controlling person" begin with wording similar to the definition in §142.0012(a) as a means of clarifying that the myriad of individuals listed in the proposed definition will only be considered a controlling person if they also meet this initial criteria.

Response: The agency did not make the recommended revision to §49.102(20), noting that the definition is patterned after definitions in 42 CFR §455.101, concerning disclosure of information for providers and fiscal agents, as well as Texas Health and Safety Code, §142.0012.

Comment: Concerning §49.102(60), a commenter stated the definition for "subcontractor" is not easily understood. The commenter asked if the term only refers to a company that prepares or delivers meals for a home delivered meals provider. The commenter also asked whether companies and people the agency uses to purchase supplies, have repair work done, etc. are vendors or subcontractors.

The commenter requested the definition for "subcontractor" be reworded and a definition for "vendor" be added.

Response: The agency did not make the requested revision to §49.102(60) [now (62)] because the agency believes it correctly defines the term. The agency replies that if supplies or repairs are necessary for a contractor to provide services under a contract, then the contractor's agreement with the person providing the supplies or performing the repairs is a subcontractor.

Comment: Concerning §49.304, a commenter stated the rule should make it clear unlicensed agency employees, unlicensed subcontractors and unlicensed volunteers signed up before the rule's effective date will be "grandfathered." Thus programs would only be required to conduct background checks on applicants for employment, subcontractors and volunteers signed up on or after the effective date of the rule.

Specifically, the commenter requested the rule include the following statement: "For contractors that are not required to have a license, current and new unlicensed staff members, unlicensed subcontractors and unlicensed volunteers who are hired prior to 9/1/2014 will be "grandfathered" into the position."

Response: The agency did not make the requested revision to §49.304. However, the agency notes that the requirements related to conducting background checks in these rules apply to contractors' employees, subcontractors, and volunteers who are offered employment, a subcontract, or a volunteer position on or after the effective date of the rules.

Comment: Concerning §49.304(b)(1), a commenter requested that home-delivered meal providers be allowed to use a public record website to conduct background checks on volunteers. That search provides extensive reporting for a modest fee. The rule appears to specifically require use of the Department of Public Safety, which charges a $3.00 fee per look-up. The commenter requested the rule be changed to allow contractors to also use other public websites and suggested adding the following wording: "Criminal background checks obtainable from a public record database that provides an extensive criminal history record may be used or they may be obtained from the Department of Public Safety database."

Response: The agency has changed the rule to allow a contractor to obtain directly or through a private agency the criminal history record of an applicant for employment, volunteer position, or subcontract from the Department of Public Safety. Thus, a contractor may use a private agency to conduct criminal his-

tory checks, but the agency must obtain the information from the Department of Public Safety.

Comment: A commenter requested the rule exempt volunteers who have no contact with clients and/or client information from all background check requirements.

Response: The agency has revised §49.304(b)(1) and (2) to limit the requirement to conduct background checks on volunteers to those volunteers who directly interact with an individual. In addition, subsection (b) has been reorganized to clarify that this limitation does not apply to employees and contractors. Similar changes were made to subsection (c), which relates to checks of the Nurse Aide Registry and the Employee Misconduct Registry.

Comment: Concerning §49.304(d)(1) and (f)(1), a commenter stated these new background check requirements checking a potential subcontractor's franchise account status and existence with the Secretary of State adds cost, administrative burden, the opportunity for additional punitive action and/or recoupment against providers for requirements that have nothing to do with quality of care. Also, it is not immediately obvious which companies are required to pay the franchise tax or register with the Secretary of State, and required annual franchise tax filings by businesses allow for additional opportunities for an entity to incorrectly be listed as "not active." The commenter requested these provision s be removed from the rule.

Response: The agency has deleted §49.304(d)(1) and (2) and (f)(1) and (2) in response to the comment. The agency believes making the inquiries to the Secretary of State and the Comptroller is good business practice to be followed by contractors, but the agency has decided to not require the actions described in those paragraphs.

Comment: Concerning §49.304(g), a commenter stated that a licensed home and community support services agency (HCSSA) must already meet 40 TAC §97.247, Verification of Employability and Use of Unlicensed Persons, which requires a HCSSA to conduct criminal history checks on all unlicensed persons if the person's duties would or do include face-to-face contact with a client. The commenter added that before an agency hires an unlicensed person, or before an unlicensed person's first face-to-face contact with a client, the agency must search the nurse aide registry (NAR) and the employee misconduct registry (EMR) and annually thereafter. The commenter further stated HCSSAs that offer contracts to another agency or organization for an unlicensed person to provide services under arrangement must also comply with the requirements in §97.289(c) - (d) relating to Independent Contractors and Arranged Services. Therefore, the commenter recommended that contractors who are HCSSAs be excluded or §49.304(g) be consistent with §97.247.

Response: The agency did not make the recommended revision to §49.304(g). 40 TAC §97.247 does not include the requirement that a HCSSAs employees, subcontractors, and volunteers notify the HCSSA when they have a change in status related to criminal history, the nurse aide registry, or the employee misconduct registry, or when they determine previously submitted information is incorrect. The agency believes that establishing these requirements regarding critical developments will benefit contractors and individuals.

Comment: Concerning §49.304(h)(1), a commenter requested adding a limitation on the search of the list of excluded individuals and entities (LEIE) that reads, "Providers are required to check the LEIE before employing an applicant or engaging a vendor and at least once per month for each month payment is made to the employee or vendor. For each month in which no payment is made, the LEIE search is not required."

Response: The agency did not make the requested revision to §49.304(h), now §49.304(f).

The State Medicaid Director letter dated January 16, 2009 states that "States should require providers to search the HHSC-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search." DADS has not been instructed to limit this search requirement to transactions over a certain amount or certain types of contractors. Furthermore, this requirement is consistent with the Health and Human Services Commission rule at 1 TAC §371.1655(25), regarding program compliance.

Comment: Concerning §49.305(i)(3), two commenters stated the requirement that a stamped signature may not be used on paper records makes no allowance for agency employees and clients who have difficulty with physical signatures and must use a stamp because of their disabilities. One commenter believes submitting documentation for services delivered constitutes "communication" with the state and therefore is subject to Subpart E - Communications, §35.160(a) and (b) of the Americans with Disabilities Act (ADA), which requires the state to provide a way for a disabled person to effectively communicate. The commenters requested clarification regarding how provider employees and clients with disabilities that require them to use a signature stamp will be accommodated.

Response: The agency has revised §49.305(i)(3) [now (i)(4)] to allow a person with a disability to use a signature stamp as an accommodation for the disability.

Comment: Concerning §49.305(k)(2)(A), one commenter requested the rule clarify that records may be submitted electronically when possible in lieu of paper copies.

Response: The agency has revised §49.305(k)(2)(A) to clarify that records must be provided in the form requested by DADS which, under certain circumstances, may be an electronic format.

Comment: Concerning §49.306, a commenter stated that although DADS addresses EVV system in Chapter 68, it seems appropriate for EVV compliance to be added to the provisional and standard contracts section of Chapter 49.

Response: The agency did not make the suggested revision because Subchapter C, the subchapter in which §49.306 is located, contains requirements related to the ongoing obligations of a contractor, whether the contract is a provisional or standard contract. The sections related to provisional and standard contracts describe the requirements for obtaining those contracts and, therefore, those sections are not appropriate for provisions related to ongoing EVV compliance.

Comment: Concerning §49.307(a)(1), a commenter stated HCSSA contractors must already meet 40 TAC §97.301, Client Records, which requires an agency to adopt and enforce a written policy relating to the retention of records. The commenter added that a HCSSA must (1) retain original client records for a minimum of five years after the discharge of the client; (2) not destroy client records that relate to any matter that is involved in litigation if the agency knows the litigation has not been finally resolved; and (3) have an arrangement for the preservation of inactive records to insure compliance with this subsection. Therefore, the commenter recommended that contractors who are already required to meet the Health and Safety Code as

HCSSAs be excluded or that the "six years elapse time" be changed to 5 years to be consistent with HCSSA licensure standards at §97.301(b)1-3.

Response: The agency declines to revise §49.307(a)(1). As noted by the commenter, §97.301 requires a HCSSA, subject to certain exceptions, to retain records for five years after the discharge of a client, which could be longer than six years from the date the records were created. The current contract for community services requires records to be retained for six years after end of the federal fiscal year in which the services were provided, except Home and Community-based Services (HCS) and Texas Home Living (TxHmL) contractors must retain records for six years from the date the records were created. Although current §49.32 requires service delivery records to be retained for five years from the date the service is delivered, which is a shorter period than the new rules require, the agency believes six years from the date the record is created is a reasonable retention period and, with the addition of this requirement, the retention period will be uniform for all community service contracts at DADS.

Comment: Concerning §49.309, a commenter stated HCSSAs must already meet 40 TAC §97.282, which requires a HCSSA to develop and enforce written policies that protect and promote the rights of all clients. The commenter further stated that §97.282 requires an agency to provide a client a written statement that informs a client that a complaint against the agency may be directed to DADS and inform clients of their right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency and clients must not be subjected to discrimination or reprisal for doing so. The commenter recommended contractors that are HCSSAs be excluded or that §49.309 be consistent with HCSSA licensure standards at 40 TAC §97.282.

Response: The agency did not make the recommended revision to §49.309. DADS acknowledges that §49.309 provides more specificity than §97.282 regarding a contractor's response to a complaint; however, §49.309 does not conflict with §97.282. Section 49.309 includes some additional requirements beyond those required to have a license. The agency believes the additional requirements are reasonable and provide additional protections for individuals receiving services under a contract. Specifically, §49.309 requires individuals to be informed of how they may file complaints when they begin receiving services and every 12 months thereafter. In addition, §49.309 also requires a contractor to provide information concerning the complaint and the investigation within 30 days after receiving the complaint.

Comment: Concerning §49.309(a)(1), a commenter requested clarification regarding the meaning of the phrase "complaint about services provided under a contract," and noted that the intent of the complaint process is to resolve complaints from program recipients, guardians, LARs, or others close to the person receiving services. Another commenter suggested that the rule should specifically state that a contractor is responsible for determining if a statement of dissatisfaction should be investigated as complaint.

Response: The agency did not revise the rule in response to the comment. The phrase is intended to cover complaints about a broad range of topics and from a variety of sources. A contractor must comply with the rule if the complaint relates to the services, even if indirectly. DADS will monitor contractors to determine if they are appropriately addressing complaints.

Comment: Concerning §49.309(a)(2), a commenter requested clarification as to whether providers need to document a request for a name if an anonymous complaint is received orally or in writing. The commenter recommended the text "except as provided by §49.309(a)(1)(B)" be added to sections requiring documentation of receipt of a complaint and follow-up requirements.

Response: The agency responds that a contractor should request the name, telephone number, and mailing address of a complainant, but should not require disclosure of that information. An anonymous complaint must be addressed in the same manner as one from a person who provides a name and contact information. To clarify this, the agency revised §49.309(a)(2)(A) to state that a contractor must request, but not require disclosure of, the name, address, and telephone number of a complainant. In addition, the agency revised §49.309(a)(2)(F) to specify that a contractor is only required to provide information to a complainant if the complainant provided a mailing address or telephone number. This change resolves any potential conflict between the requirement to provide information to a complainant and to allow anonymous complaints.

Comment: Concerning §49.310, a commenter recommended that contractors that are HCSSAs be excluded from that rule or that the section be consistent with §97.282 and §97.249, which require a HCSSA to notify clients of their right to right to be free from abuse, neglect, and exploitation; to adopt and enforce a written policy relating to the agency's procedures for reporting alleged acts of abuse, neglect, and exploitation; and, if an agency has cause to believe that a client served by the agency has been abused, neglected, or exploited by an agency employee, to report the information to Department of Family and Protective Services and DADS.

Response: The agency did not make the requested revision to §49.310. The requirements of Chapter 49 contain requirements for contractors of DADS, including those who receive Medicaid funds. Section 49.310 provides more specificity about procedures related to abuse, neglect, and exploitation to promote consistency across community-based contractors. The rules may be different from the licensing requirements, but they are not inconsistent.

Comment: Concerning §49.310(6), a commenter also stated that with regard to taking appropriate action when ANE is confirmed by investigative authority, HCSSAs are not currently entitled to dispositions of DFPS case investigation determinations.

Response: The agency has revised §49.310(6) and (7) to clarify that only a contractor that is notified of a confirmation of abuse, neglect, or exploitation is required to take action in response to the confirmation.

Comment: Concerning §49.411(b)(3)(C) and (D), a commenter stated HCSSAs must already meet 40 TAC §97.243, which requires an agency administrator to supervise and evaluate client satisfaction survey reports on all clients served. The commenter stated DADS Regulatory Services already conducts, at a minimum, an initial survey, a survey of the agency within 18 months after conducting an initial survey and conducts subsequent surveys at least every 36 months thereafter. DADS Regulatory Services also investigates complaints alleging abuse, neglect or exploitation as described in 40 TAC §97.501 - 97.502. The commenter recommended that contractors who are HCSSAs be excluded from the section or that the section be consistent with HCSSA requirements.

Response: The agency did not make the requested revision to §49.411(b)(3)(C)(D). The requirements of Chapter 49 contain requirements for contractors of DADS, including those who receive Medicaid funds. Section 49.310 provides more specificity about procedures related to abuse, neglect, and exploitation to promote consistency across community based contractors. The rules may be different from the HCSSA requirements, but they are not inconsistent.

Comment: Concerning §49.413(c), a commenter stated that depending on the number of records requested and the number of months to be reviewed, it may not be possible to provide the records in one hour due to running EVV systems. The commenter recommended adding a provision allowing DADS to agree to another time period.

Response: The agency has revised §49.413(c)(1) to acknowledge that DADS may agree to another time period in writing for a contractor to provide EVV reports.

Comment: Concerning §49.534(a)(2)(N), a commenter stated there are several scenarios in which the rule is a concern. For example, if a provider acquires a program from another provider in a particular area and a survey occurs while the new provider is working to address the issues with that program, the current language could allow for contract termination in that particular area of the state and in other contracts around the state.

The commenter also stated that larger providers may have various contracts throughout the state with unrelated management teams in each area, an issue in one area of the state does not necessarily indicate a statewide systemic problem, and a "proposed" action or sanction should not constitute good cause for actual termination of another contract when due process for the first contract has not been completed (and may not lead to termination).

Response: The agency did not make the requested revision to §49. 534(a)(2)(N). The agency acknowledges that it has broad authority under the rule to terminate a contract. However, the agency believes it is important to have the discretion to terminate one contract based on poor performance under another related contract. It is DADS intent to use discretion to terminate a contract judiciously to protect individuals against threats to their health and safety.

SUBCHAPTER A. DEFINITIONS

40 TAC §49.1

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. CONTRACTOR REQUIREMENTS

40 TAC §§49.11 - 49.18, 49.20

Statutory Authority

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER C. RECORDS

40 TAC §§49.31 - 49.33

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study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER D. BILLINGS AND PAYMENT

40 TAC §49.41, §49.42

Statutory Authority

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SUBCHAPTER E. AUDITS, MONITORING, AND REVEIWS

40 TAC §§49.51 - 49.54

Statutory Authority

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SUBCHAPTER F. SANCTIONS AND TERMINATIONS

40 TAC §§49.61 - 49.63

Statutory Authority

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER G. PERSONAL ATTENDANT WAGES

40 TAC §§49.71 - 49.73

Statutory Authority

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 49. CONTRACTING FOR COMMUNITY SERVICES

SUBCHAPTER A. APPLICATION AND DEFINITIONS

40 TAC §49.101, §49.102

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§49.101. Application.

(a) Except as provided in subsections (b) - (d) of this section, all of the subchapters of this chapter apply to an applicant or contractor for one or more of the following programs and services:

(1) Medicaid waiver programs and services under Title XIX, §1915(c) of the Social Security Act as follows:

(A) Community Living Assistance and Support Services (CLASS) Program:

(i) CLASS-case management agency (CMA);

(ii) CLASS-continued family services (CFS);

(iii) CLASS-direct service agency (DSA); and

(iv) CLASS-support family services (SFS);

(B) Deaf Blind with Multiple Disabilities (DBMD) Program;

(C) Home and Community Based Services (HCS) Program;

(D) Medically Dependent Children Program (MDCP):

(i) MDCP-adaptive aids (AA);

(ii) MDCP-home and community support services agency (HCSSA);

(iii) MDCP-minor home modifications; and

(iv) MDCP-out of home respite (OHR):

(I) MDCP-OHR-camp;

(II) MDCP-OHR-special care facility;

(III) MDCP-OHR-child care facility;

(IV) MDCP-OHR-nursing facility (NF);

(V) MDCP-OHR-hospital; and

(VI) MDCP-OHR-host family;

(E) Texas Home Living (TxHmL) Program; and

(F) transition assistance services (TAS);

(2) Medicaid state plan services under Title XIX, §1902(a)(10)(A) of the Social Security Act as follows:

(A) hospice;

(B) primary home care (PHC)/ community attendant services (CAS); and

(C) day activity and health services (DAHS);

(3) services and programs under Title XX, Subtitle A of the Social Security Act as follows:

(A) adult foster care (AFC);

(B) emergency response services;

(C) home delivered meals (HDM);

(D) residential care (RC);

(E) DAHS;

(F) family care (FC);

(G) consumer managed personal attendant services (CMPAS);

(H) special services to persons with disabilities (SSPD); and

(I) SSPD - 24-hour shared attendant care;

(4) relocation services; and

(5) financial management services under the consumer directed services option authorized under Texas Government Code, §531.051 as follows:

(A) financial management services agency (FMSA)--CLASS;

(B) FMSA-DBMD;

(C) FMSA-HCS;

(D) FMSA-MDCP;

(E) FMSA-PHC/CAS/FC; and

(F) FMSA-TxHmL.

(b) Subchapter D of this chapter (relating to Monitoring and Investigation of a Contractor) and Subchapter E, Divisions 2 and 3 of this chapter (relating to Immediate Protection; and Actions) do not apply to a contractor that has a contract for:

(1) the HCS Program; or

(2) the TxHmL Program.

(c) Subchapter D of this chapter and §49.523 of this chapter (relating to Referral Hold) do not apply to a contractor that has a contract for hospice.

(d) Sections 49.202 - 49.205 and §§49.207 - 49.211 of this chapter (relating to Provisional Contract; Provisional Contract Application Process; Additional Provisional Contract Application Requirements; License, Certification, Accreditation, and Other Requirements; Provisional Contract Application Denial; Provisional Contract Application Approval; Standard Contract; Contractor Change of Ownership or Legal Entity; and Religious Organization Applicants) and Subchapter G of this chapter (relating to Application Denial Period) do not apply to a contractor that has a contract for:

(1) CMPAS;

(2) SSPD;

(3) SSPD - 24-hour shared attendant care; or

(4) relocation services.

§49.102. Definitions.

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

(1) AA--Adaptive aids.

(2) Abuse--Abuse as defined in Texas Human Resources Code, §48.002 or, in reference to children, Texas Family Code, §261.001.

(3) AFC--Adult foster care.

(4) Applicant--A person seeking to obtain a contract.

(5) Application denial period--A period of time during which DADS denies a contract application submitted to DADS.

(6) Business day--Any day except a Saturday, a Sunday, or a national or state holiday listed in Texas Government Code §662.003(a) or (b).

(7) CAS--Community attendant services.

(8) CFS--Continued family services.

(9) Change of legal entity--An event that occurs when a contractor is required to obtain a new federal tax identification number.

(10) Change of ownership--An event that occurs when:

(A) as a result of a transfer or sale, at least 50 percent of the ownership of a contractor is held by one or more persons who owned less than 5 percent of the contractor before the transfer or sale; and

(B) the contractor is not required to obtain a new federal tax identification number.

(11) Choice list--A list of contractors from which an individual or LAR chooses to receive services unless DADS has imposed a referral hold on the contractor.

(12) CLASS Program--Community Living Assistance and Support Services Program.

(13) Clean claim--In accordance with Code of Federal Regulations, Title 42, §447.45(b), a claim for services submitted by a contractor that can be processed without obtaining additional information from the contractor or a party other than DADS, including a claim with errors originating in the Texas claims management system, but not including a claim from a contractor under investigation for fraud or abuse, or a claim under review for medical necessity.

(14) CMA--Case management agency.

(15) CMPAS--Consumer managed personal attendant services.

(16) Contract--A written agreement between DADS and another person that obligates the other person to provide a service described in §49.101 of this subchapter (relating to Application) in exchange for payment from DADS. The term includes standard and provisional contracts.

(17) Contractor--The person other than DADS who is a party to a contract.

(18) Contractual agreement--A written, legally binding agreement that is not a contract as defined in this section.

(19) Controlling ownership interest--A direct ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interests, of 5 percent or more in an applicant or contractor.

(20) Controlling person--A person who:

(A) has a controlling ownership interest;

(B) is a managing employee;

(C) has been delegated the authority to obligate or act on behalf of an applicant or contractor;

(D) is an officer or director of a corporation that is an applicant or contractor;

(E) is a partner in a partnership that is an applicant or contractor;

(F) is a member or manager in a limited liability company that is an applicant or contractor;

(G) is a trustee or trust manager of a trust that is an applicant or contractor;

(H) is a spouse of a person who is an applicant or contractor; or

(I) because of a personal, familial, or other relationship with an applicant or contractor, is in a position of actual control or authority with respect to the applicant or contractor, regardless of the person's title.

(21) Conviction--A determination of being found or proved guilty that:

(A) is any of the following:

(i) a judgment of conviction that has been entered by a federal, state or local court, regardless of whether:

(I) there is a post-trial motion or an appeal pending; or

(II) the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(ii) a finding of guilt made by a federal, state, or local court; or

(iii) an acceptance of a plea of guilty or nolo contendere by a federal, state, or local court; and

(B) does not include successful completion of a period of deferred adjudication community supervision and receipt of a dismissal and discharge in accordance with Texas Code of Criminal Procedure, Article 42.12, Section 5(c).

(22) DADS--The Department of Aging and Disability Services.

(23) DADS debarment list--A list, made before the effective date of this chapter, of persons and entities prohibited by DADS from conducting business with DADS in any capacity for a specified period.

(24) DAHS--Day activity and health services.

(25) Day--A calendar day, including weekends and holidays.

(26) DBMD Program--Deaf Blind with Multiple Disabilities Program.

(27) Desk review--A review by DADS of a contractor's service delivery or business operation that takes place away from the contractor's administrative and service delivery sites, using records provided to DADS by the contractor. The scope of the review is at the discretion of DADS.

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

(29) Direct ownership interest--An interest in the ownership of an applicant or contractor as described in subparagraphs (A) and (B) of this paragraph.

(A) Direct ownership interest is:

(i) ownership of equity in the capital, stock, or profits of an applicant or contractor; or

(ii) ownership in a mortgage, deed of trust, note, or other obligation secured by property of an applicant or contractor.

(B) The percentage of direct ownership interest of an applicant or contractor, based on ownership of a mortgage, deed of trust, note, or other obligation, is determined by multiplying the percentage of ownership in the obligation by the percentage of the applicant's or contractor's assets used to secure the obligation. For example, ownership of 10 percent of a note secured by 60 percent of a contractor's or applicant's assets equals 6 percent direct ownership interest in the applicant or contractor (that is, 0.1 x 0.6 = 0.06).

(30) DSA--Direct service agency.

(31) Exploitation--Exploitation as defined in Texas Human Resources Code, §48.002.

(32) Electronic record--Information that is stored in a medium having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities, and is retrievable in perceivable form.

(33) FC--Family care.

(34) FMSA--Financial management services agency. An entity that contracts with DADS to provide financial management services, as defined in §41.103 of this title (relating to Definitions).

(35) Governmental entity--An agency or other entity of federal, state, or local government.

(36) HCS Program--Home and Community Based Services Program.

(37) HCSSA--Home and community support services agency.

(38) HDM--Home delivered meals.

(39) HHSC--The Texas Health and Human Services Commission.

(40) Indirect ownership interest--An interest in the ownership of an applicant or contractor as described in subparagraphs (A) and (B) of this paragraph.

(A) Indirect ownership interest is an ownership interest in a person that has a direct or indirect ownership interest in an applicant or contractor.

(B) The percentage of indirect ownership interest is determined by multiplying the percentage of ownership interest in the person that has a direct ownership interest in the applicant or contractor by the percentage of direct ownership that the person has in the applicant or contractor. For example:

(i) ownership of 10 percent of the stock of a corporation that owns 80 percent of the stock of an applicant or contractor equals 8 percent indirect ownership of the applicant or contractor (that is, 0.1 x 0.8 = 0.08); and

(ii) ownership of 50 percent of the stock of a corporation that owns 10 percent of the stock of a corporation that owns 80 percent of the stock of an applicant or contractor equals 4 percent indirect ownership of the applicant or contractor (that is, 0.5 x 0.1 x 0.8 = 0.04).

(41) Individual--A person who is enrolled in a program or service described in §49.101(a) of this subchapter.

(42) LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a particular matter. The term may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(43) LEIE--List of excluded individuals and entities. In this context, "individual" does not have the meaning as defined in this section.

(44) Local authority--An entity to which HHSC's authority and responsibility, as described in Texas Health and Safety Code, §531.002(11), has been delegated.

(45) Managing employee--A person who exercises operational or managerial control over, or who conducts the day-to-day operation of, an applicant or contractor.

(46) MDCP--Medically Dependent Children Program.

(47) Neglect--Neglect as defined in Texas Human Resources Code, §48.002 or, in reference to children, Texas Family Code, §261.001.

(48) OHR--Out of home respite.

(49) Paper record--Information that is stored on paper.

(50) Person--A corporation, organization, government or governmental subdivision or agency, business trust, estate, trust, partnership, association, natural person, or any other legal entity that can function legally, sue or be sued, and make decisions through agents.

(51) Personal attendant--An employee or subcontractor of a contractor or an employee of a CDS employer who provides:

(A) PHC;

(B) FC;

(C) CAS;

(D) DAHS;

(E) RC;

(F) flexible family support in MDCP;

(G) respite services in MDCP;

(H) personal attendant services in the CMPAS Program;

(I) habilitation in the CLASS Program;

(J) residential habilitation in the DBMD Program;

(K) chore services in the DBMD Program;

(L) day habilitation in the DBMD Program;

(M) supported home living in the HCS Program; or

(N) community support in the TxHmL Program.

(52) PHC--Primary home care.

(53) Provisional contract--An initial contract that DADS enters into in accordance with §49.208 of this chapter (relating to Provisional Contract Application Approval) that has a stated expiration date.

(54) RC--Residential care.

(55) Records--Paper records and electronic records.

(56) Recoup--To reduce payments that are due to a contractor under a contract to satisfy a debt the contractor owes to DADS but does not include making routine adjustments for prior overpayments to the contractor.

(57) Referral hold--An action in which DADS prohibits a contractor from, for a period of time determined by DADS, providing services to an individual not receiving services from the contractor at the time the referral hold was imposed.

(58) SFS--Support family services.

(59) SSPD--Special Services to Persons with Disabilities (SSPD) Program.

(60) Standard contract--A contract that DADS enters into in accordance with §49.209 of this chapter (relating to Standard Contract) that does not have a stated expiration date.

(61) Subcontract--An agreement, other than a contract, between a contractor and another person that obligates the other person to provide all or part of the goods, services, work, or materials required of the contractor in a contract.

(62) Subcontractor--The person other than a contractor who is a party to a subcontract.

(63) TAS--Transition assistance services.

(64) TxHmL Program--Texas Home Living Program.

(65) Vendor hold--A temporary suspension of payments that are due to a contractor under a contract.

(66) Volunteer--A person who works for a contractor without compensation, other than reimbursement for actual expenses.

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SUBCHAPTER B. CONTRACTOR ENROLLMENT

40 TAC §§49.201 - 49.211

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§49.204. Additional Provisional Contract Application Requirements.

(a) An applicant that is licensed as an assisted living facility, applies for a Title XX RC contract, and otherwise meets application requirements must meet the requirements in §46.13 of this title (relating to Housing Options), as determined by DADS based on an on-site visit.

(b) An applicant that applies for a Title XX AFC contract and otherwise meets application requirements must meet the requirements in Chapter 48, Subchapter K of this title (relating to Minimum Standards for Adult Foster Care).

(c) Except as provided in subsections (d) and (e) of this section, an applicant that applies for an HCS or TxHmL contract and otherwise meets application requirements must complete provider applicant training and receive a score of at least 85 percent on the provider competency examination.

(d) An applicant that applies for an HCS contract does not have to complete provider applicant training or take the provider competency examination if the applicant otherwise meets application requirements and has a standard contract for the HCS Program in another service area.

(e) An applicant that applies for a TxHmL contract does not have to complete provider applicant training or take the provider competency examination if the applicant otherwise meets application requirements and has a standard contract for the HCS Program or TxHmL Program in another service area.

§49.205. License, Certification, Accreditation, and Other Requirements.

(a) To be a contractor, an applicant must have a license, certification, accreditation, or other document as follows:

(1) CLASS-CFS and CLASS-SFS require:

(A) a permit to operate a child-placing agency issued by DFPS in accordance with Chapter 745 of this title (relating to Licensing); or

(B) a HCSSA license issued by DADS in accordance with Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies) with:

(i) the licensed home health services (LHHS) category; or

(ii) the licensed and certified home health services (L&CHHS) category;

(2) CLASS-DSA requires a HCSSA license issued by DADS in accordance with Chapter 97 of this title with:

(A) the LHHS category; or

(B) the L&CHHS category;

(3) DBMD requires:

(A) a HCSSA license issued by DADS in accordance with Chapter 97 of this title with:

(i) the LHHS category; or

(ii) the L&CHHS category; and

(B) for a contractor that provides residential services to four to six individuals, an assisted living facility license Type A or Type B issued by DADS in accordance with Chapter 92 of this title (relating to Licensing Standards for Assisted Living Facilities);

(4) MDCP-AA requires, for a contractor that provides vehicle modification services, a copy of a current contractual agreement with the Department of Assistive and Rehabilitative Services (DARS) to provide vehicle modification services;

(5) MDCP-HCSSA requires a HCSSA license issued by DADS in accordance with Chapter 97 of this title with:

(A) the personal assistance services (PAS) category;

(B) the LHHS category; or

(C) the L&CHHS category;

(6) MDCP-OHR-camp requires written accreditation by the American Camping Association for providing summer camp services;

(7) MDCP-OHR-special care facility requires a special care facility license issued by the Department of State Health Services (DSHS) in accordance with 25 TAC Chapter 125 (relating to Special Care Facilities);

(8) MDCP-OHR-child care facility requires a child-care center license issued by DFPS in accordance with Chapter 745 of this title;

(9) MDCP-OHR-NF requires a nursing facility license issued by DADS in accordance with Chapter 19 of this title (relating to Nursing Facility Requirements for Licensure and Medicaid Certification);

(10) MDCP-OHR-hospital requires a hospital license issued by DSHS in accordance with 25 TAC Chapter 133 (relating to Hospital Licensing);

(11) MDCP-OHR-host family requires a foster family home license issued by DFPS in accordance with Chapter 745 of this title or verification as a child-placing agency foster family home issued by a child placing agency in accordance with Chapter 749 of this title (relating to Minimum Standards for Child-Placing Agencies);

(12) TAS requires:

(A) written documentation from DARS or the Rehabilitation Services Administration that the applicant is a center for independent living, as defined by 29 United States Code §796a;

(B) a contract other than the TAS contract; or

(C) written designation by DADS as an area agency on aging;

(13) Medicaid hospice requires:

(A) a HCSSA license for hospice issued by DADS in accordance with Chapter 97 of this title; and

(B) a written notification from the Centers for Medicare and Medicaid Services that the applicant is certified to participate as a hospice agency in the Medicare Program;

(14) PHC/CAS, and FC require a HCSSA license issued by DADS in accordance with Chapter 97 of this title with:

(A) the LHHS category;

(B) the L&CHHS category; or

(C) the PAS category;

(15) DAHS requires an adult day care license issued by DADS in accordance with Chapter 98 of this title (relating to Adult Day Care and Day Activity and Health Services Requirements);

(16) Title XX AFC requires for an AFC facility serving four to eight individuals, an assisted living facility license Type A or Type B issued by DADS in accordance with Chapter 92 of this title;

(17) Title XX ERS requires:

(A) a license as a personal emergency response system provider issued by DSHS in accordance with 25 TAC Chapter 140, Subchapter B (relating to Personal Emergency Response System Providers); or

(B) a license as an alarm systems company issued by the Texas Private Security Board in accordance with the Texas Occupations Code, Chapter 1702; and

(18) Title XX RC requires an assisted living facility license Type A or Type B issued by DADS in accordance with Chapter 92 of this title.

(b) The license, certification, accreditation, or other document required by subsection (a) of this section must be valid in the service or catchment area:

(1) in which the applicant is seeking to provide services; or

(2) covered under the contractor's contract.

§49.208. Provisional Contract Application Approval.

(a) DADS approves a provisional contract application if it is not denied in accordance with §49.207 of this subchapter (relating to Provisional Contract Application Denial).

(b) If DADS approves a provisional contract application, DADS:

(1) provides written notification to the applicant;

(2) enters into a provisional contract with the applicant; and

(3) except as provided in §49.302(b) (relating to General Requirements), places the contractor's name on the choice list for the program or service covered by the provisional contract.

(c) A provisional contract may be subject to conditions recommended by HHSC in accordance with 1 TAC Chapter 352 (relating to Medicaid and the Children's Health Insurance Program Provider Enrollment) and 1 TAC Chapter 371, Subchapter E (relating to Provider Disclosure and Screening).

(d) The effective date of a provisional contract is as follows:

(1) if the applicant applied for the contract in accordance with §49.210(a)(2) of this subchapter (relating to Contractor Change of Ownership or Legal Entity), the effective date is the effective date of the change of ownership or legal entity of the contractor; or

(2) for an applicant other than one described in paragraph (1) of this subsection, the effective date is determined by DADS.

(e) DADS and a contractor may agree to extend the term of a provisional contract. The extension of a provisional contract is not a determination by DADS that the contractor qualifies for a standard contract.

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SUBCHAPTER C. REQUIREMENTS OF A CONTRACTOR

40 TAC §§49.301 - 49.312

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§49.304. Background Checks.

(a) A contractor that is required to have a license, as described in §49.302(a) of this subchapter (relating to General Requirements), must comply with licensure requirements regarding criminal history record checks, the employee misconduct registry and the nurse aide registry for employees, subcontractors, and volunteers.

(b) A contractor that is not required to have a license, as described in §49.302(a) of this subchapter, must:

(1) before offering employment to an unlicensed applicant for employment or contracting with an unlicensed potential subcontractor, obtain directly or through a private agency the criminal history record of the applicant or potential subcontractor from the Department of Public Safety (DPS);

(2) before accepting an unlicensed volunteer applicant for a volunteer position that directly interacts with an individual, obtain directly or through a private agency the criminal history record of the applicant from DPS;

(3) review the criminal history record of the unlicensed applicant or potential subcontractor;

(4) not employ an unlicensed applicant for employment, contract with an unlicensed potential subcontractor, or accept an unlicensed applicant for a volunteer position, for the time periods set forth in Texas Health and Safety Code, §250.006, if the applicant or potential subcontractor has been convicted of an offense listed in Texas Health and Safety Code, §250.006; and

(5) not employ an unlicensed applicant for employment, contract with an unlicensed potential subcontractor, or accept an unlicensed applicant for a volunteer position if the applicant or potential subcontractor has been convicted of an offense that the contractor determines is a contraindication to the applicant's employment, contracting, or volunteering.

(c) A contractor that is not required to have a license, as described in §49.302(a) of this subchapter, must:

(1) before offering employment to an unlicensed applicant for employment or contracting with an unlicensed potential subcontractor, search DADS Employee Misconduct Registry and the Nurse Aide Registry for the name of the applicant or potential subcontractor;

(2) before accepting an unlicensed volunteer applicant for a volunteer position that directly interacts with an individual, search

DADS Employee Misconduct Registry and the Nurse Aide Registry for the name of the applicant; and

(3) not employ an unlicensed applicant for employment, contract with a unlicensed potential subcontractor, or accept an unlicensed applicant for a volunteer position if the applicant or potential subcontractor is listed on:

(A) the DADS Employee Misconduct Registry as unemployable; or

(B) the Nurse Aide Registry as revoked or suspended.

(d) A contractor must:

(1) before contracting with a potential subcontractor or offering employment to an applicant for employment, search the Debarred Vendor List maintained by the Texas Comptroller of Public Accounts; and

(2) not contract with the potential subcontractor or employ the applicant if the potential subcontractor or applicant is listed on the Debarred Vendor List and the period of debarment has not expired.

(e) A contractor must develop and implement a policy that requires an employee, volunteer, or subcontractor to report to the contractor if any of the information obtained in accordance with subsection (b)(1), (c)(1), or (d)(1) of this section has changed. If a contractor becomes aware that information the contractor obtained in accordance with subsection (b)(1), (c)(1), or (d)(1) of this section was erroneous or has subsequently changed so the contractor would not be allowed to employ the person, contract with the person, or accept the person for volunteer status in accordance with subsection (b)(3) or (4), (c)(2), or (d)(2) of this section, the contractor must terminate the person's employment, volunteer status, or contract.

(f) A contractor must:

(1) review the LEIE maintained by the United States Department of Health and Human Services, Office of Inspector General, and the LEIE maintained by the Texas Health and Human Services Commission, Office of Inspector General:

(A) before hiring an applicant for employment or contracting with a potential subcontractor; and

(B) at least monthly, for each employee and subcontractor;

(2) not employ an applicant for employment or contract with a potential subcontractor to perform any duties that may be paid for directly or indirectly through a contract if the applicant or potential subcontractor is listed on either LEIE described in paragraph (1) of this subsection;

(3) prohibit an employee or subcontractor listed on either LEIE described in paragraph (1) of this subsection from performing any duties that may be paid for directly or indirectly through a contract; and

(4) if an employee or subcontractor is listed on either LEIE described in paragraph (1) of this subsection, immediately report to HHSC, Office of Inspector General, the identity of an excluded employee or subcontractor and amount paid by the contractor to the employee or subcontractor for services provided under a contract in accordance with the self-reporting protocol of HHSC, Office of Inspector General.

§49.305. Records.

(a) A contractor must develop and maintain records in accordance with its contract, this subchapter, and DADS rules governing services provided under the contract.

(b) A contractor must:

(1) use forms required by DADS or, if a specific form is not required by DADS, develop records that include elements required by DADS; and

(2) ensure that:

(A) a beginning time for a service is not documented until after the service being documented has been initiated; and

(B) an ending time or a time period for a service is not documented until after the service has been provided.

(c) A contractor's records must support a claim for services submitted under its contract.

(d) A contractor's records must be maintained in accordance with generally accepted accounting principles, referred to as GAAP, established by the Financial Accounting Standards Board.

(e) A contractor must develop and maintain records that:

(1) document the extent of services provided;

(2) document compliance with this chapter; and

(3) include records required by rules governing services provided under its contract.

(f) A contractor must develop and maintain records for an employee, subcontractor, or volunteer that include:

(1) a description of the employee, subcontractor, or volunteer's responsibilities;

(2) the employee's completed application;

(3) records that the employee, subcontractor, or volunteer is qualified for the position for which the person is employed, contracting, or volunteering, in accordance with rules governing services provided under the contract;

(4) records that the contractor conducted the reviews described in §49.304 of this subchapter (relating to Background Checks);

(5) records that the employee, subcontractor, or volunteer received any training required by rules governing services provided under the contract; and

(6) records of any disciplinary action.

(g) For purposes of subsection (f)(4) of this section, records maintained to show compliance with §49.304(f) of this subchapter must include:

(1) documentation of the first and last name, date of birth, and social security or employer identification number of an employee or subcontractor required to be the subject of a review described in §49.304(f)(1) of this subchapter;

(2) the printed first and last name and signature of the person conducting the review;

(3) documentation of the date the review was conducted;

(4) documentation of whether the employee and subcontractor who was the subject of the review was listed on either of the LEIEs described in §49.304(f)(1) of this subchapter; and

(5) a copy of the report made in accordance with §49.304(f)(4) of this subchapter.

(h) A contractor must develop and implement written procedures to:

(1) prevent falsification or unauthorized access, disclosure, modification, or destruction of records and data;

(2) ensure the availability, integrity, authenticity, completeness, and confidentiality of records and data; and

(3) ensure that appropriate audit trails and sufficiently complete transaction histories are maintained to identify the person or position that makes an entry, modification, or correction to records or data that supports a claim for services under its contract.

(i) If a contractor uses paper records described in this section, the contractor must:

(1) ensure records are completed in ink;

(2) retain the original records;

(3) except as provided in DADS rules governing services provided under the contract, ensure records are signed and dated by the person making the entry;

(4) ensure a stamped signature is used only by a person with a disability as an accommodation for the disability; and

(5) ensure that if a correction to records is necessary, the correction is made by:

(A) marking a single line through the error;

(B) adding the date the correction was made and the initials of the person who made the correction; and

(C) not using correction fluid or tape or otherwise obliterating the original entry.

(j) If a contractor uses electronic records described in this section:

(1) develop and implement written procedures, which must include maintaining current virus protection software, to prevent the loss or corruption of data due to malicious code;

(2) develop and implement written procedures governing the use of electronic signatures that:

(A) ensure authenticity of an electronic signature;

(B) describe the method of authentication used, such as password, personal identification number, digital signature, or other unique identifier, by document type;

(C) identify the person or position who is authorized to sign electronically by document type; and

(D) describe security measures used to prevent unauthorized use of electronic signatures; and

(3) use an electronic record system that:

(A) documents any change in content that was made to the electronic record;

(B) documents the date the change was made;

(C) documents the name and employee number or other unique identifier of the person who made the change; and

(D) allows a record to be retrievable as a paper record.

(k) A contractor must:

(1) ensure records are available for review in accordance with the contract; and

(2) as requested by DADS or any federal or state agency authorized to have access to records:

(A) provide, at no charge, a copy of any records to DADS and the federal or state agency in the form requested by DADS or the federal or state agency; or

(B) allow DADS and the federal or state agency to make a copy of any records, at no charge.

§49.308. Subcontracts.

If a contractor uses a subcontractor to provide a service to an individual, the contractor must:

(1) have a written agreement with the subcontractor that requires the subcontractor and any of its subcontractors to comply with applicable provisions of the contract, this subchapter, and DADS rules governing services provided under the contract, as if the subcontractor and its subcontractors were the contractor;

(2) monitor the subcontractor to ensure that the subcontractor is in compliance with the written agreement referenced in paragraph (1) of this section; and

(3) maintain records of its monitoring of the subcontractor.

§49.309. Complaint Process.

(a) A contractor must develop and implement written procedures for investigating and resolving a complaint about services provided under a contract, other than an allegation of abuse, neglect, or exploitation, that:

(1) allow a complaint to be submitted to the contractor:

(A) either orally or in writing; and

(B) anonymously; and

(2) require the contractor to:

(A) request, but not require disclosure of, the name, mailing address, and telephone number of a complainant;

(B) investigate and resolve a complaint within 30 days after the complaint is received by the contractor;

(C) document the name of the person who conducted the investigation;

(D) document the name of persons contacted during an investigation;

(E) obtain written statements from persons contacted during an investigation or document conversations with those persons; and

(F) provide the following information to the complainant within 30 days after a complaint is received by the contractor, unless the complainant did not provide a mailing address or phone number:

(i) the findings of the investigation;

(ii) the contractor's resolution of the complaint;

(iii) the telephone number of the DADS Consumer Rights and Services hotline (1-800-458- 9858); and

(iv) an explanation that the DADS hotline may be used if the complainant is not satisfied with the contractor's resolution of the complaint.

(b) The contractor must give the information described in subsection (a)(2)(F) of this section as follows:

(1) in person, if the complainant is the individual receiving services; or

(2) if the complainant is not the individual receiving services:

(A) by mail, if the contractor knows the complainant's mailing address; or

(B) by telephone, if the contractor does not know the complainant's mailing address, but knows the complainant's telephone number.

(c) A contractor must maintain a written log that contains the following information:

(1) the date the contractor received a complaint;

(2) a description of the complaint;

(3) the findings of the investigation;

(4) the contractor's resolution of the complaint and the date of resolution; and

(5) the date the contractor provided information to the complainant in accordance with subsection (b) of this section.

(d) A contractor must provide the following information to an individual and LAR:

(1) a description of the contractor's complaint process;

(2) the telephone number of the DADS Consumer Rights and Services hotline (1-800-458-9858); and

(3) an explanation that the DADS hotline may be used to file a complaint with DADS.

(e) A contractor must provide the information described in subsection (d) of this section orally and in writing, as follows:

(1) before or at the time the individual begins receiving program services from the contractor; and

(2) at least once every 12 months thereafter.

§49.310. Abuse, Neglect, and Exploitation Allegations.

A contractor must develop and implement written procedures for reporting and investigating an allegation of abuse, neglect or exploitation regarding an individual that:

(1) comply with applicable laws and rules governing services provided under the contract;

(2) require the contractor to report an allegation of abuse, neglect, or exploitation to the appropriate investigative authority;

(3) ensure that the contractor's employees, subcontractors, and volunteers:

(A) are knowledgeable of:

(i) acts that constitute abuse, neglect, or exploitation of an individual;

(ii) the requirement to report acts of abuse, neglect, or exploitation, or suspicion of such acts to the appropriate investigative authority;

(iii) how to report allegations of abuse, neglect, or exploitation to the appropriate investigative authority; and

(iv) methods to prevent the occurrence of abuse, neglect, and exploitation; and

(B) report suspected abuse, neglect, or exploitation as instructed by the contractor;

(4) ensure that individuals and LARs are informed, orally and in writing, of how to report allegations of abuse, neglect, or exploitation:

(A) before or at the time the individual begins receiving program services from the contractor; and

(B) at least once every 12 months thereafter;

(5) if the contractor suspects an individual has been or is being abused, neglected, or exploited or is notified of an allegation of abuse, neglect, or exploitation, require the contractor to:

(A) take necessary actions to secure the safety of the individual; and

(B) notify, as soon as possible but no later than 24 hours after the contractor reports or is notified of an allegation, the individual, or the individual's LAR of the allegation report and the actions that have been or will be taken;

(6) if abuse, neglect, or exploitation is confirmed by the investigative authority and the contractor is notified of the confirmation, require the contractor to take appropriate action to prevent the reoccurrence of abuse, neglect or exploitation, including, when warranted, disciplinary action against the employee, subcontractor, or volunteer confirmed to have committed abuse, neglect, and exploitation;

(7) at least annually, require the contractor to review incidents of confirmed abuse, neglect, or exploitation of which the contractor is notified and identify program process improvements that will prevent the reoccurrence of such incidents and improve service delivery; and

(8) prohibit the contractor from discharging or otherwise retaliating against:

(A) an employee, subcontractor, volunteer, individual, or other person because the employee, subcontractor, volunteer, individual, or other person files a complaint, presents a grievance, or otherwise provides good faith information relating to possible abuse, neglect, or exploitation of an individual; or

(B) an individual because someone on behalf of the individual files a complaint, presents a grievance, or otherwise provides good faith information relating to possible abuse, neglect, or exploitation of the individual.

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SUBCHAPTER D. MONITORING AND INVESTIGATION OF A CONTRACTOR

DIVISION 1. APPLICABILITY OF SUBCHAPTER

40 TAC §49.401

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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DIVISION 2. MONITORING AND INVESTIGATION

40 TAC §§49.411 - 49.414

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§49.413. Investigation.

(a) If DADS receives an oral or written allegation that indicates a contractor may have violated a contract or program requirement, DADS conducts an unannounced investigation of the contractor. The investigation is conducted on-site or by a desk review.

(b) To conduct an investigation, DADS:

(1) conducts an entrance conference with the contractor if the investigation is conducted on-site;

(2) performs other activities, which may include:

(A) reviewing the contractor's records;

(B) reviewing the contractor's policies and procedures;

(C) reviewing consumer satisfaction surveys;

(D) interviewing a person with knowledge relevant to the contract, including an individual receiving services or the contractor's employee; and

(E) observing an individual receiving services.

(c) A contractor must provide records requested by DADS as follows:

(1) for an investigation conducted on-site, the contractor must provide the records to DADS within one hour after the entrance conference described in subsection (b)(1) of this section, unless another time period is agreed to by DADS in writing for an EVV report; and

(2) for an investigation conducted by a desk review, the contractor must provide the records to DADS within one business day after DADS request.

(d) DADS notifies the contractor, in writing, of the results of the investigation.

(e) If, based on an investigation, DADS determines that the contractor is out of compliance with the contract, DADS may:

(1) impose an action or sanction in accordance with Subchapter E of this chapter (relating to Enforcement by DADS and Termination by Contractor);

(2) conduct additional monitoring in accordance with §49.411 of this division (relating to Contract and Fiscal Monitoring) or §49.412 of this division (relating to Financial Monitoring of FMSAs); or

(3) take a combination of the actions described in paragraphs (1) and (2) of this subsection.

(f) If, during an investigation, DADS determines that the contractor is not protecting an individual's health and safety, DADS may require the contractor to:

(1) immediately protect the individual's health and safety; and

(2) submit an immediate protection plan in accordance with §49.511 of this chapter (relating to Immediate Protection and Immediate Protection Plan).

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SUBCHAPTER E. ENFORCEMENT BY DADS AND TERMINATION BY CONTRACTOR

DIVISION 1. APPLICABILITY OF SUBCHAPTER

40 TAC §49.501

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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DIVISION 2. IMMEDIATE PROTECTION

40 TAC §49.511

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DIVISION 3. ACTIONS

40 TAC §§49.521 - 49.523

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§49.522. Corrective Action Plan.

(a) DADS requires corrective action if the contractor's compliance score for a standard is less than 90 percent as described in §49.411(d) of this chapter (relating to Contract and Fiscal Monitoring).

(b) DADS may require corrective action if DADS determines the contractor has not complied with its contract, including a determination of non-compliance described in §49.411(e) of this chapter, §49.412(d) of this chapter (relating to Financial Monitoring of FMSAs), or §49.413(e) of this chapter (relating to Investigation). Corrective action may include the contractor paying or ensuring payment to a personal attendant who was not paid the wage required by §49.312 of this chapter (relating to Personal Attendants) the difference between the amount required and the amount paid to the personal attendant.

(c) If DADS requires corrective action in accordance with subsection (a) or (b) of this section, DADS notifies the contractor in writing that the contractor must submit and implement a written corrective action plan.

(d) If DADS notifies the contractor in accordance with subsection (c) of this section, the contractor must submit a written corrective action plan to DADS within 10 business days after the date of the notice from DADS.

(e) A corrective action plan submitted in accordance with subsection (c) of this section must:

(1) describe the non-compliance that DADS identified from the monitoring or investigation resulting in the corrective action plan;

(2) describe the activities the contractor will perform to correct or prevent the non-compliance described in paragraph (1) of this subsection from reoccurring;

(3) include the title of the person responsible for performing the activities described in paragraph (2) of this subsection; and

(4) include a schedule for performing the activities described in paragraph (2) of this subsection.

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DIVISION 4. SANCTIONS

40 TAC §§49.531 - 49.534

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DIVISION 5. APPEALS

40 TAC §49.541

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DIVISION 6. TERMINATION BY CONTRACTOR

40 TAC §49.551

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§49.551. Termination of Contract by Contractor.

(a) If a contractor intends to terminate a contract, the contractor must notify DADS of the intended termination. The notification must:

(1) include:

(A) the contract number;

(B) the type of program or service; and

(C) the effective date of the termination; and

(2) be received by DADS at least 60 days before the effective date of the termination.

(b) If a contractor notifies DADS that it intends to terminate a contract, the contractor must:

(1) cooperate fully with DADS, the local authority if applicable, and other contractors to transfer individuals receiving services from the contractor; and

(2) submit documentation or take other action as directed by DADS.

(c) If DADS receives notification that a contractor intends to terminate a contract, DADS:

(1) notifies individuals receiving services from the contractor or LARs that:

(A) the contractor is terminating the contract and that DADS has placed or will place the contractor's payments on a vendor hold; and

(B) that the individuals or LARs may choose to receive services from a contractor listed on the choice list, subject to program-specific requirements; and

(2) removes the contractor's name from the appropriate choice list.

(d) If a contractor terminates a contract, DADS notifies the contractor and any controlling person, in writing, of the application denial period set in accordance with §49.702(e) or (f) of this chapter (relating to Application Denial Period).

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For further information, please call: (512) 438-3734

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SUBCHAPTER F. REVIEW BY DADS OF EXPIRING OR TERMINATED CONTRACT

40 TAC §49.601

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER G. APPLICATION DENIAL PERIOD

40 TAC §49.701, §49.702

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 51. MEDICALLY DEPENDENT CHILDREN PROGRAM

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §51.103, concerning definitions; §51.203, concerning eligibility requirements; §51.219, concerning maintaining enrollment; §51.231, concerning service limitations; §51.233, concerning choosing a provider; §51.235, concerning consumer directed services option; §51.237, concerning service schedule changes; §51.241, concerning service suspensions; §51.243, concerning service reductions, service denials, and case closures; §51.245, concerning respite services or adaptive aids outside of the contracted service delivery area; §51.251, concerning appeals; §51.401, concerning contracting requirements; §51.411, concerning general service delivery requirements; §51.415, concerning notification to the individual; §51.417, concerning notification to the case manager; §51.419, concerning service suspensions; §51.471, concerning

general requirements; §51.475, concerning inspection and follow-up; §51.505, concerning purchase completion documentation; §51.509, concerning claims and service delivery records; §51.511, concerning billable time and activities; §51.513, concerning non-billable time and activities; and §51.515, concerning record keeping; new §51.413, concerning response to service authorization; §51.418, concerning protective devices; §51.421, concerning requirements for attendants providing respite and flexible family support services; §51.423, concerning respite and flexible family support services; §51.441, concerning CDS backup plans; §51.481, concerning employment assistance; §51.483, concerning supported employment; and §51.485, concerning service provider qualifications for providing employment assistance and supported employment; and the repeals of §51.205, concerning disability criteria; §51.232, concerning exception to service limit; §51.413, concerning response to service authorization; §51.421, concerning requirements for attendants; §51.441, concerning consumer directed services; §51.501, concerning service delivery record; §51.503, concerning in-home record; and §51.507, concerning reimbursement, in Chapter 51, Medically Dependent Children Program. The amendments to §§51.103, 51.203, 51.241, 51.243, 51.251, 51.411, 51.511 and new §§51.418, 51.423, 51.481, 51.483, and 51.485 are adopted with changes to the proposed text published in the April 18, 2014 issue of the *Texas Register* (39 TexReg 3179). The amendments to §§51.219, 51.231, 51.233, 51.235, 51.237, 51.245, 51.401, 51.415, 51.417, 51.419, 51.471, 51.475, 51.505, 51.509, 51.513, 51.515; new §§51.413, 51.421, and 51.441, and the repeal of §§51.205, 51.232, 51.413, 51.421, 51.441, 51.501, 51.503, and 51.507 are adopted without changes to the proposed text.

The adopted rules add employment assistance, a service that helps an individual locate competitive employment, and supported employment, a service that helps an individual maintain competitive employment. These new services implement an amendment to the MDCP waiver application and Texas Human Resources Code, §32.075, which requires DADS to provide employment assistance and supported employment to individuals in the various Medicaid waiver programs. The adopted rules also require that the service providers of employment assistance and supported employment have (1) a bachelor's degree in specified fields and six months of paid or unpaid work experience providing services to people with disabilities, (2) an associate's degree in specified fields and one year of paid or unpaid work experience providing services to people with disabilities, or (3) a high school diploma (or a state-recognized equivalent) and two years of paid or unpaid work experience providing services to people with disabilities. These required qualifications help ensure that service providers of employment assistance and supported employment have sufficient expertise to provide these services. The adopted rules also include certain requirements a program provider must comply with to receive payment for employment assistance and supported employment such as not using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training and not providing employment assistance or supported employment to an individual with the individual present at the same time that certain other services are provided.

The adopted rules also define supported employment to allow an individual to receive this service and be self-employed or work from home. This definition provides a policy consistent with other waiver programs and enhances an individual's opportunities to have a desired job or career.

The adopted rules revise the eligibility section of the rule to allow an individual to be eligible for initial enrollment if the individual is determined eligible by HHSC to receive Medicaid through a state plan program under an eligibility group listed in the MDCP waiver instead of meeting one of the disability criteria for initial enrollment. The adopted rules delete residency and citizenship eligibility requirements and list rules in the Texas Administrative Code (TAC) that describe the financial and non-financial Medicaid eligibility criteria HHSC reviews.

The adopted rules define "primary caregiver" to include persons who are not parents or guardians of the individual receiving MDCP services because other persons, including relatives, often provide the daily uncompensated care. The adopted rules change the definition for "flexible family support" to allow for "routine uncompensated care" provided by a primary caregiver instead of "daily uncompensated care" to allow greater flexibility for individuals who live independently and receive MDCP services.

The adopted rules define the term "backup plan" and require a program provider to have a backup plan in case the program provider is unable to deliver respite or flexible family support services as specified on the service schedule. The adopted rules require the backup plan to designate a service provider or a primary caregiver designee who meets the qualifications for an attendant in §51.421, Requirements for Attendants Providing Respite and Flexible Family Support Services, as a backup service provider. The adopted rules state that a primary caregiver may choose not to accept a backup service provider. The adopted rules require the program provider to send a backup plan to the case manager within 14 days after completing the backup plan.

The adopted rules require all minor home modifications to comply with the Americans with Disabilities Act Standards. The adopted rules change the qualifications for minor home modification providers and inspectors to require five years of experience as a contractor, knowledge of Texas Accessibility Standards, and general liability insurance for errors and omissions. These changes are designed to assure that these persons have the experience and knowledge necessary to provide quality services. The adopted rules delete the reference to the Texas Residential Construction Commission, as this entity no longer exists.

The adopted rules modify documentation and record keeping requirements to reflect streamlining changes and clarify existing procedures. The adopted rules delete duplicative contract information contained in new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register,* and revise service definitions. The adopted rules delete the requirement to maintain seven days of service delivery documentation in the individual's home and the requirement to send copies of practitioner's orders to the case manager.

The adopted rules allow an attendant to serve two individuals in the same household, allowing flexibility for families that have more than one individual receiving MDCP waiver services.

The adopted rules clarify when an individual is eligible to receive in-home respite and identify locations in which in-home respite may be provided. The adopted rules allow out-of- home respite to be provided with a practitioner's orders and identify locations in which out-of- home respite may be provided. The adopted rules allow an individual to take any adaptive aids the individual is

using to an out-of-home respite facility to ensure the individual's needs are met during out-of-home respite services.

The adopted rules add definitions for "restrictive intervention" and "protective device" because policy regarding restrictive intervention was added when DADS renewed the waiver application. The adopted rules establish that a protective device is a restrictive intervention and the requirements that must be met before using a protective device. The adopted rules prohibit a program provider from using a protective device to modify or control an individual's behavior, for disciplinary purposes, for convenience, or as a substitute for an effective, less restrictive method. The adopted rules require a program provider that uses a protective device to document any use of the protective device. The adopted rules establish the requirements for a program provider to evaluate and document the effects of the protective device on the individual's health and welfare, to review the use of a protective device to determine its effectiveness and need to continue it, and to revise the service plan if it is determined that a protective device is not effective or needed.

The adopted rules update terms and definitions used in the chapter. The adopted rules add definitions for "legally authorized representative (LAR)," "financial management services FMS)," and "financial management services agency (FMSA)," which are all terms used in the consumer directed services option; change the definitions of "program provider," and "service provider;" and add a definition for a "home and community support services agency (HCSSA)" to clarify which requirements apply to each of these entities. The adopted rules delete the definition of "adjunct support services" and replace it with "flexible family support services" because the name of the service changed when DADS renewed the waiver application. The adopted rules delete the definition of "board of nurse examiners," which is not referenced in Chapter 51. The adopted rules add a definition for "termination" and delete the definition for "case closure" to standardize terminology used in other waiver programs. The adopted rules replace "parent and guardian" with "primary caregiver," recognizing that a person other than a parent or guardian may provide routine or daily uncompensated care, and change the definition of "individual" to clarify that a reference in the chapter to "individual" includes the individual's primary caregiver, unless the context indicates otherwise.

The adopted rules provide greater clarity as to when services may be denied, reduced or terminated and establish processes for program providers and case managers to follow when there is a request to terminate an individual's services.

A change was made to the proposed rules to add a definition for "competitive employment" in §51.103(10) as "employment that pays an individual at least minimum wage if the individual is not self-employed." The agency made this change to be consistent with the assurances in an MDCP waiver amendment which states that employment assistance assists an individual to locate a job that pays at least minimum wage and that supported employment assists an individual to sustain a job that pays at least minimum wage.

Changes were made to proposed §51.103(10), now (11), to state that the term "contract" includes a provisional contract that DADS enters into in accordance with 40 TAC §49.208, Provisional Contract Application Approval, that has a stated expiration date or a standard contract that DADS enters into in accordance with 40 TAC §49.209, Standard Contract, that does not have a stated expiration date. The agency made these changes to provide program providers with information and references to the two types of contracts provided for in new Chapter 49, adopted elsewhere in this issue of the *Texas Register.*

Changes were made to proposed §51.103(18), now (19), and (56), now (57), to change "paid employment" to "competitive employment." The agency made these changes to be consistent with the assurances in an MDCP waiver amendment, which states that employment assistance assists an individual to locate a job that pays at least minimum wage and that supported employment assists an individual to sustain a job that pays at least minimum wage.

A change was made in proposed §51.103(40), now (41), to change "advanced practice nurse" to "advanced practice registered nurse." The agency made this change to update the title for an advanced practice registered nurse used in Occupations Code, Chapter 301, Nurses.

Changes were made in proposed §51.103(43), now (44), to reformat the definition, to change "belt" to "lap belt," delete "body strap," list "helmet" with the other examples of a protective device, and delete §51.103(44)(B). The agency made these changes so that the definition of this term is consistent with the definition of this term DADS proposed in Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program. The adopted rule states that a protective device is an item or device, such as a safety vest, lap belt, bed rail, safety padding, adaptation to furniture, or helmet, if (1) used only to protect an individual from injury or for body positioning of the individual to ensure health and safety and (2) not used as a mechanical restraint to modify or control behavior.

Minor changes were made in proposed §51.103(47), now (48), to correct grammar and punctuation in the definition of a "restrictive intervention."

Changes were made to proposed §51.203(a)(2) to add "by HHSC" and to add "under an eligibility group listed in the MDCP waiver available at http://www.dads.state.tx.us." The agency made these changes because HHSC, not a DADS case manager, determines the eligibility of an individual to receive Medicaid through a state plan program and because the eligibility groups are listed in the MDCP waiver available on DADS website.

Changes were made to proposed §51.203(b) to delete the eligibility criteria in paragraphs (1) and (2). Changes were made in proposed §51.203(b)(4), now (b)(2), to delete the word "financial;" to add a reference to Chapter 360, Medicaid Buy-In, Chapter 361, Medicaid Buy-In for Children Program, and Chapter 366, Medicaid Eligibility for Women, Children, Youth, and Needy Families, Subchapters E, F, G, J, and K; and update the title of Chapter 358 by replacing "Medicaid Eligibility" with "Medicaid Eligibility for the Elderly and People with Disabilities." The agency made these changes because HHSC, in accordance with the rules referenced in the TAC, determines if an individual meets the applicable financial and non-financial Medicaid eligibility criteria, including the eligibility criteria deleted in §51.203(b)(1) and (2).

Changes were made to proposed §51.241(d) to add a reference to §51.251, Appeals, and make minor changes for clarification. The agency added the reference because §51.251, describes how DADS notifies an individual in writing if DADS suspends the individual's services.

The agency deleted proposed §51.243(b)(1)(B) and §51.243(d)(4) that would allow DADS to deny or terminate services to an individual if DADS is unable to locate a HCSSA

program provider that reasonably expects to be able to meet the individual's medical and nursing needs in the individual's residence. The agency made these deletions because it is the agency's responsibility to ensure a contracted program provider can be located to provide MDCP services.

Changes were made to proposed §51.243(f) to reformat the rule and to add the case manager responsibility proposed in §51.243(g)(1). The agency made these changes to reorganize the case manager's responsibilities.

Changes were made to proposed §51.243(g) to delete the case manager responsibility moved to §51.243(f) and to delete that the case manager within two working days sends a copy of the written notice of termination to the program provider and replace it with "DADS sends a copy of the notice to the individual's program provider." The agency also added a new requirement to state that "DADS notifies an individual in writing, as described in §51.251 of this subchapter (relating to Appeals), if DADS denies an applicant's request for eligibility or reduces, denies, or terminates an individual's services." The agency added the new requirement so that the section is consistent with §51.241(d).

Changes were made to proposed §51.251(b) to add "request a fair hearing to" and to format the subsection. The agency made the changes for clarification and to reorganize the rule.

The agency added new §51.251(c) to state "An applicant whose request for eligibility is denied or is not acted upon with reasonable promptness, or an individual whose services have been terminated, suspended, denied, or reduced by DADS, receives notice of the right to request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A." The agency made these changes to provide a reference to the requirements for the case manager to ensure an applicant or individual receives a notice of a DADS action and because the timeframe for providing the notice depends on the type of action and the reason for the action.

Changes were made to proposed §51.251(c), now (d), to make a minor editorial change and to add a new requirement to state that "If the individual submits an oral request, the individual must submit a written request to the case manager within 5 working days after the date of the oral request. If the request is submitted orally, DADS considers the date of the oral request as the date the request is submitted." The agency added the new requirement to describe the process for an individual to submit an oral request and to establish the date of the request if submitted orally.

Changes were made to proposed §51.251(d), now (e), to add "at the current level." The agency made these changes to clarify that services continue at the current level if the case manager notifies the program provider to continue services.

Changes were made to proposed §51.251(f), now (g), to state that services do not continue during the appeal process (1) for a suspension because of an individual's reckless behavior; or (2) termination without advance notice. The agency made these changes to clarify that there are two circumstances when services do not continue during the appeal process.

Changes were made to proposed §51.411(c) to delete that a program provider must not use a primary caregiver in a backup plan and to replace it with the requirement for a backup plan to designate a service provider or a primary caregiver designee who meets the qualifications for an attendant in §51.421, Requirements for Attendants providing Respite and Flexible Family Support Services, as a backup service provider. The agency made these changes so that a backup plan describes the arrangements in place to have a backup service provider to ensure the provision of scheduled respite or flexible family support services. The agency also added that a primary caregiver may choose not to accept a backup service provider. The agency made this addition to be consistent with the licensing standard in 40 TAC §97.290, Backup Services and After Hours Care.

Changes were made to proposed §51.411(f) to change "program provider" to "respite or flexible family support service provider" and to add "type," after "service provider." The agency made these changes so the service provider to which the rule applies is clearly identified and to clarify that the requirements apply when it is a change in the type of service provider authorized in the IPC.

The agency deleted §51.418(a) from the proposal and replaced it with the statement that a protective device is a restrictive intervention that a program provider may use in accordance with this section. The agency made these changes so that §51.418(a) is consistent with §42.408(a), Protective Devices, in the DBMD Program.

Changes were made to proposed §51.418(b) to add that a protective device must not be used to modify an individual's behavior and to replace "effective assistance" with "an effective, less restrictive method." The agency made these changes to be consistent with the definition for "protective device" in §51.103(44) and to use consistent terminology in the section.

Changes were made to proposed §51.418(c) to require a program provider, before using a protective device, to (1) have a HCSSA RN conduct an assessment of the individual's needs; (2) consider less restrictive methods that, if effective, would accomplish the purpose of the protective device; and (3) document in the program provider's case record the reasons why less restrictive methods would not be effective. The agency made these changes because it considers an RN assessment of an individual's needs to be a necessary first step in using a protective device. In addition, the agency recognizes that it may not be possible to attempt less restrictive methods for all individuals, so the agency is requiring a program provider to consider less restrictive methods that, if effective, would accomplish the purpose of the protective device, and to document why less restrictive methods would not be effective.

The agency deleted proposed §51.418(c)(4) that would require a program provider before using a protective device to obtain a "physician's" order for the use of a protective device and instructions on how and when to use it. Changes were made to proposed §51.418(c)(7), now (c)(6), to replace the requirement deleted in §51.418(c)(4) with the requirement for a written service plan to be signed by a "practitioner" and to allow a program provider to make the written service plan part of the individual's plan of care, as defined in 40 TAC §97.2, Definitions. The agency made these changes because in MDCP a "practitioner," as defined in §51.103, may sign an individual's plan of care and to allow a program provider to include the written plan for the use of a protective device on the individual's plan of care.

Changes were made to proposed §51.418(c)(7)(B), now (c)(6)(B), to delete "how to implement the physician's orders" and replace it with "how to use the protective device and any contraindications specific to the individual." The agency made these changes to replace how to use the protective device, deleted from §51.418(c)(4), and require the written service plan to describe any contraindications specific to the individual.

Changes were made to proposed §51.418(c)(8), now (c)(7), to add that the service planning team also "reviews" the service plan, to delete "in writing," and to change "service plan" to "written service plan." The agency made these changes to require the service planning team to review and approve the written service plan instead of only approving the service plan in writing.

Changes were made to proposed §51.418(c)(9), now (c)(8), to replace "person" with "service provider," to add "of the protective device," and to delete "and the training is documented in the program provider's case record." The agency added a new §51.418(c)(9) to require the program provider, before using a protective device, to "ensure the training is documented in the service provider's record." The agency made these changes because these rules should state "service provider" to use the correct term and to have separate rules for the required training and training documentation.

Changes were made to proposed §51.418(d)(2) to clarify that a HCSSA RN is responsible for evaluating and documenting the effects of protective device on an individual's health and welfare and reviewing the use of a protective device, with input from the individual's service planning team and other professional personnel. This change is consistent with requirements in the DBMD program.

Minor editorial changes were made to proposed §51.418(d)(2)(A) and (B) to correct the grammar.

Changes were made to proposed §51.418(d)(3) to change "physician" to "practitioner." The agency made these changes consistent with this change in §51.418(c)(6).

A change was made in proposed §51.481(1)(D) to replace "paid employment" with "competitive employment." The agency made this change to be consistent with the MDCP waiver amendment on employment assistance.

A change was made to proposed §51.481(3)(A)(ii) to change "and" to "or." The agency made this change because a program provider must not pay an employer for any of the activities listed in the rule.

A change was made to proposed §51.483(1)(A) to change "disability" to "assessed needs." The agency made this change to be consistent with the MDCP waiver.

Changes were made to proposed §51.483(1)(A) and (3)(B)(i)(II) to correct grammar.

Changes were made to proposed §51.485(a) to clarify that a service provider of employment assistance and a service provider of supported employment must not be the legally responsible person of an individual receiving employment assistance or supported employment.

A change was made to proposed §51.485(a)(3) to delete "employment." The agency made this change consistent with the experience requirements in §51.485(a)(1) and (2).

The agency deleted §51.511(5), which lists "transition assistance services." The agency made this change because a "program provider" as defined in §51.103 does not bill for transition assistance services. The agency added new §51.511(b) to state that a transition assistance services provider may bill for transition assistance services authorized by DADS on the DADS "Transition Assistance Services (TAS) Assessment and Authorization" form.

DADS received written comments from the Texas Academy of Physician Assistants TAPA). A summary of the comment and the response follows.

Comment: A commenter requested the addition of "physician assistant" in §51.423(c) to allow a physician assistant to order out-of-home respite services for an individual who resides in the individual's home or a foster home. The commenter stated that this change would comply with Texas law regarding the practice of a physician assistant and allow better access to out-of- home respite services for eligible individuals.

Response: The agency agrees with the commenter and changed "physician" to "practitioner" in §51.423(c) to allow a practitioner as defined in §51.103(41), including a physician assistant, to order out-of-home respite services.

SUBCHAPTER A. INTRODUCTION

40 TAC §51.103

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.103. Definitions.

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

(1) §1915(c) waiver program--A home or community-based service authorized by §1915(c) of the Social Security Act and approved by the Centers for Medicare and Medicaid Services.

(2) Activities of daily living--Activities that are essential to daily self care, including bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer and ambulation, positioning, range of motion, and assistance with self-administered medications.

(3) Adaptive aid--A device that is needed to treat, rehabilitate, prevent, or compensate for a condition that results in a disability or a loss of function and helps an individual perform the activities of daily living or control the environment in which the individual lives.

(4) Appeal--A request for a fair hearing to challenge a program or service suspension, denial, termination, or service reduction.

(5) Attendant--An employee of a program provider or of an individual who has selected the CDS option who:

(A) provides direct care to the individual; and

(B) meets the requirements in §51.421 of this chapter (relating to Requirements for Attendants Providing Respite and Flexible Family Support Services).

(6) Backup plan--A documented plan to ensure that services are provided to an individual when a service provider is not available to deliver services as specified on the service schedule.

(7) Basic child care--Watchful attention and supervision of an individual while the individual's primary caregiver is at work, in job training, or at school.

(8) Case manager--A DADS employee who is responsible for case management activities for an individual, including eligibility determination, enrollment, assessment and reassessment of the individual's need, service plan development, and intercession on the individual's behalf.

(9) CDS option--Consumer directed services option. A service delivery option as defined in §41.103 of this title (relating to Definitions).

(10) Competitive employment--Employment that pays an individual at least the minimum wage if the individual is not self-employed.

(11) Contract--A written agreement between DADS and a program provider to provide MDCP services to an individual. A contract is a provisional contract that DADS enters into in accordance with §49.208 of this title (relating to Provisional Contract Application Approval) that has a stated expiration date or a standard contract that DADS enters into in accordance with §49.209 of this title (relating to Standard Contract) that does not have a stated expiration date.

(12) Cost ceiling--The maximum dollar amount available to an individual for MDCP services per IPC year.

(13) DADS--Department of Aging and Disability Services.

(14) DADS RN--A DADS employee who is an RN.

(15) Day--A calendar day, unless otherwise specified in the text. A calendar day includes weekends and holidays.

(16) Delegated task--A task that a physician or RN delegates in accordance with state law.

(17) Discriminate--To treat a person differently based on the person's race, color, national origin, gender, or age, without a reason approved by DADS.

(18) DFPS--Department of Family and Protective Services.

(19) Employment assistance--Assistance provided to an individual to help the individual locate competitive employment in the community.

(20) Facility-based respite--Respite services provided to an individual in a licensed hospital or nursing facility.

(21) Family member--A person who is related by blood, by affinity, or by law to an individual.

(22) FMS--Financial management services. A service, as defined in §41.103 of this title, that is provided to an individual participating in the CDS option.

(23) FMSA--Financial management services agency. An entity, as defined in §41.103 of this title, that provides FMS to an individual participating in the CDS option.

(24) Flexible family support services--A diverse array of DADS approved, individualized, disability-related services that support independent living, participation in community based child care, employment, and participation in post-secondary education.

(25) Foster home--A foster home as defined in the Human Resources Code, §42.002.

(26) Guardian--A person appointed as a guardian of the estate or of the person by a court.

(27) HHSC--Texas Health and Human Services Commission.

(28) HCSSA--A home and community support services agency licensed by DADS in accordance with Texas Health and Safety Code, Chapter 142.

(29) Host family--A program provider with whom an individual lives when the individual's parents are unable to care for the individual in their home.

(30) Imminent danger--An immediate, real threat to a person's health or safety.

(31) Individual--A person who has been determined eligible to receive MDCP services. A reference in this chapter to "individual" includes the individual's primary caregiver, unless the context indicates otherwise.

(32) Interest list--A list of people who have contacted DADS and expressed an interest in MDCP services but have not applied for nor been determined eligible for MDCP services.

(33) IPC--Individual plan of care. A plan that documents:

(A) the services provided to an individual through both MDCP and third-party resources, and the sources or providers of those services;

(B) medical information about the individual obtained by a DADS RN;

(C) a social assessment of the individual and the individual's family obtained by the case manager;

(D) the projected cost of the MDCP services;

(E) the authorization begin date stated on the service authorization form; and

(F) a program provider's service schedule for respite or flexible family support services.

(34) IPC year--A period recorded on an IPC with a beginning and end date.

(35) LAR--Legally authorized representative. A term defined in §41.103 of this title for an individual who selects the CDS option.

(36) LVN--Licensed vocational nurse. A person licensed by the Texas Board of Nursing or who holds a license from another state recognized by the Texas Board of Nursing to practice vocational nursing in Texas.

(37) MDCP--Medically Dependent Children Program. A §1915(c) waiver program that provides community-based services to help the primary caregiver care for an individual in the community.

(38) Medical necessity--The medical criteria a person must meet for admission to a Texas nursing facility.

(39) Minor home modification--A physical change to an individual's residence that is needed to prevent institutionalization or to support the most integrated setting for an individual to remain in the community.

(40) Parent--An individual's natural or adoptive parent or the spouse of the natural or adoptive parent.

(41) Practitioner--A physician currently licensed in Texas, Louisiana, Arkansas, Oklahoma, or New Mexico; a physician assistant currently licensed in Texas; or an RN approved by the Texas Board of Nursing to practice as an advanced practice registered nurse.

(42) Primary caregiver--A person, including a parent or guardian, who:

(A) for an individual who receives a service other than flexible family support services, provides daily uncompensated care; or

(B) for an individual who receives flexible family support services, routinely provides uncompensated care.

(43) Program provider--A person, as defined in §49.102 of this title (relating to Definitions), that has a contract with DADS to provide MDCP services, excluding an FMSA.

(44) Protective device--An item or device, such as a safety vest, lap belt, bed rail, safety padding, adaptation to furniture, or helmet, if:

(A) used only:

(i) to protect an individual from injury; or

(ii) for body positioning of the individual to ensure health and safety; and

(B) not used as a mechanical restraint to modify or control behavior.

(45) Reckless behavior--Acting with conscious indifference to the consequences.

(46) Residence--The place where an individual lives.

(47) Respite services--Direct care services needed because of an individual's disability that provide a primary caregiver temporary relief from caregiving activities when the primary caregiver would usually perform such activities.

(48) Restrictive intervention--An action or procedure that limits an individual's movement, access to other individuals, locations, or activities, or that restricts an individual's rights.

(49) RN--Registered nurse. A person licensed by the Texas Board of Nursing or who holds a license from another state recognized by the Texas Board of Nursing to practice professional nursing in Texas.

(50) Service authorization form--A DADS form that authorizes a program provider to deliver MDCP services.

(51) Service initiation date--The first day a program provider begins providing an MDCP service.

(52) Service planning team--A team comprised of persons convened and facilitated by a DADS case manager for the purpose of developing, reviewing, and revising an individual's IPC. In addition to a DADS case manager, the team:

(A) includes;

(i) the individual; and

(ii) the primary caregiver; and

(B) may include:

(i) the program provider; and

(ii) other persons whom the individual or primary caregiver invites to participate.

(53) Service provider--A person who provides an MDCP service directly to an individual and who is an employee or contractor of a program provider.

(54) Service reduction--A DADS action that temporarily or permanently decreases services delivered to an individual.

(55) Service schedule--A schedule for delivering respite or flexible family support services to an individual that is agreed upon and signed by the individual or the individual's primary caregiver. A service schedule may be:

(A) a fixed service schedule that specifies certain days, times of day, or time periods for delivery of the services; or

(B) a variable service schedule that specifies the number of authorized hours of services to be delivered per day, per week, or per month, but does not specify certain days, times of day, or time periods for delivery of the services.

(56) Service suspension--A temporary cessation of MDCP services by a program provider or DADS without loss of program or Medicaid eligibility.

(57) Supported employment--Assistance provided, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self- employed, work from home, or perform in a work setting at which individuals without disabilities are employed.

(58) Termination--An action taken by DADS that ends an authorized MDCP service or ends an individual's enrollment in MDCP.

(59) Texas Accessibility Standards--Texas Department of Licensing and Regulation building standards adopted to meet the provisions of Texas Government Code, Chapter 469, and to meet or exceed the construction and alterations requirements of Title III of the Americans with Disabilities Act (42 U.S.C. §§12181-12189).

(60) Third-party resources--Goods and services available to an individual from a source other than MDCP, such as Medicaid home health, Texas Health Steps Comprehensive Care Program, and private insurance.

(61) Transition assistance services--One-time service provided to a Medicaid-eligible resident of a nursing facility located in Texas to assist the resident in moving from the nursing facility into the community to receive MDCP services.

(62) Working day--Any day except a Saturday, a Sunday, or a national or state holiday listed in Texas Government Code §662.003(a) or (b).

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SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND SERVICES
DIVISION 1. ELIGIBILTY

40 TAC §51.203

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.203. Eligibility Requirements.

(a) To be eligible for initial enrollment in MDCP, a person must:

(1) meet one of the following disability criteria;

(A) receive disability benefits from the Social Security Administration;

(B) receive disability benefits from railroad retirement; or

(C) be determined to have a disability by HHSC; or

(2) be determined eligible by HHSC to receive Medicaid through a state plan program under an eligibility group listed in the MDCP waiver available at http://www.dads.state.tx.us.

(b) In addition to the eligibility requirement in subsection (a) of this section, to be eligible to participate in MDCP, a person must:

(1) be under 21 years of age;

(2) meet the Medicaid eligibility criteria described in Texas Administrative Code, Title 1, Chapter 360 (relating to Medicaid Buy-In), Chapter 358 (relating to Medicaid Eligibility for the Elderly and People with Disabilities), Chapter 361 (relating to Medicaid Buy-In for Children Program), or Chapter 366 (relating to Medicaid Eligibility for Women, Children, Youth, and Needy Families), Subchapters E, F, G, J, and K;

(3) meet medical necessity as described in §51.207 of this division (relating to Medical Necessity);

(4) have an IPC with a cost for MDCP services at or below 50 percent of the reimbursement rate that would have been paid for the same individual to receive nursing facility services considering all other resources, including resources described in §40.1 of this title (relating to Use of General Revenue for Services Exceeding the Individual Cost Limit of a Waiver Program); and

(5) if the person is under 18 years of age, reside:

(A) with a family member; or

(B) in a foster home that includes no more than four children unrelated to the individual.

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40 TAC §51.205

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DIVISION 2. ENROLLMENT

40 TAC §51.219

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that

operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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DIVISION 3. SERVICES

40 TAC §§51.231, 51.233, 51.235, 51.237, 51.241, 51.243, 51.245

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.241. Service Suspensions by DADS.

(a) Except as provided in subsection (b) of this section, DADS suspends an individual's services if:

(1) the individual is admitted for purposes other than respite services in accordance with §51.423(c)(1) of this chapter (relating to Respite and Flexible Family Support Services) to:

(A) a hospital;

(B) a nursing facility;

(C) a state supported living center;

(D) a state mental health facility;

(E) a rehabilitation hospital; or

(F) an intermediate care facility for individuals with an intellectual disability or related conditions; or

(2) the individual or someone in the individual's residence exhibits reckless behavior that may result in imminent danger to the individual, a service provider, DADS staff, or another person in the individual's residence.

(b) To avoid a suspension of services for the reason described in subsection (a)(1) of this section, an individual or an individual's primary caregiver must obtain approval from the individual's case manager if the admission will result in a break in service delivery that exceeds 60 days.

(c) DADS may suspend an individual's services if the individual or someone in the individual's residence discriminates against a service provider or DADS staff.

(d) DADS notifies an individual in writing, as described in §51.251 of this subchapter relating to Appeals), if DADS suspends the individual's services. DADS sends a copy of the notice to the individual's program provider.

(e) If a case manager becomes aware of the circumstance described in subsection (a)(2) of this section, the case manager immediately:

(1) files a report with local law enforcement;

(2) makes a referral to DFPS;

(3) suspends the individual's services; and

(4) initiates efforts to resolve the situation, including holding a service planning team meeting.

§51.243. Denials, Terminations, and Service Reductions.

(a) Service reductions. DADS reduces services to an individual if:

(1) third-party resources become available to the individual;

(2) the individual's annual cost ceiling decreases;

(3) budgetary constraints require cost reductions; or

(4) the individual's need for service decreases.

(b) Denials.

(1) DADS denies services to an individual if:

(A) DADS does not approve the individual's initial program eligibility; or

(B) DADS does not authorize:

(i) a service requested when the initial IPC is authorized;

(ii) a service requested during the initial IPC year;

(iii) a service requested on an IPC that was not authorized on a prior IPC; or

(iv) a portion of the amount or level of a service requested on an IPC that was not authorized on a prior IPC.

(2) DADS may deny services to an individual if:

(A) the individual or the individual's primary caregiver does not participate in the development or implementation of the IPC; or

(B) budgetary constraints require cost reductions.

(c) Terminations without advance notice. DADS terminates an individual's services if:

(1) DADS confirms the death of the individual;

(2) the primary caregiver notifies DADS that the individual's admission to an institution is for long-term care purposes;

(3) the individual enrolls in another §1915(c) waiver program;

(4) DADS receives a written statement signed by the individual that the individual no longer wants services;

(5) the individual's whereabouts are unknown and the post office returns mail directed to the individual, indicating no forwarding address; or

(6) DADS establishes that the individual has been accepted for Medicaid services by another state.

(d) Terminations with advance notice. DADS may terminate an individual's services with advance notice if:

(1) the individual no longer meets the eligibility requirements described in §51.203 of this subchapter (relating to Eligibility Requirements);

(2) the individual, as described in §51.219(a)(2)(B) of this subchapter (relating to Maintaining Enrollment), does not receive any MDCP services:

(A) for more than 60 consecutive days without approval from the case manager; or

(B) for more than 180 consecutive days;

(3) the individual or the individual's primary caregiver does not participate in the development or implementation of the IPC; or

(4) the individual or the individual's primary caregiver refuses to participate in the redetermination of eligibility or the monitoring of service delivery.

(e) A program provider may recommend that DADS terminate services for the reasons stated in subsection (d)(3) or (4) of this section. Within two working days after the program provider determines there is a reason to request termination, the program provider must:

(1) send a written request to the case manager; and

(2) include written documentation that supports the recommendation including:

(A) a description of the circumstances and interventions the program provider attempted before deciding to recommend the termination of MDCP services; and

(B) a description of the program provider's use of strategies and negotiations with the individual and the results of those actions.

(f) If the case manager becomes aware of a circumstance described in subsection (d)(3) or (4) of this section, or receives a program provider's recommendation to terminate services as described in subsection (e) of this section, the case manager:

(1) attempts to resolve the circumstance, including holding a service planning team meeting; and

(2) if unable to resolve the circumstance, sends written notice of the termination to the individual within two working days.

(g) DADS notifies an individual in writing, as described in §51.251 of this subchapter relating to Appeals), if DADS denies an applicant's request for eligibility or reduces, denies, or terminates an individual's services. DADS sends a copy of the notice to the individual's program provider.

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40 TAC §51.232

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DIVISION 4. APPEALS

40 TAC §51.251

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§51.251. Appeals.

(a) Appeals and fair hearings are conducted as described in 1 TAC Chapter 357, Subchapter A, (relating to Uniform Fair Hearing Rules).

(b) An individual may request a fair hearing to appeal a DADS action. In this section, a DADS action means:

(1) a service suspension as described in §51.241 of this subchapter (relating to Service Suspensions by DADS); or

(2) a service reduction, denial, or termination as described in §51.243 of this subchapter relating to Denials, Terminations, and Service Reductions).

(c) An applicant whose request for eligibility is denied or is not acted upon with reasonable promptness, or an individual whose services have been terminated, suspended, denied, or reduced by DADS, receives notice of the right to request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A.

(d) To appeal a DADS action, an individual must submit a request for a fair hearing orally or in writing to the case manager within 90 days from the date on the notice of the DADS action. If the individual submits an oral request, the individual must submit a written request to the case manager within 5 working days after the date of the oral request. If the request is submitted orally, DADS considers the date of the oral request as the date the request is submitted.

(e) Except as provided in subsection (g) of this section, if an individual who is currently receiving services requests a fair hearing before the effective date of the DADS action on the notice, the case manager notifies the program provider to continue services at the current level.

(f) If an individual who is currently receiving services does not submit a request for a fair hearing before the effective date of DADS action on the notice, the program provider must, unless otherwise directed by the case manager, discontinue services on the effective date of the DADS action on the notice.

(g) Services do not continue during the appeal process:

(1) for a suspension because of the reckless behavior described in §51.241(a)(2) of this subchapter; or

(2) for a termination without advance notice as described in §51.243(c) of this subchapter.

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SUBCHAPTER D. PROVIDER REQUIREMENTS

DIVISION 1. CONTRACTING REQUIREMENT

40 TAC §51.401

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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DIVISION 2. SERVICE DELIVERY REQUIREMENTS FOR ALL PROVIDERS

40 TAC §§51.411, 51.413, 51.415, 51.417, 51.419

The amendments and new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.411. General Service Delivery Requirements.

(a) A program provider must ensure that each service is provided in accordance with an individual's IPC and with Appendix C of the MDCP waiver application approved by CMS and found at www.dads.state.tx.us.

(b) A program provider must provide respite or flexible family support services as specified on the service schedule, unless an individual changes the service schedule in accordance with §51.237 of this chapter (relating to Service Schedule Changes).

(c) A program provider must have a backup plan in case the program provider is unable to deliver respite or flexible family support services as specified on the service schedule. A backup plan must designate a service provider or a primary caregiver designee who meets the qualifications for an attendant in §51.421 of this subchapter, (relating to Requirements for Attendants providing Respite and Flexible Family Support Services), as a backup service provider. A primary caregiver may choose not to accept a backup service provider.

(d) Within 14 days after a program provider receives an initial assessment or annual reassessment service authorization form, a program provider must send the case manager a copy of the program provider's backup plan for service delivery.

(e) Within 14 days after the backup plan changes, a program provider must send the case manager a copy of the revised backup plan.

(f) Before changing the respite or flexible family support service provider type authorized in the IPC, a program provider must coordinate the change with the case manager and the individual and obtain a new service authorization form.

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40 TAC §51.413

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §51.418

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.418. Protective Devices.

(a) A protective device is a restrictive intervention that a program provider may use in accordance with this section.

(b) A program provider must not use a protective device to modify or control an individual's behavior, for disciplinary purposes, for convenience, or as a substitute for an effective, less restrictive method.

(c) Before a program provider uses a protective device, the program provider must:

(1) have a HCSSA RN conduct an assessment of the individual's needs;

(2) consider less restrictive methods that, if effective, would accomplish the purpose of the protective device;

(3) document in the program provider's case record the reasons why less restrictive methods would not be effective;

(4) obtain and retain in the program provider's case record written consent of the individual or primary caregiver to use a protective device;

(5) provide oral and written notification to the individual or primary caregiver of the right at any time to withdraw consent for the use of a protective device;

(6) have a HCSSA RN, with input from the individual, the individual's primary caregiver, the individual's service planning team, and other professional personnel, develop a written service plan, which may be part of the individual's plan of care, as defined in §97.2 of this title relating to Definitions), signed by a practitioner, that describes:

(A) the type of device and the circumstances under which it may be used;

(B) how to use the protective device and any contraindications specific to the individual;

(C) how and when to document the use of the protective device;

(D) how to monitor the protective device; and

(E) when and whom the program staff must notify of a protective device's use;

(7) ensure the service planning team reviews and approves the written service plan;

(8) ensure that each service provider who will use a protective device has been trained in the proper use of the protective device; and

(9) ensure the training is documented in the service provider's record.

(d) A program provider that uses a protective device must:

(1) document in the program provider case record any use of a protective device in accordance with the written service plan;

(2) ensure that a HCSSA RN, with input from the individual's service planning team and other professional personnel, at least annually, and as the individual's needs change:

(A) evaluate and document in the program provider's case record the effects of the protective device on the individual's health and welfare; and

(B) review the use of a protective device to determine its effectiveness and the need to continue the protective device; and

(3) ensure that a HCSSA RN, in accordance with subsection (c)(6) of this section, revises the service plan when the individual's service planning team and practitioner determine that a protective device is not effective or needed.

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DIVISION 3. SERVICE DELIVERY REQUIREMENTS FOR RESPITE AND FLEXIBLE FAMILY SUPPORT SERVICES

40 TAC §51.421

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §51.421, §51.423

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.423. Respite and Flexible Family Support Services.

(a) Respite services are subject to the limitations found in §51.231 of this chapter (relating to Service Limitations).

(b) An individual may receive in-home respite services if necessary to provide relief for the primary caregiver for a period when the primary caregiver normally provides uncompensated care.

(1) In-home respite services must be authorized in the individual's IPC before delivery.

(2) In-home respite services are provided:

(A) in the individual's home or foster home; or

(B) in community settings, including a park, a respite provider's home, or a relative's home.

(c) An individual who resides in the individual's own home or a foster home may receive out-of- home respite services if ordered by the individual's practitioner.

(1) Out-of-home respite services must be provided in a DADS contracted:

(A) hospital;

(B) special care facility;

(C) licensed nursing facility;

(D) camp; or

(E) child day care facility.

(2) An out-of-home respite facility must:

(A) allow an individual to take any adaptive aids the individual is using to the out-of-home respite facility; and

(B) deliver services:

(i) as authorized on the IPC before being delivered; and

(ii) in accordance with the applicable licensure requirements for the out-of-home respite facility.

(d) Flexible family support services. Flexible family support services must be authorized on the IPC before being delivered. Flexible family support services may only be provided to an individual while:

(1) a primary caregiver is working, attending job training, or attending school; and

(2) the individual, because of the individual's disability, needs direct care services that help the individual participate in child care, post-secondary education, employment, independent living, or support the individual's move to an independent living situation.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Lawrence Hornsby
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DIVISION 5. SERVICE DELIVERY REQUIREMENTS FOR CONSUMER DIRECTED SERVICES

40 TAC §51.441

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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40 TAC §51.441

The new section is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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DIVISION 8. SERVICE DELIVERY REQUIREMENTS FOR MINOR HOME MODIFICATIONS

40 TAC §51.471, §51.475

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human

Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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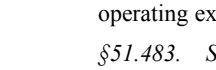

DIVISION 9. SERVICE DELIVERY REQUIREMENTS FOR EMPLOYEE ASSISTANCE AND SUPPORTED EMPLOYMENT

40 TAC §§51.481, 51.483, 51.485

The new sections are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.481. Employment Assistance.

A program provider must ensure that employment assistance:

(1) consists of a service provider performing the following activities:

(A) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

(B) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements;

(C) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;

(D) transporting the individual to help the individual locate competitive employment in the community; and

(E) participating in service planning team meetings;

(2) is not provided to an individual with the individual present at the same time that respite, flexible family support services, or supported employment is provided; and

(3) does not include using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(A) paying an employer:

(i) to encourage the employer to hire an individual; or

(ii) to supervise, train, support, or make adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(B) paying the individual:

(i) as an incentive to participate in employment assistance activities; or

(ii) for expenses associated with the start-up costs or operating expenses of an individual's business.

§51.483. Supported Employment.

A program provider must ensure that supported employment:

(1) consists of a service provider performing the following activities:

(A) making employment adaptations, supervising, and providing training related to an individual's assessed needs;

(B) transporting the individual to support the individual to be self-employed, work from home, or perform in a work setting; and

(C) participating in service planning team meetings;

(2) is not provided to an individual with the individual present at the same time that respite, flexible family support services, or employment assistance is provided; and

(3) does not include:

(A) sheltered work or other similar types of vocational services furnished in specialized facilities; or

(B) using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses such as:

(i) paying an employer:

(I) to encourage the employer to hire an individual; or

(II) to supervise, train, support, or make adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(ii) paying the individual:

(I) as an incentive to participate in supported employment activities; or

(II) for expenses associated with the start-up costs or operating expenses of an individual's business.

§51.485. Service Provider Qualifications for Providing Employment Assistance and Supported Employment.

(a) A service provider of employment assistance and a service provider of supported employment must be at least 18 years of age, not be the legally responsible person of the individual receiving employment assistance or supported employment, and have:

(1) a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;

(2) an associate's degree in rehabilitation, business, marketing, or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or

(3) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities.

(b) A program provider must ensure that the experience required by subsection (a) of this section is evidenced by:

(1) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and

(2) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. CLAIMS PAYMENT AND DOCUMENTATION

40 TAC §§51.501, 51.503, 51.507

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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40 TAC §§51.505, 51.509, 51.511, 51.513, 51.515

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§51.511. Billable Time and Activities.

(a) A program provider may bill for and DADS approves payment for the following services if the service is approved on the service authorization form and provided in accordance with this chapter:

(1) respite services;

(2) flexible family support services;

(3) minor home modifications, including:

(A) cost of labor;

(B) materials;

(C) sales tax;

(D) actual cost of written specification development up to $200; and

(E) actual cost of the inspection up to $150;

(4) adaptive aids, including:

(A) invoice cost of the item;

(B) actual cost, when the item is purchased through a supplier; and

(C) sales tax;

(5) employment assistance, if the program provider, before including employment assistance on an individual's IPC, ensures, and maintains documentation in the individual's record, that employment assistance is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.); and

(6) supported employment, if the program provider, before including supported employment on an individual's IPC, ensures, and maintains documentation in the individual's record, that supported employment is not available to the individual under a program funded un-

der the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

(b) A transition assistance services provider may bill for transition assistance services authorized by DADS on the DADS Transition Assistance Services (TAS) Assessment and Authorization form and provided in accordance with Chapter 62 of this title (relating to Contracting to Provide Transition Assistance Services).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 52. CONTRACTING TO PROVIDE EMERGENCY RESPONSE SERVICES

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§52.201, 52.501, and 52.503, concerning general contracting requirements; record keeping; and payment, in Chapter 52, Contracting to Provide Emergency Response Services, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3203).

The amendments are adopted to update rules in Chapter 52 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register*. New Chapter 49 establishes a comprehensive rule base for contractors of community based services, including emergency response services (ERS). Therefore, rules are being amended to remove provisions addressed in the new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

DADS received no comments regarding adoption of the amendments.

SUBCHAPTER B. CONTRACTING REQUIREMENTS

40 TAC §52.201

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. CLAIMS PAYMENT AND DOCUMENTATION

40 TAC §52.501, §52.503

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 55. CONTRACTING TO PROVIDE HOME-DELIVERED MEALS

40 TAC §55.5, §55.39

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §55.5, concerning contracting requirements for provider agencies, and §55.39, concerning recordkeeping, in Chapter 55, Contracting to Provide Home-Delivered Meals, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3205).

The purpose of the amendments is to update rules in Chapter 55 in conjunction with new Chapter 49, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including home-delivered meals. Therefore, the rules are being amended to remove provisions addressed in new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

DADS received no comments regarding adoption of the amendments.

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 58. CONTRACTING TO PROVIDE SPECIAL SERVICES TO PERSONS WITH DISABILITIES

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts an amendment to §58.11, concerning what general contract requirements must the provider agency follow, and the repeal of §58.131, concerning what are the recordkeeping requirements for the SSPD Program, and §58.137, concerning what must the provider agency do to get paid by DHS, in Chapter 58, Contracting to Provide Special Services to Persons with Disabilities, without changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3207).

The purpose of the amendment and repeal is to update and delete rules in Chapter 58 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community based services, including special services to persons with disabilities. Therefore, the rules are being amended and repealed to remove provisions addressed in the new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

DADS received no comments regarding adoption of the amendment and repeals.

SUBCHAPTER B. PROVIDER AGENCY CONTRACTS

40 TAC §58.11

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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SUBCHAPTER I. CLAIMS PAYMENT AND DOCUMENTATION REQUIREMENTS

40 TAC §58.131, §58.137

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 60. CONTRACTING TO PROVIDE PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

40 TAC §60.6, §60.8

The Texas Health and Human Services Commission (HHSC) adopts, on behalf of the Department of Aging and Disability Services (DADS), amendments to §60.6, concerning definitions; and §60.8, concerning contracting requirements, in Chapter 60, Contracting to Provide Programs of All-Inclusive Care for the Elderly (PACE), without changes to the proposed text as published in the May 16, 2014, issue of the *Texas Register* (39 TexReg 3850).

BACKGROUND AND PURPOSE

The amendments are adopted to clarify contracting procedures and add contracting requirements to PACE program rules. The adopted rules specify that an entity seeking to become a provider agency must be selected by DADS through a request for proposals, be approved by the Centers for Medicare and Medicaid Services (CMS), enter into a program agreement with CMS and DADS, and be licensed as an adult daycare center. The adopted rules also specify that an applicant must apply for a PACE contract to provide services as if applying for a provisional contract as required by 40 Texas Administrative Code, Chapter 49. A new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register,* outlines other requirements that an applicant must follow, including maintaining licensure as an adult daycare center. The adopted rules clarify which portions of Chapter 49 apply to a provider agency's PACE contract and establish that at the end of a PACE contract's term, DADS may renew or terminate the contract. Under the adopted rules, if the program agreement is terminated, then DADS terminates the PACE contract.

In addition, the adopted rules add a definition for "PACE contract," which is a written agreement between DADS and a provider agency to provide PACE services for one year. The adopted rules also clarify existing definitions for "provider agency" and "service area," and change references to the Department of Human Services to DADS.

DADS received no comments regarding adoption of the amendments.

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 62. CONTRACTING TO PROVIDE TRANSITION ASSISTANCE SERVICES

The Texas Health and Human Services Commission (HHSC) adopts, on behalf of the Department of Aging and Disability Services (DADS), amendments to §62.11, concerning contracting requirements, and §62.41, concerning record keeping; and the repeal of §62.43, concerning reimbursement in Chapter 62, Contracting to Provide Transition Assistance Services.

The amendment to §62.11 is adopted with changes to the proposed text published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3208). The amendment to §62.41 and the repeal of §62.43 are adopted without changes to the proposed text.

The purpose of the amendments and repeal is to update and delete rules in Chapter 62 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a com-

prehensive rule base for contractors of community-based services, including transition assistance services. Therefore, the rules are being amended and repealed to remove provisions addressed in new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

Minor editorial changes were made in the text of §62.11. The agency made these changes to correct the formatting, delete unnecessary rule text, and to delete the undefined acronym "TAS."

DADS received no comments regarding adoption of the amendments and repeal.

SUBCHAPTER B. PROVIDER AGENCY REQUIREMENTS

40 TAC §62.11

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§62.11. Contracting Requirements.

A provider agency must comply with this chapter and Chapter 49 of this title (relating to Contracting for Community Services).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. CLAIM PAYMENTS AND DOCUMENTATION

40 TAC §62.41

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Lawrence Hornsby
General Counsel
Department of Aging and Disability Services
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For further information, please call: (512) 438-3734

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40 TAC §62.43

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 438-3734

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CHAPTER 69. CONTRACT ADMINISTRATION

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts the repeal of Chapter 69, consisting of §§69.1 - 69.4, 69.11 - 69.19, 69.31 - 69.40, 69.51 - 69.55, 69.71 - 69.73, 69.81, 69.91 - 69.93, 69.101 - 69.103, 69.111 - 69.118, 69.131 - 69.139, 69.151 - 69.160, and 69.171 - 69.186, concerning Contract Administration, without changes to the proposal as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3210).

BACKGROUND AND PURPOSE

The repeals are adopted to remove Chapter 69, Contract Administration, from the DADS rule base. The rules in Chapter 69 will no longer be needed because new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register* will govern contracts for community services. Contracts are also governed by applicable statutes, as well as rules of the Health and Human Services Commission in Title 1, Chapter 391, making the rules in Chapter 69 unnecessary.

DADS received no comments regarding adoption of the repeals.

SUBCHAPTER A. GENERAL INFORMATION

40 TAC §§69.1 - 69.4

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. PURCHASE OF GOODS AND SERVICES AND AWARD OF SUBGRANTS

40 TAC §§69.11 - 69.19

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. PROCUREMENT PROTESTS

40 TAC §§69.31 - 69.40

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. SUBGRANTS AND SUBCONTRACTS

40 TAC §§69.51 - 69.55

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. COST PRINCIPLES

40 TAC §§69.71 - 69.73

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER F. NONRENEWAL OR REDUCTION OF BLOCK GRANT FUNDS

40 TAC §69.81

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER G. CONTRACT RENEWAL AND TERMINATION

40 TAC §§69.91 - 69.93

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which

provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER H. DISPUTES

40 TAC §§69.101 - 69.103

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER I. AUDITS

40 TAC §§69.111 - 69.118

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER J. RECOVERY OF IMPROPER PAYMENTS

40 TAC §§69.131 - 69.139

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER K. INFORMATION AND RECORDS

40 TAC §§69.151 - 69.160

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER L. DEBARMENT AND SUSPENSION

40 TAC §§69.171 - 69.186

The repeals are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

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CHAPTER 98. ADULT DAY CARE AND DAY ACTIVITY AND HEALTH SERVICES REQUIREMENTS

SUBCHAPTER H. DAY ACTIVITY AND HEALTH SERVICES (DAHS) CONTRACTUAL REQUIREMENTS

40 TAC §§98.202, 98.210, 98.212

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§98.202, 98.210, and 98.212, concerning program overview; administrative errors and corrections; and sanctions, in Chapter 98, Adult Day Care and Day Activity and Health Services Requirements. The amendment to §98.210 is adopted with changes to the proposed text as published in the April 18, 2014, issue of the *Texas Register* (39 TexReg 3218). The amendments to §98.202 and §98.212 are adopted without changes to the proposed text.

The amendments are adopted to update rules in Chapter 98 in conjunction with new Chapter 49, Contracting for Community Services, adopted elsewhere in this issue of the *Texas Register.* New Chapter 49 establishes a comprehensive rule base for contractors of community-based services, including day activity and health services. Therefore, the rules are being amended to update language and delete provisions addressed in new Chapter 49.

These rules govern conduct occurring on or after the effective date of the rules. Conduct occurring before the effective date of these rules is governed by the rules in effect on the date the conduct occurred and the former rules continue in effect for that purpose.

A minor editorial change was made in §98.210(a)(1) and (2) to correct grammar.

DADS received no comments regarding adoption of the amendments.

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall

study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§98.210. Financial Errors.

(a) In the absence of acceptable secondary documentation, financial errors include the errors described in this section.

(1) The DAHS facility is reimbursed for services, but DADS Daily Attendance and Daily Transportation Record form is missing for the period for which services are reimbursed. DADS applies the error to the total number of units reimbursed for the billing period.

(2) The DAHS facility is reimbursed for units that exceed the units recorded on DADS Daily Attendance and Daily Transportation Record form. DADS applies the error to the total number of units reimbursed in excess of the units recorded.

(3) The DAHS facility is reimbursed for units of service and the client did not receive services or was Medicaid ineligible (not applicable to Title XX clients). DADS applies the error to the total number of units reimbursed for the days the client did not receive services or was Medicaid ineligible.

(b) Corrections of critical omissions or errors in DAHS facility documentation must be postmarked or date stamped as received by DADS within 14 days after the regional nurse mails DADS Notification of Critical Omissions/Errors in Required Documentation form to the DAHS facility. If the DAHS facility fails to meet this time frame:

(1) the date of prior approval can be no earlier than the postmark or DADS-stamped date on the corrected documentation; or

(2) DADS may refer the individual to another DAHS facility of the individual's choice.

(A) If there is space in another DAHS facility, the regional nurse notifies the case manager by the next workday to give the individual or individual's family/representative the option to be referred to another DAHS facility.

(B) The case manager will contact the individual within three workdays after being notified by the regional nurse and refer the individual to another DAHS facility, if the individual or the individual's family/representative prefers this option.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Department of Aging and Disability Services
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PART 2. DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES

CHAPTER 105. AUTISM PROGRAM

The Texas Health and Human Services Commission (HHSC), on behalf of the Department of Assistive and Rehabilitative Services (DARS), adopts the repeal of Chapter 105, §§105.101, 105.103, 105.105, 105.107, 105.109, 105.111, 105.113, 105.115, 105.117, 105.119, 105.121, 105.123, 105.125, 105.127, 105.129, 105.131, and 105.133 without changes to the proposal as published in the May 30, 2014, issue of the *Texas Register* (39 TexReg 4199). The text will not be republished.

HHSC on behalf of DARS adopts as replacement of the repealed rules and/or their subject matter new Chapter 105, concerning the Autism Program, consisting of Subchapter A, §§105.101, 105.103, and 105.105 concerning General Rules; Subchapter B, §§105.201,105.207, 105.209, 105.211, 105.213, and 105.215 concerning DARS Comprehensive ABA Services; Subchapter C, §§105.301, 105.307, 105.309, 105.311, 105.313, and 105.315 concerning DARS Focused ABA Services; Subchapter D, §§105.401, 105.407, 105.409, 105.411, 105.413, and 105.415 concerning DARS Combined ABA Services; Subchapter E, §105.507 and §105.509 concerning Rights of Participants; Subchapter F, §105.607 and §105.609 concerning Fees; and Subchapter G, §§105.707, 105.709, 105.711, 105.713, 105.715, 105.717, 105.719, and 105.721 concerning Contractor Requirements. Sections 105.105, 105.211, 105.307, 105.311, 105.313, 105.409, 105.413, 105.509, 105.607, 105.707, 105.713, and 105.717 are adopted with changes to the proposed text as published in the May 30, 2014, issue of the *Texas Register* (39 TexReg 4119). The text of the rules will be republished. Sections 105.101, 105.103, 105.201, 105.207, 105.209, 105.213, 105.215, 105.301, 105.309, 105.315, 105.401, 105.407, 105.411, 105.415, 105.507, 105.609, 105.709, 105.711, 105.715, 105.719, and 105.721 are adopted without changes to the proposed text as published in the May 30, 2014, issue of the *Texas Register* (39 TexReg 4119). The text of the rules will not be republished.

BACKGROUND AND JUSTIFICATION

DARS adopts the repealed and new rules pursuant to the 2014-2015 General Appropriations Act (Article II, Special Provisions Sections 57(a), Senate Bill 1, 83rd Legislature, Regular Session, 2013) that requires DARS to expand the Autism Program to additional parts of Texas contingent on developing a plan to serve more children. DARS internally reviewed and analyzed Chapter 105 and now adopts the repeal of the current rules in Chapter 105 and their replacement with new rules that enable DARS to expand services to serve more children.

SECTION-BY-SECTION SUMMARY

DARS adopts Subchapter A, General Rules, which allows DARS to designate the purpose of the Autism Program, cite the program's legal authority, and define program terminology.

DARS adopts Subchapter B, DARS Comprehensive ABA Services, which outlines the purpose of the subchapter, eligibility requirements for DARS comprehensive ABA services, the contractor's procedures to enroll eligible children to receive the services, the services provided, the length of services, and the participation requirements for DARS Comprehensive ABA services.

DARS adopts Subchapter C, DARS Focused ABA Services, which outlines the purpose of the subchapter, eligibility re-

quirements for DARS Focused ABA services, the contractor's procedures to enroll eligible children to receive the services, the services provided, the length of services, and the participation requirements for DARS Focused ABA services.

DARS adopts Subchapter D, DARS Combined ABA Services, which outlines the purpose of the subchapter and clarifies that DARS Combined ABA Services is an option that is only available to children enrolled and receiving services in the DARS Autism Program on or before August 31, 2014; eligibility requirements for the services; the contractor's procedures to enroll eligible children to receive the services; the services provided; the length of services; and the participation requirements for DARS Combined ABA services.

DARS adopts Subchapter E, Rights of Participants, regarding the rights of the children and families, and the complaint process.

DARS adopts Subchapter F, Fees, which provides rules for contractors to determine the monthly cost to families for services, the limitation on cost per child, and the payer of last resort.

DARS adopts Subchapter G, Contractor Requirements, which outlines the expectations of contractors regarding staff qualifications, criminal background checks, performance management, safety, confidentiality of information, maintenance and review of an interest list, administration of pre-tests and post-tests, and administration of training for parents.

COMMENTS

DARS received input from 16 families or parents with a child who has a diagnosis on the autism spectrum, contractor staff members, Disability Rights Texas, and the Texas Association for Behavior Analysis. The public comments are summarized as follows.

DARS received comments regarding the proposed changes during the comment period. A summary of the comments and the agency's responses follow.

General Comments: Many commenters expressed support for the rule changes related to 85 percent child attendance requirements, the expansion of the age range for services to children up to 15 years of age, requirements for staff training and supervision, and Registered Behavior Technician credentials. Many parents expressed their appreciation for the DARS Autism Program and indicated that with the support of the program, they have seen progress in their child's behavioral and social challenges.

Response: The DARS Autism Program continues to be committed to working with the contractors and providing services to families with young children who have autism spectrum disorder (ASD).

§105.105, Definitions

Comment: DARS received two comments regarding §105.105(3). One commenter suggested the definition for ABA be amended to state that ABA is the scientific study and application of behavioral principles and procedures to change socially-important behavior. It focuses on increasing behaviors that improve functioning, as well as decreasing behaviors that impede health, safety, and successful functioning. Another commenter indicated that the definition of ABA should state that it does not include physically aversive interventions or state what is not good ABA practice.

Response: No changes were made in response to these comments.

Comment: DARS received two comments regarding §105.105(4). One commenter expressed that the proposed definition of ASD includes disorders found in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and requested that DARS consider expanding the definition to include children who were diagnosed prior to the release of the fifth edition of the DSM. Another commenter expressed that neither the Individuals with Disabilities Education Act (IDEA) in 34 CFR 300.8 nor the Texas Administrative Code rules for the Texas Education Agency use the DSM to define ASD. The commenter suggested the definition should be broad enough to include children who have been identified as having autism under IDEA.

Response: DARS is adopting this rule with changes that clarify the intent of the requirement is to allow an appropriate ASD diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder, not otherwise specified, made under a previous DSM, as acceptable. The DARS Autism Program requires a professional who is qualified to make a DSM diagnosis that is acceptable to an insurance provider. This is necessary for DARS to be the payer of last resort; therefore, an educational diagnosis of ASD is not acceptable.

Comment: DARS received one comment regarding §105.105(12). The commenter requested clarification of what is meant by a DARS contractor treating all areas of developmental and behavioral needs in the definition of DARS Comprehensive ABA Services and requested clarification of the range of developmental needs that should be assessed. Additionally, the commenter indicated that "all areas" may include physical limitations, structural speech problems, nutritional issues, and many other areas and asked what the expectation is of a DARS contractor for addressing these areas of development need.

Response: No changes were made in response to this comment. All areas that are appropriately addressed by ABA services should be assessed and if other needs are identified, a referral should be made to the appropriate entity for additional services. The contractor providing comprehensive ABA services will be required to administer a battery of pre- and post-testing protocols that addresses all developmental areas.

Comment: DARS received one comment regarding §105.105(15). The commenter suggested redefining the term "family" to include all children under 19 years of age as part of the family.

Response: DARS is adopting this rule with changes to clarify that the intent of the rule is to include all children under age 19 as part of the family.

§105.207, Eligibility

Comment: DARS received one comment regarding §105.207(a)(2). The commenter suggested that DARS consider eliminating the lower age cap to the age of diagnosis. This would allow children to access treatment at an earlier age.

Response: DARS is adopting this rule without change. The statewide DARS Early Childhood Intervention program serves children under the age of three, including those with ASD.

Comment: DARS received one comment regarding §105.207(a)(3). The commenter expressed that many of the DARS clients provide documentation of a diagnosis from the

school district; however, many school diagnosticians are not psychologists or psychiatrists and do not meet the definition of a qualified professional. The commenter suggested amending the definition to allow as a qualified professional anyone who by their degree or license is allowed to make a diagnosis.

Response: DARS is adopting this rule without change. The DARS Autism Program requires a professional who is qualified to make a DSM diagnosis that is acceptable to an insurance provider. This is necessary for DARS to be the payer of last resort. However, DARS is making a change to §105.105(21) (which is renumbered to §105.105(22) in adopted amendments to definitions) to clarify that a qualified professional is one who is actively licensed.

§105.209, Enrollment

Comment: One commenter expressed that this rule appears to leave out any requirement that the contractor provide notification to the families during the enrollment process of their available rights and procedural safeguards. The commenter suggested that the contractors inform the families upfront of their rights and procedural safeguards.

Response: DARS is adopting this rule without change. DARS agrees with the comment and will address the issue of providing notification to families of their available rights and procedural safeguards in the terms and conditions of the contract.

§105.211, Services Provided

Comment: DARS received 18 comments regarding §105.211(1). One commenter indicated that research has repeatedly shown that approximately 50 percent of children who receive one-to-one intensive ABA treatment before the age of 4 for 25 - 40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis. One commenter expressed that the proposed rule to cap the children's treatment intensity to "no more than 20 hours per week" is not evidence-based and does not seem congruent with the findings and recommendations stated in the report by the University of Texas' School of Education which does not include a cap on treatment. The commenter suggested that all children be admitted to the program at maximum treatment intensity for the first 6 months with a treatment intensity of 35.5 hours per week, or admitting each child for maximum treatment intensity for the first 6 months and then using the child's treatment data to determine subsequent treatment intensity. Sixteen parents with children enrolled in the DARS Autism Program expressed that they appreciated the grant assistance from DARS for ABA treatment. The parents indicated that they have seen great improvement in their children's progress and expressed that they would like to see the current number of hours in treatment continue and not be reduced to 16 - 20 hours per week. Another commenter requested clarification of the rule prohibiting the use of procedures that cause "pain or discomfort." The commenter requested that the types of procedures that would not be considered restrictive should be stated and clarified, and that a contractor should be able to submit requests to DARS for review of certain more restrictive procedures that would be approved in individual cases. The commenter requested that DARS establish a peer review committee with each program nominating a representative for the committee to review the restrictive procedures.

Response: DARS is adopting this rule with change. DARS is removing the phrase "physically aversive interventions that would result in pain or discomfort are not permitted" in this section and in §105.311 and §105.409. DARS is not making any changes related to the number of treatment hours. Treatment hours are within the evidence-based effective range as identified in the University of Texas report.

Comment: DARS received one comment regarding §105.211(2). The commenter expressed that the contractor should include the parents when developing the child's treatment plan.

Response: DARS is adopting this rule with changes to clarify that the intent of the rule is to have the contractor include the family when developing the child's treatment plan.

Comment: DARS received one comment regarding §105.211(8). The commenter expressed that the contractor should include the parents when developing the child's transition plan.

Response: DARS is adopting this rule with changes to clarify that the intent of the rule is to have the contractor include the family when developing the child's transition plan.

§105.215, Participation Requirements

Comment: DARS received one comment regarding §105.215(a). The commenter suggested that the attendance requirement be a good faith commitment on the part of the family due to unforeseen circumstances.

Response: DARS is adopting this rule without change. Section 105.215(e) states that the requirements may be waived with written approval by DARS.

Comment: DARS received one comment regarding §105.215(b). One commenter asked how the contractor could enforce any consequences should a family not be able to fulfill the commitment to 24 months of treatment services.

Response: DARS is adopting this rule without change. The intent is that families are informed of the participation requirements and at the time of the enrollment the contractor determines whether the family will commit to the participation requirements. The contractor determines if the family is an appropriate fit for services. The contractor will not be required to enforce any consequences when the family has an unforeseen circumstance that may cause the family to exit the DARS Autism Program early.

Comment: DARS received one comment regarding §105.215(c). The commenter asked what the responsibility would be of the DARS contractor when a parent fails to participate in parent training. The commenter suggested that the language be amended to include multiple warning notices to the family advising them that failure to fulfill this requirement would result in their child being discharged from the DARS Autism Program.

Response: DARS is adopting this rule without change. The rule allows the contractor flexibility to develop policies and procedures to ensure the family participates in parent training. Additionally, proposed §105.215(e) support the contractor by requiring parents to participate in parent training and allows the requirement to be waived with written approval by DARS.

§105.307, Eligibility

Comment: DARS received one comment regarding §105.307(a)(3). The commenter expressed that many of the DARS clients provide documentation of a diagnosis from the school district; however, many school diagnosticians are not psychologists or psychiatrists and do not meet the definition of a qualified professional. The commenter suggested that the definition be amended to include as a qualified professional

anyone who, by their degree and/or license, is qualified to make a diagnosis.

Response: No changes were made in response to this comment. The DARS Autism Program requires a professional who is qualified to make a DSM diagnosis that is acceptable to an insurance provider. This is necessary for DARS to be the payer of last resort.

Comment: DARS received two comments regarding §105.307(c)(2): One commenter requested clarification of what is meant by the eligibility requirement for Focused ABA services which states that "the child does not have multiple developmental needs." The commenter expressed that the fifth edition of the (DSM) indicates that children with ASD have a minimum of two areas of need. The commenter suggested that if the term "multiple" refers to more than two areas of developmental needs, the language should be clarified to provide more direction for the contractors. Another commenter suggested amending the guideline to read "the child does not have significant developmental needs."

Response: DARS is adopting this rule with changes. DARS will remove this paragraph from the rule to avoid confusion.

Comment: DARS received one comment regarding §105.307(c)(3). The commenter requested clarification of §105.307(c)(3), which states that eligibility for Focused Therapies includes participation by children ages three to five when "DARS Comprehensive ABA services are not available." The commenter asked what is encompassed in the phrase "not available."

Response: No changes were made in response to this comment. "Not available" means that DARS Comprehensive ABA services are not provided in a geographic area of the state or there are no openings to enroll the child in Comprehensive ABA services where there is a DARS Autism Program.

§105.309, Enrollment

Comment: One commenter expressed that this rule appears to leave out any requirement that the contractor provide notification to the families during the enrollment process of their available rights and procedural safeguards. The commenter suggested that the contractors inform the families upfront of their rights and procedural safeguards.

Response: DARS is adopting this rule without change. DARS will consider this recommendation for future rule revisions and solicit additional stakeholder input.

§105.311, Services Provided

Comment: DARS received one comment regarding §105.311(1). The commenter indicated that this section states that a contractor must provide no more than 30 hours per month of DARS Focused ABA services to enrolled children. This service is provided generally by a Board Certified Behavior Analyst (BCBA), not a direct care level employee. The commenter requested that DARS consider two different rates for contractors: one rate for the Comprehensive ABA Services and a different rate for the Focused ABA Services.

Response: DARS is adopting this rule without change to the number of hours of Focused ABA services. Rates are established in the terms and conditions of the contract.

Comment: DARS received one comment regarding §105.311(2). The commenter expressed that the contractor should include the parents when developing the child's treatment plan.

Response: DARS is adopting this rule with changes to clarify that the intent of the rule is to have the contractor include the family when developing the child's treatment plan.

Comment: DARS received one comment regarding §105.311(8). The commenter expressed that the contractor should include the parents when developing the child's transition plan.

Response: DARS is adopting this rule with changes to clarify that the intent of the rule is to have the contractor include the family when developing the child's transition plan.

Comment: DARS received another comment regarding this section. The commenter stated that they currently bill DARS based on actual attendance by each child. The current rate includes all aspects of the comprehensive model. The commenter asked if the contractor would be able to bill for treatment planning, program writing, etc., for Focused ABA services. For example, the Home and Community Based Services Wavier (HCS) allows for billing of writing Behavior Support Plans and other related activities.

Response: No changes were made in response to this comment. Rates are established in the terms and conditions of the contract.

§105.313, Length of Services

Comment: DARS received two comments regarding §105.313(c). One commenter expressed concern about the limited number of months of treatment and asked if there would be occasions where more than six months of services could be available to families within a fiscal year. The commenter also asked if DARS would need to be notified when a child left or re-entered services; and would the contractor need DARS approval for re-entry. Another commenter expressed concern about the six-month limit per fiscal year and suggested that DARS have mechanisms for requesting exceptions when a child has made insufficient progress in six months and is assessed by the BCBA.

Response: DARS is adopting this rule with changes. DARS is making a technical change to this rule to revise the service period from a fiscal year to a 12-month rolling period to ensure equity and that the rule is consistent with the DARS Autism Data Reporting System. The contractors will document in the DARS Autism Data Reporting System when the children exit and re-enter the DARS Autism Program. The contractor will not need DARS approval for re-entry into the Focused ABA services. DARS is also making a change to §105.313(d)(2)(A) to revise the service period from a fiscal year to a 12-month rolling period. DARS is not making changes related to the six-month limit per fiscal year.

§105.315, Participation Requirements

Comment: DARS received one comment regarding this rule. The commenter suggested that the attendance requirement be a good faith commitment on the part of the family due to unforeseen circumstances.

Response: DARS is adopting this rule without change. Section 105.315(d) states that the requirements may be waived with written approval by DARS.

§105.409, Services Provided

Comment: DARS received one comment regarding §105.409(2). The commenter expressed that the contractor should include the parents when developing the child's treatment plan.

Response: DARS is adopting this rule with changes to clarify that the intent of the rule is to have the contractor include the family when developing the child's treatment plan.

Comment: DARS received one comment regarding §105.409(7). The commenter expressed that the contractor should include the parents when developing the child's transition plan.

Response: DARS is adopting this rule with changes to clarify that the intent of the rule is to have the contractor include the family when developing the child's transition plan.

§105.413, Participation Requirement

Comment: One commenter suggested that the attendance requirement be a good faith commitment on the part of the family due to unforeseen circumstances.

Response: Except for the deletion of §105.413(b), DARS is adopting this rule without change; and the subsections have been relettered accordingly. Please see response to §105.721. Section 105.413(d) related to Participation Requirements states that the requirements may be waived with written approval by DARS.

§105.509, Complaint Process

Comment: One commenter suggested that the rule include language that DARS notify the family when contact is made with the contractor about the complaint filed and what information is being shared about the nature of the complaint so that DARS can determine the resolution.

Response: No changes were made in response to this comment. Section 105.509(e)(3) indicates that DARS will provide a written decision within 60 calendar days to the complainant addressing each allegation.

§105.607, Cost Share

Comment: DARS received one comment regarding §105.607(a). The commenter suggested that the cost share be eliminated, or calculated based on expenses as the majority of the parents can't afford the cost-share due to medical and other expenses associated with having a special needs child.

Response: No changes were made in response to this comment. Section 105.607(b)(2) take into consideration the family's expenses when determining the cost share for the family. Additionally, allowable deductions from the adjusted gross income of the family is defined in §105.105 of this chapter.

Comment: DARS received one comment suggesting that the rule include a procedure for families to challenge a calculation error or some other potential mistake made by the service contractor.

Response: DARS is adopting this rule with changes by adding §105.607(d), which provides actions for parents to take if the parent disagrees with the contractor's determination of the family's ability to pay, the calculated adjusted income, or the assigned maximum charge.

§105.707, Staff Qualifications

Comment: DARS received one comment regarding §105.707(a)(3). The commenter expressed that finding a BCBA with experience in providing services to the entire age range for the DARS Autism Program will be difficult; however, the commenter recognized the BCBA guidelines to not work outside their experience range. The commenter recommended that the DARS contractor have at least one BCBA on staff with one year experience for each age covered in the contract but not require each BCBA to have the experience across the full range.

Response: DARS is adopting this rule with changes to §105.707(a)(3) and adding §105.707(b). The intent of this section is to allow a contractor to have one or more BCBAs with experience in providing services to children within the age range that the contractor is serving.

Comment: DARS received one comment regarding §105.707(a)(5). The commenter indicated that in the past, a six-month grace period has been offered to staff in the Behavior Analyst I (BAI) position after all requirements have been met to receive their master's degree. The commenter recommends that the six-month grace period continue to be offered because the Behavior Analysis Certification Board only offers the BCBA certification exam a few times a year and the grace period would allow time for staff to sit for the exam and receive the results.

Response: No changes were made in response to this comment. Contractor staff members who provide assessment, oversee treatment of children, and train and supervise paraprofessional personnel involved in direct service delivery must be a BCBA.

Comment: DARS received three comments regarding §105.707(b)(3). One commenter was concerned about not being able to find paraprofessional staff to meet the minimum requirements outlined in this section. One commenter was concerned that meeting these requirements would not be possible and indicated that the training and supervision requirements are stringent enough. Another commenter expressed that they have hired at least 60 direct service staff during the last 6 years and have found that prior experience is not an important variable; instead, the quality of training and ongoing monitoring and supervision have a bigger impact. The commenter suggested removing the experience requirement for direct-service staff and pointed out that DARS's other eligibility requirements are still consistent with the Behavior Analyst Certification Board's eligibility requirements for the Registered Behavior Technician. One commenter requested that DARS allow the participation of students who are on internships or various practicums to participate in the direct delivery of services provided the interns are under formal placement and under supervision.

Response: DARS is adopting this section with changes as a result of the comments received. DARS is deleting the requirement in §105.707(b)(3). By deleting this requirement, the contractors will have more flexibility to hire direct delivery staff and allow students who are on internships to provide direct services.

Comment: DARS received two comments regarding §105.707(c)(1). One commenter expressed that once a formal training program is developed by a BCBA, it is not necessary for the training to be provided by a BCBA. The Behavior Analyst Certification Board allows a Board Certified Assistant Behavior Analyst (BCaBA) to train Registered Behavior Technicians. The commenter proposed changing this requirement to allow formalized training to be overseen by BCBA supervisors. One commenter indicated that they would have to hire additional

staff to focus solely on the training requirements and ultimately increasing the cost to provide the services for the DARS Autism Program.

Response: DARS is adopting this rule with changes to clarify that formalized training must be developed and overseen by a BCBA. The change is adopted as §105.707(d)(1). Furthermore, DARS is also changing the proposed §105.707(c)(2) to clarify that a BCBA or BCaBA may provide training. The change is adopted as §105.707(d)(2). In addition, DARS defined BCaBA as board certified assistant behavioral analyst and the new definition is adopted as §105.101(5).

Comment: DARS received one comment regarding proposed §105.707 (c)(3). The commenter agreed with having a written exam as part of the post-initial training but did not feel it was realistic to have staff take a written exam on an ongoing basis.

Response: DARS is adopting this rule with changes to proposed §105.707(c)(3) and adopted as §105.707(d)(3) to clarify that the contractor may require either a written exam or direct observation with fidelity checklists.

Comment: DARS received one comment regarding §105.707(c)(6). The commenter agreed that it is important to have ethics and professional conduct training as this is already required every three years for a BCBA; however, the commenter didn't feel it is a realistic requirement for all direct service providers to receive this training prior to working with clients.

Response: DARS is adopting this rule with changes to proposed §105.707(c)(6) and adopted as §105.707(d)(6). DARS will remove the three-hour requirement. This allows the contractor the flexibility to provide appropriate training for all direct delivery staff on ethics and professional conduct.

Comment: DARS received one comment regarding §105.707(c)(7). The commenter expressed that the training on typical child development is important; however, including this topic in staff training will result in an increase in agency cost. The commenter suggested that the state provide this information so providers can give the same information in training.

Response: No changes were made in response to this comment. DARS believes this training is fundamental to the successful delivery of DARS Autism Program services. Proposed §105.707(c)(7) is adopted as §105.707(d)(7).

Comment: DARS received one comment regarding §105.707(d)(1) - (3). The commenter indicated that while it is important to train direct service staff to be responsive to the data they are collecting, the commenter did not feel it is realistic to have a BCBA review the data twice a week with the direct service staff. The commenter expressed that they would have to require the direct service staff to work additional hours to meet with the BCBA, and this would result in an increase in agency cost.

Response: No changes were made in response to this comment. DARS believes this training is fundamental to the successful delivery of DARS Autism Program services. Proposed §105.707(d)(1) - (3) is adopted as §105.707(e)(1) - (3).

§105.709, Criminal Background Checks

Comment: DARS received two comments regarding this rule. One commenter indicated that this rule requires contractors to complete a finger-print based background check for those who will have direct contact with children and families and requested that a definition for "direct contact" be added to §105.105. Another commenter suggested that the background check include a check in the sex offender registry.

Response: DARS is adopting this rule without changes.

§105.713, Safety

Comment: DARS received one comment regarding this rule. The commenter suggested that the contractor safety procedures include parental notifications by the contractor so that families are made aware of any emergency happening with their child.

Response: DARS is adopting this rule with changes. A statement is added to this rule requiring the contractor to inform families when any emergency situation arises with the child.

§105.715, Confidentiality of Information

Comment: One commenter suggested that DARS advise the contractor that they are subject to the Family Educational Rights and Privacy Act if they are collecting information from the schools to assist in developing treatment or transitions plans for the child.

Response: DARS is adopting this rule without changes. This will be addressed through the terms and conditions of the contract.

§105.717, Maintenance and Review of an Interest List

Comment: Two commenters indicated that having to review the interest list every three months to determine if families are still eligible and interested in services would be extremely time consuming. One of the contractors suggested that the interest list should be reviewed every six months.

Another commenter suggested that the rule language include that the contractor provide potential enrollees on the interest list with information regarding an estimated wait time for services.

Response: DARS is adopting this rule with changes. DARS agrees with the comment to change the review of the interest list to every six months instead of every three months. DARS disagrees with the comment to require the contractor to provide estimated wait times as this could be confusing and misleading to families.

§105.719, Administration of Pre-test and Post-test Protocols Determined by DARS

Comment: DARS received two general comments regarding this section. One commenter expressed the importance of collecting outcome data to evaluate the program's effectiveness but did not think the current tests (PEP-3 and PDD-BI) are appropriate for the Focused ABA Services. The commenter suggested organizing a meeting among the providers to discuss a more appropriate way of capturing outcome data. Another commenter expressed that any protocol assessments and scores or results be provided to the parents or families of the child.

Response: DARS is adopting this rule without change.

Comment: DARS received one comment regarding §105.719(b). The commenter asked if the contractor would be penalized if the exit assessment is not returned by the family.

Response: DARS is adopting this rule without change.

§105.721, Parent Training

Comment: DARS received one general comment suggesting that language be added to the rule that the parent training be culturally competent and sensitive and, when necessary, that the training be provided in the native language of the parents.

Response: DARS is adopting this rule without change. DARS will consider this recommendation for future rule revisions and will solicit additional stakeholder input.

Comment: DARS received two comments regarding §105.721(a). One commenter had concerns about being able to provide parent training once every two weeks. The commenter asked whether there was a required duration for the trainings and what the contractor's responsibilities would be if the family does not meet the training requirement, whether the family could make up the training and the timeline for making up the training, and how many violations the family could have before the family is removed from the DARS Autism Program. One commenter expressed that this requirement would be difficult to implement as families currently have difficulty attending parent training once a month due to work schedules or other family obligations.

Response: DARS is adopting this rule without change. The rule allows the contractor flexibility to develop policies and procedures to ensure the family participates in parent training. Additionally, the rules in §§105.215; 105.315; and 105.413 of this chapter support the contractor by requiring parents to participate in parent training and allow the requirement to be waived with written approval by DARS.

Comment: DARS received one comment regarding §105.721(c). The commenter likes the idea of being able to have flexibility with group or individual training but believes it would be necessary to have the flexibility to bill DARS for training regardless of whether the child is present or not, especially if the parent training is in a group setting with other parents.

Response: DARS is adopting this rule without change. DARS will address this comment in the terms and conditions of the contract. DARS will delete §105.413(b) to allow the families of children enrolled on or before August 31, 2014 to continue with the current rules regarding parent training.

40 TAC §§105.101, 105.103, 105.105, 105.107, 105.109, 105.111, 105.113, 105.115, 105.117, 105.119, 105.121, 105.123, 105.125, 105.127, 105.129, 105.131, 105.133

STATUTORY AUTHORITY

The adopted repeals are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The repeals are adopted pursuant to HHSC's statutory rulemaking authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

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Sylvia F. Hardman
General Counsel
Department of Assistive and Rehabilitative Services
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Proposal publication date: May 30, 2014
For further information, please call: (512) 424-4050

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SUBCHAPTER A. GENERAL RULES

40 TAC §§105.101, 105.103, 105.105

STATUTORY AUTHORITY

The adopted new rules are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The new rules are adopted pursuant to HHSC's statutory rulemaking authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

§105.105. Definitions.

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

(1) Adjusted gross income--The gross income of the family, as defined in this section, minus allowable deductions. Adjusted income is used to determine a family's monthly cost share.

(2) Allowable deductions--Expenses that are not reimbursed by other sources. Allowable deductions are limited to:

(A) the actual medical or dental expenses of the parent or dependent that are primarily related to alleviating or preventing a physical or mental defect or illness, were paid over the previous 12 months, are expected to continue during the eligibility period, and are limited to the cost of:

(i) diagnosis, cure, alleviation, treatment, or prevention of disease;

(ii) treatment of any affected body part or function;

(iii) legal medical services delivered by physicians, surgeons, dentists, and other medical practitioners;

(iv) medication, medical supplies, and diagnostic devices;

(v) premiums paid for insurance that covers the expenses of medical or dental care;

(vi) transportation to receive medical or dental care; and

(vii) medical or dental debt that is being paid on an established payment plan;

(B) child-care and respite expenses for a family member;

(C) costs and fees associated with the adoption of a dependent child; and

(D) court-ordered child support payments paid for a child who is not counted as a family member or dependent.

(3) Applied behavior analysis (ABA)--The process of using behavioral principles to evaluate and teach socially relevant behavior, teach new skills, and increase desirable behaviors.

(4) Autism spectrum disorders--The disorders found in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) related to autism. An autism spectrum disorder (ASD) diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified, made under a previous DSM, is acceptable.

(5) BCaBA--A board certified assistant behavior analyst.

(6) BCBA--A board certified behavior analyst.

(7) BCBA-D--A board certified behavior analyst-doctoral.

(8) Child--A son, daughter, foster child, or stepchild who is under age 19 living in the home.

(9) Contractor--A service provider under contract with DARS to provide autism services.

(10) Cost share--The amount of monthly financial contribution required of a family for a child to participate in the DARS Autism Program, as described in §105.607 of this chapter (relating to Cost Share).

(11) DARS--Texas Department of Assistive and Rehabilitative Services.

(12) DARS Combined ABA services--ABA services that are provided to children three through eight years of age by a DARS contractor that may include either or both comprehensive ABA and focused ABA services.

(13) DARS Comprehensive ABA services--ABA services that are provided to children three through five years of age by a DARS contractor to treat all areas of developmental and behavioral needs.

(14) DARS Focused ABA services--ABA services that are provided to children 3 through 15 years of age by a DARS contractor to treat one or more deficits or behaviors of excess rather than the full range of developmental domains.

(15) Dependent--A child age 19 or older, parent, stepparent, grandparent, brother, sister, stepbrother, stepsister, or in-law; whose gross income is less than $3,900 a year; and for whom more than half of the person's support is provided for by the parent(s) or guardian(s) during the calendar year.

(16) Family--The child's parent(s) or guardian(s), the child, other children under 19 years of age; and other dependents of the parent or guardian.

(17) Fiscal year--The state fiscal year. Begins on September 1 and ends on August 31 of the following year.

(18) Gross income--All income received by the family for determination of the family's cost share, from whatever source, that is considered income by the Internal Revenue Service before federal allowable deductions are applied.

(19) Individualized Education Program (IEP)--A written document that is developed for each public school child who is eligible for special education.

(20) Interest list--A list, maintained by the contractor, of families who have indicated an interest in receiving services, and who meet the eligibility criteria.

(21) LEA--Local educational agency.

(22) Qualified professional--An actively licensed physician or psychologist with training and background related to the diagnosis and treatment of neurodevelopmental disorders.

(23) Texas resident--A person who is in Texas and intends to remain in the state, either permanently or for an indefinite period.

(24) Third-party payer--A company, organization, insurer, or government agency other than DARS that makes payment for health care services received by an enrolled child.

(25) Transition plan--A plan that identifies and documents appropriate steps and transition services to support the child and family to smoothly and effectively transition from the DARS Autism Program to LEA special education services or other community activities, places, or programs the family would like the child to participate in after exiting the DARS Autism Program.

(26) Treatment plan--A written plan of care, including treatment goals, for providing ABA treatment services to an eligible child and the child's family to enhance the child's development. Intensity and length of services is determined by the treatment goals.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Department of Assistive and Rehabilitative Services
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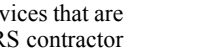

SUBCHAPTER B. DARS COMPREHENSIVE ABA SERVICES

40 TAC §§105.201, 105.207, 105.209, 105.211, 105.213, 105.215

STATUTORY AUTHORITY

The adopted new rules are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The new rules are adopted pursuant to HHSC's statutory rulemaking authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

§105.211. Services Provided.

The contractor must:

(1) provide no less than 16 and no more than 20 hours per week of ABA services to enrolled children;

(2) develop with the family a written treatment plan for each child served, including plans for generalization of learned skills and behaviors to other environments;

(3) provide and document parent training as a component of the services;

(4) provide ongoing analysis and evaluation of each child's progress;

(5) document services provided to each child;

(6) administer pre- and post-treatment protocols as determined by DARS;

(7) document efforts to coordinate services with the school setting the child attends to promote generalization;

(8) create with the family and maintain documented transition plans for each child leaving DARS Comprehensive ABA services; and

(9) maintain in the child's record the following documentation related to the transition plan:

(A) timelines for each transition activity;

(B) the family's choice for the child to transition into a community or educational program or for the child to remain in the home; and

(C) appropriate steps and transition services to support the family's exit from the DARS Autism Program to LEA special education services or other appropriate activities, places, or programs the family would like the child to participate in after exiting services.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. DARS FOCUSED ABA SERVICES

40 TAC §§105.301, 105.307, 105.309, 105.311, 105.313, 105.315

STATUTORY AUTHORITY

The adopted new rules are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The new rules are adopted pursuant to HHSC's statutory rulemaking authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

§105.307. Eligibility.

(a) To be eligible for DARS Focused ABA services, a child must:

(1) be a Texas resident;

(2) be 3 through 15 years of age; and

(3) have a documented diagnosis on the autism spectrum made by a qualified professional.

(b) The parent must participate in parent training, described in §105.721 of this chapter (relating to Parent Training) in order for their child to receive services.

(c) Children who are three through five years of age are eligible for these services when:

(1) the child exhibits behaviors that prevents participation in DARS Comprehensive ABA services; or

(2) DARS Comprehensive ABA services are not available.

(d) Eligibility for DARS Focused ABA services does not guarantee enrollment into the DARS Autism Program.

(1) Children become eligible on their third birthday and become ineligible on their sixteenth birthday.

(2) A child considered eligible for services by the contractor based on the criteria in this section is added to the contractor's interest list when there is no opening for DARS Focused ABA services in the local DARS Autism Program.

§105.311. Services Provided.

The contractor must:

(1) provide no more than 30 hours per month of DARS Focused ABA services to enrolled children;

(2) develop a written treatment plan with the family for each child served, including plans for generalization of learned skills and behaviors to other environments;

(3) provide and document parent training as a component of the services;

(4) provide ongoing analysis and evaluation of each child's progress;

(5) document services provided to each child;

(6) administer pre- and post-treatment protocols as determined by DARS;

(7) document efforts to coordinate services with the school setting the child attends to promote generalization;

(8) create with the family and maintain documented transition plans for each child leaving DARS Focused ABA services; and

(9) maintain in the child's record the following documentation related to the transition plan:

(A) timelines for each transition activity;

(B) the family's choice for the child to transition into a community or educational program or for the child to remain in the home; and

(C) appropriate steps and transition services to support the family's exit from the DARS Autism Program to LEA special education services or other appropriate activities, places, or programs the family would like the child to participate in after exiting services.

§105.313. Length of Services.

(a) The length of services for a child is based on the child's specific needs not to exceed a maximum of 24 months in the DARS Autism Program.

(b) A change in the contract between DARS and its contractors, or a change in the contractor, does not restart the six-month annual limit or the maximum 24 months of service.

(c) Services may not exceed six months in a 12-month rolling period, not all of which must be consecutive.

(d) Children are exited from DARS Focused ABA services when:

(1) treatment goals are met;

(2) service limits have been reached as follows:

(A) six months of service have been provided within a 12-month rolling period; or

(B) 24 months of lifetime service have been provided; or

(C) they reach their sixteenth birthday.

(e) Children who exit DARS Focused ABA services with remaining months of service may reapply for additional DARS Focused ABA services based on eligibility determination, the child's needs, available funding, and the contractor's ability to serve more children in accordance with §105.307 of this chapter (relating to Eligibility).

(f) A family may choose, at its own expense, for a child to continue receiving services from the contractor after the six-month annual limit or 24-month limit. DARS is not liable for any costs incurred after the maximum 24 months of service has been provided, including any costs incurred by a contractor providing those services.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

TRD-201403591
Sylvia F. Hardman
General Counsel
Department of Assistive and Rehabilitative Services
Effective date: September 1, 2014
Proposal publication date: May 30, 2014
For further information, please call: (512) 424-4050

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SUBCHAPTER D. DARS COMBINED ABA SERVICES

40 TAC §§105.401, 105.407, 105.409, 105.411, 105.413, 105.415

STATUTORY AUTHORITY

The adopted new rules are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The new rules are adopted pursuant to HHSC's statutory rulemaking authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

§105.409. Services Provided.

The contractor must:

(1) provide DARS Combined ABA services to enrolled children on the autism spectrum using ABA;

(2) develop a treatment plan with the family for each child served;

(3) provide and document parent training as a component of the services;

(4) provide ongoing analysis and evaluation of each child's progress;

(5) document services provided to each child;

(6) administer post-treatment protocols in accordance with contractual procedures established between the contractor and DARS;

(7) create with the family and maintain documented transition plans for each child leaving DARS Combined ABA services; and

(8) maintain in the child's record the following documentation related to the transition plan:

(A) timelines for each transition activity;

(B) the family's choice for the child to transition into a community or educational program or for the child to remain in the home; and

(C) appropriate steps and transition services to support the family's exit from DARS Autism Program to LEA special education services or other appropriate activities, places, or programs the family would like the child to participate in after exiting services.

§105.413. Participation Requirement.

(a) Attendance must be maintained at a level of at least 85 percent of scheduled DARS Combined ABA services over the duration of therapy. This is necessary for the child to fully benefit from the DARS Autism Program, regardless of the reason for the absence.

(b) The parent and the child must participate in post-test protocols before exiting DARS Combined ABA services.

(c) If the parent and the child fail to meet these requirements, the child may be dismissed from the DARS Autism Program. The requirements may be waived with written approval by DARS.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

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Sylvia F. Hardman
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Department of Assistive and Rehabilitative Services
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For further information, please call: (512) 424-4050

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SUBCHAPTER E. RIGHTS OF PARTICIPANTS

40 TAC §105.507, §105.509

STATUTORY AUTHORITY

The adopted new rules are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The new rules are adopted pursuant to HHSC's statutory rulemaking authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

§105.509. Complaint Process.

(a) An individual or organization on behalf of a child enrolled in the DARS Autism Program may file a complaint with DARS alleging that a requirement of the DARS Autism Program was violated. A complaint may be filed directly with DARS without having been filed with the contractor.

(b) A complaint regarding the DARS Autism Program must be filed within 180 calendar days of the alleged violation. A complaint

filed 180 calendar days after the alleged violation may be dismissed without further review by the DARS Autism Program.

(c) A complaint may be filed in any of the following ways:

(1) by mail to the DARS Autism Program Specialist, Texas Department of Assistive and Rehabilitative Services, 4800 North Lamar Boulevard, Austin, Texas 78756; or

(2) by email to dars.inquiries@dars.state.tx.us.

(d) The complaint must contain the following information:

(1) the name of the person filing the complaint;

(2) the name of the child for whom the complaint is filed;

(3) the name of the contractor;

(4) the date of the incident;

(5) the requirement and/or rule that was allegedly violated;

(6) a summary of the facts of the alleged violation; and

(7) the relief requested.

(e) DARS staff:

(1) logs the date the complaint was received;

(2) evaluates the complaint and seeks facts from the parties involved;

(3) provides a written decision within 60 calendar days to the complainant addressing each allegation;

(4) provides technical assistance and appropriate follow-up to the parties involved in the complaint as necessary; and

(5) retains the documentation of the complaint for five years.

(f) A complainant may appeal the determination of the complaint in writing, addressed to the Director, Center for Policy and External Relations, 4800 North Lamar Boulevard, Austin, Texas 78756. Such appeals must be submitted within 30 calendar days from the date of the written decision and will be addressed within 30 calendar days of receipt by DARS. The appeal determination is final.

(g) More information regarding the complaint process may be obtained by calling DARS Inquiries at 1-800-628-5115.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

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Sylvia F. Hardman
General Counsel
Department of Assistive and Rehabilitative Services
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For further information, please call: (512) 424-4050

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SUBCHAPTER F. FEES

40 TAC §105.607, §105.609

STATUTORY AUTHORITY

The adopted new rules are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The new rules are adopted pursuant to HHSC's statutory rule-making authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

§105.607. Cost Share.

(a) The contractor is required to use the cost share schedule and instructions provided by DARS to calculate the amount of monthly cost share owed by the family for the services of each eligible child, regardless of the availability of private insurance or other third-party payer reimbursements. The family's obligation for payment of any deductible, co-payment, or coinsurance is limited to the monthly cost share amount.

(b) Factors that affect the amount of monthly cost share include the:

(1) monthly costs of services provided by the contractor as determined by the number of hours of service provided multiplied by the contractor's negotiated hourly rate with DARS;

(2) adjusted gross income of the family as determined by the federal tax return filed for the previous year; or if the family did not file, the family's gross income minus the allowable deductions as defined in §105.105 of this chapter (relating to Definitions);

(3) family size calculated by summing the number of custodial parents or guardians, the child, and other dependents of the parents or guardians as defined in §105.105 of this chapter; and

(4) number of children from a single family who are enrolled in the DARS Autism Program.

(c) Cost share for a single family with multiple children in service must be calculated for each child monthly. The family will owe 100 percent of the cost share amount for the child with the highest cost share and 50 percent of each additional child's cost share.

(d) If the parent disagrees with the contractor's determination of the family's ability to pay, the calculated adjusted income, or the assigned maximum charge, the parent can:

(1) request a review by the contractor's manager or program director;

(2) file an informal or formal complaint with the contractor;

(3) contact the DARS Inquiries Line at 1-800-628-5115 for help resolving a problem or concern with the contractor; and

(4) file a formal complaint with DARS as noted in §105.509 of this chapter (relating to Complaint Process);

(e) Information about DARS procedures and cost share schedule used to administer the DARS Autism Program are available on the DARS website and for viewing at DARS, 4800 North Lamar Boulevard, Austin, Texas, between 8:00 a.m. and 5:00 p.m. on business days.

(f) The contractor is required to bill and collect cost share amounts owed by the family and by other responsible parties. DARS funds must not be used to pay for any portion of the required cost share.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

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Sylvia F. Hardman
General Counsel
Department of Assistive and Rehabilitative Services
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For further information, please call: (512) 424-4050

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SUBCHAPTER G. CONTRACTOR REQUIREMENTS

40 TAC §§105.707, 105.709, 105.711, 105.713, 105.715, 105.717, 105.719, 105.721

STATUTORY AUTHORITY

The adopted new rules are authorized by the Texas Human Resources Code, Chapter 111, §111.051, and Chapter 117. The new rules are adopted pursuant to HHSC's statutory rulemaking authority under Texas Government Code, Chapter 531, §531.0055(e), which provides the Executive Commissioner of HHSC with the authority to promulgate rules for the operation of and provision of health and human services by the health and human services agencies.

§105.707. Staff Qualifications.

(a) Contractor staff members who provide assessment and oversee treatment of children, and who train and supervise paraprofessional personnel involved in direct service delivery must have:

(1) a master's or doctoral degree from an accredited institution of higher education in psychology, behavior analysis, or a related field;

(2) documented graduate-level coursework in behavioral assessment and intervention, selecting outcomes and strategies, behavior change procedures, experimental methods, and measuring and interpreting behavioral data;

(3) at least one year of experience in providing services to children within the age range of 3 through 15 years of age with diagnoses on the autism spectrum;

(4) knowledge of typical child development for children 3 through 15 years of age; and

(5) a BCBA or BCBA-D certification.

(b) The DARS contractor must have at least one BCBA with one year of experience in providing services for each age covered in the range of 3 through 15 years of age with a diagnosis on the autism spectrum.

(c) All staff members who provide direct services to children must at a minimum:

(1) have a high school diploma; and

(2) be 18 years of age.

(d) All direct service staff members must receive training before working independently and on an ongoing basis. Training must:

(1) be formalized training developed and overseen by BCBA supervisors on methods for data collection, procedures for implementing discrete trial teaching, prompting procedures, behavior management strategies for addressing problem behavior, and other ABA techniques and program specific methods;

(2) be provided by a BCBA or BCaBA through didactic instruction, workshops, readings, observation of modeling of techniques by supervisors, role-play with supervisors, and training in the natural environment in which supervisors provide specific feedback and additional training as needed;

(3) be assessed for effectiveness through written exams (with criteria to determine mastery) or direct observation by BCBA supervisors of therapists working directly with children (with fidelity checklists to determine accurate use of procedures and criteria to determine mastery) to ensure individual acquisition of the skills necessary to accurately implement ABA treatments;

(4) cover all of the tasks in the Behavior Analyst Certification Board's Registered Behavior Technician Task List and Guidelines for Responsible Conduct for Behavior Analysts that have been designated as relevant for behavior technicians;

(5) have a cumulative duration of at least 40 hours;

(6) include ethics and professional conduct training; and

(7) include training on typical child development for children 3 through 15 years of age.

(e) All direct service staff members must be supervised by a BCBA or BCBA-D. Supervision must:

(1) occur at least once every two weeks;

(2) include direct observation of ABA programming to assess if procedures are implemented accurately and to inform the supervisor on the potential need to adjust teaching procedures; and

(3) include ongoing review, no less than two times per week, of data from ABA programs and data pertaining to problem behavior.

§105.713. Safety.

The contractor must maintain an emergency evacuation plan at the contractor's service site that complies with all applicable local, state, and federal laws, rules, and regulations governing provision of services under this chapter. The contractor will inform the family when any emergency situation arises with the child.

§105.717. Maintenance and Review of an Interest List.

(a) When a contractor is not able to accept an eligible child into the DARS Autism Program immediately, and the family is interested, the contractor places the family on an interest list. The interest list is reviewed every six months to determine if families are still eligible and interested in services.

(b) Children are removed from the interest list when an opening for services is available, the child is no longer eligible for the DARS Autism Program, or when the family indicates they are no longer interested.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 8, 2014.

TRD-201403595

Sylvia F. Hardman
General Counsel
Department of Assistive and Rehabilitative Services
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For further information, please call: (512) 424-4050

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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.

Proposed Rule Reviews

Texas Film Commission

Title 13, Part 8

In accordance with §2001.039, Texas Government Code, the Office of the Governor, Texas Film Commission, submits notice of the agency's intention to review the rules found in 13 TAC Chapters 121 (Texas Moving Image Industry Incentive Program) and 122 (Temporary Use of State Buildings and Grounds by Television or Film Production Companies). Review of the rules under these chapters will determine whether the reasons for adoption of the rules continue to exist.

Comments on this rule review may be may be hand-delivered to Office of the Governor, General Counsel Division, 1100 San Jacinto, Austin, Texas 78701; mailed to P.O. Box 12428, Austin, Texas 78711-2428; faxed to (512) 463-1932; or emailed to david.zimmerman@gov.texas.gov, and should be addressed to the attention of David Zimmerman, Assistant General Counsel. Comments must be received no later than 30 days from the date of publication of this rule review in the *Texas Register.*

TRD-201403636
David Zimmerman
Assistant General Counsel, Office of the Governor
Texas Film Commission
Filed: August 8, 2014

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Adopted Rule Reviews

Office of the Attorney General

Title 1, Part 3

The Office of the Attorney General (OAG) has completed its review of 1 TAC Chapter 52 Administration, Subchapter A, General Provisions.

The proposed rule review was published in the May 30, 2014, issue of the *Texas Register* (39 TexReg 4275).

The rules were reviewed as a result of the OAG's general rule review. The OAG finds that the reasons for initially adopting Chapter 52, Subchapter A, General Provisions, continue to exist and readopts these rules, without changes, pursuant to the requirements of Texas Government Code, §2001.039.

The OAG received no comments with respect to the review of these rules.

TRD-201403826
Katherine Cary
General Counsel
Office of the Attorney General
Filed: August 13, 2014

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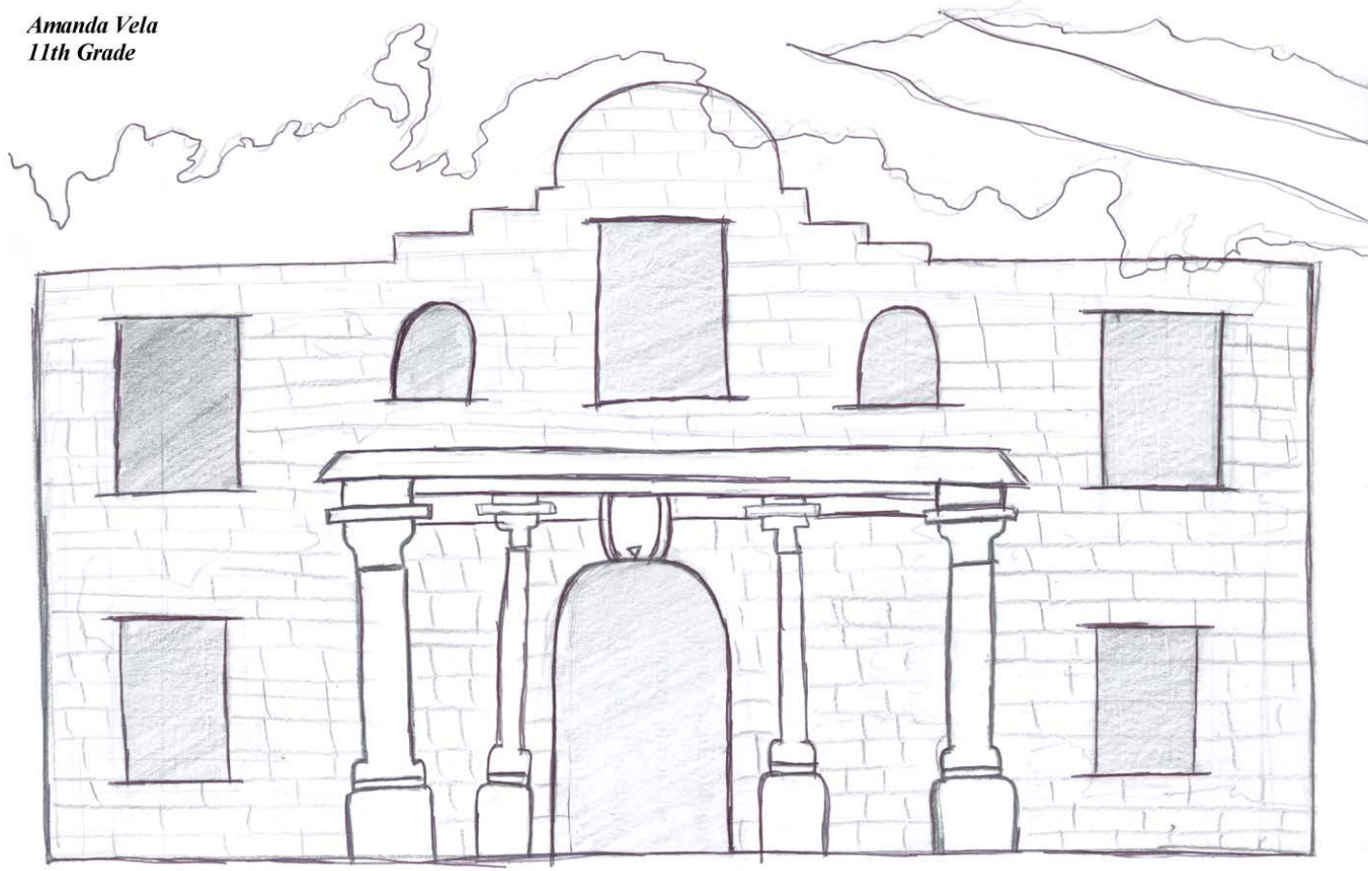
Amanda Vela
11th Grade



TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 30 TAC §17.14(a)

Tier I Table

The property listed in this table is property that the executive director has determined is used wholly for pollution control purposes when used as shown in the Description section of the table and when no marketable product arises from using the property. The items listed are described in generic terms without the use of brand names or trademarks. The use percentages on all property on the table are established based on standard uses of the pieces of equipment involved. If the executive director determines that the equipment is not being used in a standard manner (*e.g.*, use in production or recovery of a marketable product), the executive director may require that a Tier III application, using the Cost Analysis Procedure, be filed by the applicant to calculate the appropriate use determination percentage. For items where the description limits the use determination to the incremental cost difference, the cost of the property or device with the pollution control feature is compared to a similar device or property without the pollution control feature. The table is a list adopted under Texas Tax Code, §11.31(g).

Air Pollution Control Equipment

Particulate Control Devices

No.	Media	Property	Description	%
A-1	Air	Dust Collection Systems	Structures containing filters, blowers, ductwork - used to remove particulate matter from exhaust gas streams in order to prevent release of particulate matter to ambient air.	100
A-2	Air	Demisters or Mist Eliminators Added	Mesh pads or cartridges - used to remove entrained liquid droplets from exhaust gas streams.	100
A-3	Air	Electrostatic Precipitators	Wet or dry particulate collection created by an electric field between positive or negative electrodes and collection surface.	100
A-4	Air	Dry Cyclone Separators	Single or multiple inertial separators with blowers and ductwork used to remove particulate matter from exhaust gas streams.	100
A-5	Air	Scrubbers	Wet collection device using spray chambers, wet cyclones, packed beds, orifices, venturi, or high- pressure sprays to remove particulates and chemicals from exhaust gas streams. System may include pumps, ductwork, and blowers needed for the equipment to function.	100
A-6	Air	Water/ Chemical Sprays and Enclosures for Particulate Suppression	Spray nozzles, conveyor and chute covers, windshields, piping, and pumps used to reduce fugitive particulate emissions.	100
A-7	Air	Smokeless Ignitors	Installed on electric generating units to control particulate emissions and opacity on start-up.	100

Combustion Based Control Devices

No.	Media	Property	Description	%
A-20	Air	Thermal Oxidizers	Thermal destruction of air pollutants by direct flame combustion.	100
A-21	Air	Catalytic Oxidizer	Thermal destruction of air pollutants that uses a catalyst to promote oxidation.	100

A-22	Air	Flare/Vapor Combustor	Stack, burner, flare tip, and blowers used to destroy air contaminants in a vent gas stream.	100

Non-Volatile Organic Compounds Gaseous Control Devices

No.	Media	Property	Description	%
A-40	Air	Molecular Sieve	Microporous filter used to remove hydrogen sulfide (H_2S) or nitrogen oxides (NO_X) from a waste gas stream.	100
A-41	Air	Strippers Used in Conjunction with Final Control Device	Stripper, with associated pumps, piping - used to remove contaminants from a waste gas stream or waste liquid stream.	100

Monitoring and Sampling Equipment

No.	Media	Property	Description	%
A-60	Air	Fugitive Emission Monitors	Organic vapor analyzers - used to discover leaking piping components.	100
A-61	Air	Continuous & Noncontinuous Emission Monitors	Monitors, analyzers, buildings, air conditioning equipment, and optical gas imaging instruments used to demonstrate compliance with emission limitations of regulated air contaminants, (including flow and diluent gas monitors and dedicated buildings).	100
A-62	Air	Monitoring Equipment on Final Control Devices	Temperature monitor or controller, flow-meter, pH meter, and other meters for a pollution control device. Monitoring of production equipment or processes is not included.	100
A-63	Air	On or Off-Site Ambient Air Monitoring Facilities	Towers, structures, analytical equipment, sample collectors, monitors, and power supplies used to monitor for levels of contaminants in ambient air.	100
A-64	Air	Noncontinuous Emission Monitors, Portable	Portable monitors, analyzers, structures, trailers, air conditioning equipment, and optical gas imaging instruments used to demonstrate compliance with emission limitations.	100
A-65	Air	Predictive Emission Monitors	Monitoring of process and operational parameters that are used solely to calculate or determine compliance with emission limitations.	100
A-66	Air	Sampling Ports	Construction of stack or tower sampling ports used for emission sampling or for the monitoring of process or operational parameters that are used to calculate or determine compliance with emission limitations.	100

Nitrogen Oxides Controls

No.	Media	Property	Description	%
A-80	Air	Selective Catalytic and Non-catalytic Reduction Systems	Catalyst bed, reducing agent injection and storage, monitors - used to reduce nitrogen oxides (NO_X) emissions from combustion sources. Non-catalytic systems use a reducing agent without a catalyst.	100
A-81	Air	Catalytic Converters for Stationary Sources	Used to reduce NO_X emissions from internal combustion engines.	100
A-82	Air	Air/Fuel Ratio Controllers for Piston- Driven Internal Combustion Engines	Used to control the air/fuel mixtures and reduce NO_X formation for fuel injected, naturally aspirated, or turbocharged engines.	100

A-83	Air	Flue Gas Recirculation	Ductwork and blowers used to redirect part of the flue gas back to the combustion chamber for reduction of NO_X formation. May include fly ash collection in coal fired units.	100
A-84	Air	Water/Steam Injection	Piping, nozzles, and pumps to inject water or steam into the burner flame of utility or industrial burners or the atomizer ports for gas turbines, used to reduce NO_X formation.	100
A-85	Air	Over-fire Air & Combination of asymmetric over-fire air with the injection of anhydrous ammonia or other pollutant-reducing agents	The asymmetric over- fire air layout injects preheated air through nozzles through a series of ducts, dampers, expansion joints, and valves also anhydrous ammonia or other pollutant-reducing agent injection is done at the same level.	100
A-86	Air	Low-NO_X Burners	Installation of low-NO_X burners. The eligible portion is the incremental cost difference. For a replacement burner, the incremental cost difference is calculated by comparing the cost of the new burner with the cost of the existing burner. For new installations, the incremental cost difference is calculated by comparing the cost of the new burner to the cost of a similarly sized burner without NOx controls from the most recent generation of burners.	100
A-87	Air	Water Lances	Installed in the fire box of boilers and industrial furnaces to eliminate hot spots, thereby reducing NO_X formation.	100
A-88	Air	Electric Power Generation Burner Retrofit	Retrofit of existing burners on electric power generating units with components for reducing NO_X including directly related equipment.	100
A-89	Air	Wet or Dry Sorbent Injection Systems	Use of a sorbent for flue gas desulfurization or NOx control.	100

Volatile Organic Compounds (VOC) Control

No.	Media	Property	Description	%
A-110	Air	Carbon Adsorption Systems	Carbon beds or liquid-jacketed systems, blowers, piping, condensers - used to remove VOC emissions and odors from exhaust gas streams.	100
A-111	Air	Storage Tank Secondary Seals and Internal Floating Roofs	Used to reduce VOC emissions caused by evaporation losses from aboveground storage tanks.	100
A-112	Air	Replacement of Existing Pumps, Valves, or Seals in Piping Service	The incremental cost difference between the cost of the original equipment and the replacement equipment is eligible only when the replacement of these parts is done for the sole purpose of eliminating fugitive emissions of VOCs. New systems do not qualify for this item.	100
A-113	Air	Welding of Pipe Joints in VOC Service (Existing Pipelines)	Welding of existing threaded or flanged pipe joints to eliminate fugitive emission leaks.	100
A-114	Air	Welding of Pipe Joints in VOC Service (New Construction)	The incremental cost difference between the cost of using threaded or flanged joints and welding of pipe joints in VOC service.	100
A-115	Air	External Floating Roofs	Used to reduce VOC emissions caused by evaporation losses from aboveground storage tanks. Must be installed to meet or exceed §115.112 of this title (relating to Control Requirements).	100

Mercury Control

No.	Media	Property	Description	%
A-130	Air	Sorbent Injection Systems	Sorbents sprayed into the flue gas that chemically react to absorb mercury. The sorbents are then removed by a particulate removal device. Equipment may include pumps, tanks, blowers, nozzles, ductwork, hoppers, and particulate collection devices needed for the equipment to function.	100
A-131	Air	Fixed Sorbent Systems	Equipment, such as stainless steel plate with a gold coating that is installed in the flue gas to absorb mercury.	100
A-132	Air	Mercury Absorbing Filters	Filters that absorb mercury such as those using the affinity between mercury and metallic selenium.	100
A-133	Air	Oxidation Systems	Equipment used to change elemental mercury to oxidized mercury. This can be catalysts (similar to Selective Catalytic Reduction (SCR) catalyst) or chemical additives that can be added to the flue gas or directly to the fuel.	100
A-134	Air	Photochemical Oxidation	Use of an ultraviolet light from a mercury lamp to provide an excited state mercury species in flue gas, leading to oxidation of elemental mercury. These units are only eligible if mercury is removed from flue gas.	100
A-135	Air	Chemical Injection Systems	Equipment used to inject chemicals into the combustion zone or flue gas that chemically bonds mercury to the additive, which is then removed in a particulate removal device.	100

Sulfur Oxides Controls

No.	Media	Property	Description	%
A-160	Air	Wet and Dry Scrubbers	Circulating fluid bed and moving bed technologies using a dry sorbent or various wet scrubber designs that inject a wet sorbent into the scrubber.	100
A-161	Air	Selective Catalytic and Non-catalytic Reduction Systems	Catalyst bed, reducing agent injection and storage, monitors - used to reduce sulfur oxide emissions from combustion sources. Non-catalytic systems use a reducing agent without a catalyst.	100

Miscellaneous Control Equipment

No.	Media	Property	Description	%
A-180	Air	Hoods, Duct and Collection Systems connected to Final Control Devices	Piping, headers, blowers, hoods, and ducts used to collect air contaminants and route them to a control device.	100
A-181	Air	Stack Modifications	Construction of stack extensions to meet a permit requirement.	100
A-182	Air	New Stack Construction	The incremental cost difference between the stack height required for production purposes and the stack height required for pollution control purposes.	100
A-183	Air	Stack Repairs	Repairs made to an existing stack for that stack to provide the same level of pollution control as was previously provided.	100
A-184	Air	Vapor/Liquid Recovery Equipment (for venting to a control device)	Piping, blowers, vacuum pumps, and compressors used to capture a waste gas or liquid stream and vent to a control device, including those used to eliminate emissions associated with loading tank trucks, rail cars, and barges.	100
A-185	Air	Paint Booth Control Devices	Pollution control equipment associated with the paint booth - including the items such as the control device, water curtain, filters, or other devices to capture paint fumes.	100

A-186	Air	Particulate Control Device Connected to a Blast Cleaning System	Particulate control device.	100
A-187	Air	Amine or Chilled Ammonia Scrubber	Installed to provide post combustion capture of pollutants (including carbon dioxide upon the effective date of a final rule adopted by the United States Environmental Protection Agency (EPA) regulating carbon dioxide as a pollutant).	100
A-188	Air	Catalyst-based Systems	Installed to allow the use of catalysts to reduce pollutants in emission streams.	100
A-189	Air	Enhanced Scrubbing Technology	Installed to enhance scrubber performance, including equipment that promotes the oxidation of elemental mercury in the flue gas prior to entering the scrubber.	100

Water and Wastewater Pollution Control Equipment

Solid Separation and De-watering

No.	Media	Property	Description	%
W-1	Water	API Separator	Separates oil, water, and solids by settling and skimming.	100
W-2	Waste water	CPI Separator	Mechanical oil, water, and solids separator.	100
W-3	Waste water	Dissolved Air Flotation	Mechanical oil, water, and solids separator.	100
W-4	Waste water	Skimmer	Used to remove hydrocarbon from process wastewater.	100
W-5	Waste water	Decanter	Used to decant hydrocarbon from process wastewater.	100
W-6	Waste water	Belt Press, Filter Press, or Plate and Frame	Mechanical de-watering devices.	100
W-7	Water	Centrifuge	Separation of liquid and solid waste by centrifugal force, typically a rotating drum.	100
W-8	Water	Settling Basin	Simple tank or basin for gravity separation of suspended solids.	100
W-9	Water	Equalization	Tank, sump, or headbox used to settle solids and equilibrate process wastewater streams.	100
W-10	Water	Clarifier	Circular settling basins usually containing surface skimmers and sludge removal rakes.	100

Disinfection

No.	Media	Property	Description	%
W-20	Water	Chlorination	Wastewater disinfection treatment using chlorine.	100
W-21	Water	De-chlorination	Equipment for removal of chlorine from water or wastewater.	100
W-22	Water	Electrolytic Disinfection	Disinfect water by the use of electrolytic cells.	100
W-23	Water	Ozonization	Equipment that generates ozone for the disinfection of wastewater.	100
W-24	Water	Ultraviolet	Disinfection of wastewater by the use of ultraviolet light.	100
W-25	Water	Mixed Oxidant Solution	Solution of chlorine, chlorine dioxide, and ozone to replace chlorine for disinfection.	100

Biological Systems

No.	Media	Property	Description	%
W-30	Water	Activated Sludge	Wastewater treatment using microorganisms to metabolize biodegradable organic matter in aqueous waste streams. Can include tanks, aeration equipment, clarifiers, and equipment used to handle sludge.	100
W-31	Water	Adsorption	Use of activated carbon to remove organic contaminants from wastewater.	100
W-32	Water	Aeration	Passing air through wastewater to increase oxygen available for bacterial activities that remove contaminants.	100
W-33	Water	Rotary Biological Contactor	Use of large rotating discs that contain a bio- film of microorganisms that promote biological purification of the wastewater.	100
W-35	Water	Trickling Filter	Fixed bed of highly permeable media in which wastewater passes through and forms a slime layer to remove contaminants.	100
W-36	Water	Wetlands and Lagoons (artificial)	Artificial marsh, swamp, or pond that uses vegetation and natural microorganisms as bio- filters to remove sediment and other pollutants from wastewater or stormwater.	100
W-37	Water	Digester	Enclosed, heated tanks for treatment of sludge that is broken down by bacterial action.	100

Other Equipment

No.	Media	Property	Description	%
W-50	Water	Irrigation	Equipment that is used to disburse treated wastewater through irrigation on the site.	100
W-51	Water	Outfall Diffuser	Device used to diffuse effluent discharge from an outfall.	100
W-52	Water	Activated Carbon Treatment	Use of carbon media such as coke or coal to remove organics and particulate from wastewater. May be used in either fixed or fluidized beds.	100
W-53	Water	Oxidation Ditches and Ponds	Process of pumping air bubbles into a pond to assist in oxidizing organic and mineral pollution.	100
W-54	Water	Filters: Sand, Gravel, or Microbial	Passing wastewater through a sand or gravel bed to remove solids and reduce bacteria.	100
W-55	Water	Chemical Precipitation	Process used to remove heavy metals from wastewater.	100
W-56	Water	Ultra-filtration	Use of semi-permeable membrane and hydrostatic pressure to filter solids and high molecular weight solutes from wastewater.	100
W-57	Water	Conveyances, Pumps, Sumps, Tanks, Basins	Used to segregate storm water from process water, control storm water runoff, or convey contaminated process water.	100
W-58	Water	Wastewater Treatment Facility/Plant	New wastewater treatment facilities (including on-site septic systems) constructed to process wastewater generated on site.	100
W-59	Water	High-Pressure Reverse Osmosis	The passing of a contaminated water stream over a permeable membrane at high pressure to collect contaminants.	100
W-60	Water	Hydro-cyclone Vapor Extraction	An air-sparged hydro-cyclone for the removal of VOCs from a wastewater stream.	100
W-61	Water	Chemical Oxidation	Use of hydrogen peroxide or other oxidants for wastewater treatment.	100

W-62	Water	Storm Water Containment Systems	Structures or liners used for containment of runoff from rainfall. The land that is actually occupied by the containment structure is eligible for a positive use determination.	100
W-63	Water	Wastewater Impoundments	Ponds used for the collection of water after use and before circulation.	100
W-64	Water	Oil/Water Separator	Mechanical device used to separate oils from storm water.	100

Control/Monitoring Equipment

No.	Media	Property	Description	%
W-70	Water	pH Meter, Dissolved Oxygen Meter, or Chart Recorder	Used for wastewater operations control and monthly reporting requirements.	100
W-71	Water	On-line Analyzer	Device that conducts chemical analysis on sample streams for wastewater operations control.	100
W-72	Water	Neutralization	Control equipment used to adjust pH of wastewater treatment components.	100
W-73	Water	Respirometer	Device used to measure oxygen uptake or carbon dioxide (CO_2) release in wastewater treatment systems.	100
W-74	Water	Diversion	Structures used for the capture and control of storm water and process wastewater or emergency diversion of process material. Land means only land that is actually occupied by the diversion or storage structure.	100
W-76	Water	Building	Used for housing wastewater control and monitoring equipment.	100
W-77	Water	De-foaming Systems	Systems consisting of nozzles, pilings, spray heads, and piping used to reduce surface foam.	100

Solid Waste Management Pollution Control Equipment

Solid Waste Management

No.	Media	Property	Description	%
S-1	Land/ Water	Stationary Mixing and Sizing Equipment	Immobile equipment used for solidification, stabilization, or grinding of self-generated waste material for the purpose of disposal.	100
S-2	Land/ Water	Decontamination Equipment	Equipment used to remove waste contamination or residues from vehicles that leave the facility.	100
S-3	Land/ Water	Solid Waste Incinerator (not used for energy recovery and export or material recovery)	Solid waste incinerators, feed systems, ash handling systems, and controls.	100
S-4	Land/ Water/Air	Monitoring and Control Equipment	Alarms, indicators, and controllers, for high liquid level, pH, temperature, or flow in waste treatment system. Does not include fire alarms.	100
S-5	Land/ Water	Solid Waste Treatment Vessels	Any vessel used for waste treatment.	100
S-6	Land/ Water	Secondary Containment	External structure or liner used to contain and collect liquids released from a primary containment device and/or ancillary equipment. Main purpose is to prevent groundwater or soil contamination.	100

S-7	Land/ Water	Liners (Noncommercial Landfills and Impoundments)	A continuous layer or layers of natural and/or man-made materials that restrict downward or lateral escape of wastes or leachate in an impoundment or landfill.	100
S-8	Land/ Water	Leachate Collection and Removal Systems	A system capable of collecting leachate or liquids, including suspended solids, generated from percolation through or drainage from a waste. Systems for removal of leachate may include sumps, pumps, and piping.	100
S-9	Land/ Water	Leak Detection Systems	A system capable of detecting the failure of a primary or secondary containment structure or the presence of a liquid or waste in a containment structure.	100
S-10	Land/ Water	Final Cover Systems for Landfills (Noncommercial)	A system of liners and materials to provide drainage, erosion prevention, infiltration minimization, gas venting, and a biotic barrier.	100
S-11	Land/ Water	Lysimeters	An unsaturated zone monitoring device used to monitor soil-pore liquid quality at a waste management unit (e.g., below the treatment zone of a land treatment unit).	100
S-12	Water	Groundwater Monitoring Well and Systems	A groundwater well or system of wells designed to monitor the quality of groundwater at a waste management unit (e.g., detection monitoring systems or compliance monitoring systems).	100
S-13	Air	Fugitive Emission Monitors	A monitoring device used to monitor or detect fugitive emissions from a waste management unit or ancillary equipment.	100
S-14	Land/ Water	Slurry Walls/Barrier Walls	A pollution control method using a barrier to minimize lateral migration of pollutants in soils and groundwater.	100
S-15	Water	Groundwater Recovery or Remediation System	A groundwater remediation system used to remove or treat pollutants in contaminated groundwater or to contain pollutants (e.g., pump-and-treat systems).	100
S-16	Water	Noncommercial Injection Wells (Including Saltwater Disposal Wells) and Ancillary Equipment	Injection well, pumps, collection tanks and piping, pretreatment equipment, and monitoring equipment.	100
S-17	Land/ Water	Noncommercial Landfills (used for disposal of self - generated waste materials) and Ancillary Equipment	Excavation, clay and synthetic liners, leak detection systems, leachate collection and treatment equipment, monitor wells, waste hauling equipment, decontamination facilities, security systems, and equipment used to manage the disposal of waste in the landfill.	100
S-18	Land/ Water	Resource Conservation Recovery Act Containment Buildings (used for storage or treatment of hazardous waste)	Pads, structures, solid waste treatment equipment used to meet the requirements of 30 TAC Chapter 335, Subchapter O – Land Disposal Restrictions, §335.431.	100
S-19	Land/ Water	Surface Impoundments and Ancillary Equipment (Including Brine Disposal Ponds)	Excavation, ponds, clay and synthetic liners, leak detection systems, leachate collection and treatment equipment, monitor wells, and pumps.	100
S-20	Land/ Water	Waste Storage Used to Collect and/or Store Waste Prior to Treatment or Disposal	Tanks, containers and ancillary equipment such as pumps, piping, secondary containment, and vent controls (e.g., Resource Conservation Recovery Act Storage Tanks, 90-Day Storage Facilities, Feed Tanks to Treatment Facilities).	100

S-21	Air	Fugitive Emission Containment Structures	Structures or equipment used to contain or reduce fugitive emissions or releases from waste management activities (e.g., coverings for conveyors, chutes, enclosed areas for loading and unloading activities).	100
S-22	Water	Double-Hulled Barge	If double-hulled to reduce chance of leakage into public waters, calculate the incremental cost difference between a single-hulled barge and a double-hulled barge.	100
S-23	Land	Composting Equipment	Used to compost material where the compost will be used on site. (Does not include commercial composting facilities.)	100
S-24	Land	Compost Application Equipment	Equipment used to apply compost that has been generated on-site.	100
S-25	Land	Vegetated Compost Sock	Put in place as part of a facility's permanent Best Management Plan (BMP).	100
S-26	Air	Foundry Sand Reclamation Systems for Foundries	Components of a sand reclamation system that provide specific pollution control. Includes hooding over shaker screens vented to a dust collector, conveyor covers, and emission control devices at other points.	100
S-27	Land	Fencing installed for the control of windblown trash or access control.	Fencing installed at landfills, solid waste transfer stations, or storage/treatment areas located at hazardous waste management facilities to meet environmental regulations.	100

Miscellaneous Pollution Control Equipment

No.	Media	Property	Description	%
M-1	Air/ Land/ Water	Spill Response/ Cleanup Equipment Pre-positioned and Stored for Addressing Future Emergencies	Boats, barges, booms, skimmers, trawls, pumps, power units, packaging materials and containers, vacuum trailers, storage sheds, diversion basins, tanks, and dispersants.	100
M-2	Air/ Land	Hazardous Air Pollutant Abatement Equipment - required removal material contaminated with asbestos, lead, or some other hazardous air pollutant	High-Efficiency Particulate Arresting (HEPA) Vacuum Equipment, Negative Air Pressure Enclosures, Glove Bags, and Disposal Containers.	100
M-3	Air/ Land/ Water	Vacuum Trucks, Street Sweepers and Watering Trucks	Mobile Surface Cleaning Equipment - used exclusively to control particulate matter on plant roads. (Does not include sweepers or scrubbers used to control particulate matter within buildings.)	100
M-4	Land	Compactors, Barrel Crushers, Balers, Shredders	Compactors and similar equipment used to change the physical format of waste material for on-site disposal of facility-generated waste.	100
M-5	Air	Environmental Paving Located at Industrial Facilities	Paving of outdoor vehicular traffic areas in order to meet or exceed an adopted air quality rule, regulation, or law. Does not include paving of parking areas or driveways for convenience purposes or storm water control. Does not include dirt or gravel. Value of the paving must be stated on a square foot basis with a plot plan provided that shows the paving in question.	100
M-6	Air/ Land/ Water	Sampling Equipment	Equipment used to collect samples of exhaust gas, wastewater, soil, or other solid waste to be analyzed for specific contaminants or pollutants.	100
M-7	Water	Dry Stack Building for Poultry Litter	A pole-barn type structure used to temporarily store poultry litter in an environmentally safe manner.	100

M-8	Land/ Water	Poultry Incinerator	Incinerators used to dispose of poultry carcasses.	100
M-9	Land/ Water	Structures, Enclosures, Containment Areas, Pads for Composting Operations	Required to meet 'no exposure' storm water regulations.	100
M-10	Air	Methane Capture Equipment	Equipment used to capture methane generated by the decomposition of waste material on site. Methane must be sent to a control device rather than used.	100
M-11	Land	Drilling Mud Recycling System	Consisting of only the Shaker Tank System, Shale Shakers, Desilter, Desander, and Degasser.	100
M-12	Land	Drilling Rig Spill Response Equipment	Includes only the Ram Type Blowout Preventers, Closing Units, and Choke Manifold Systems.	100
M-13	Air	Odor Neutralization and Chemical Treatment Systems	Carbon adsorption, zeolite adsorption, and other odor neutralizing and chemical treatment systems to meet local ordinance or to prevent/correct nuisance odors at off-site receptors.	100
M-14	Air	Odor Dispersing and Removal Systems	Electrostatic precipitators, vertical dispersing fans, stack extensions, and other physical control equipment used to dilute, disperse, or capture nuisance odor vent streams.	100
M-15	Air	Odor Detectors	Olfactometers, gas chromatographs, and other analytical instrumentation used specifically for detecting and measuring ambient odor, either empirically or chemical specific.	100
M-16	Land	Cathodic Protection	Cathodic protection installed to prevent corrosion of metal tanks and piping.	100
M-17	Water	Fish and Other Aquatic Organism Protection Equipment	Equipment installed to protect fish and other aquatic organisms from entrainment or impingement in an intake cooling water structure. Equipment includes: Aquatic Filter Barrier Systems, Fine-Mesh Traveling Intake Screens, Fish Return Buckets, Sprays, Flow-Altering Louvers, Fish Trough, Fish Behavioral Deterrents, and Wetland Creation.	100
M-18	Water/ Land	Double-walled Piping	The difference between cost of single walled piping and the cost of double-walled piping, when the double-walled piping is installed to prevent unauthorized discharges.	100
M-19	Water/ Land	Double-walled Tanks	The difference between cost of single walled tanks and the cost of double-walled tanks, when the double-walled tanks are installed to prevent unauthorized discharges.	100

Equipment Located at Tank Installations including Service Stations

Spill and Overfill Prevention Equipment

No.	Media	Property	Description	%
T-1	Water	Tight Fill Fittings	Liquid tight connections between the delivery hose and fill pipe.	100
T-2	Water	Spill Containers	Spill containment manholes equipped with either a bottom drain valve to return liquids to the tank or a hand pump for liquid removal.	100
T-3	Water	Automatic Shut-off Valves	Flapper valves installed in the fill pipe to automatically stop the flow of product.	100
T-4	Water	Overfill Alarms	External signaling device attached to an automatic tank gauging system.	100

T-5	Water	Vent Restriction Devices	Float vent valves or ball float valves to prevent backflow through vents.	100

Secondary Containment

No.	Media	Property	Description	%
T-10	Water	Double-walled Tanks	The difference between cost of single-walled tanks and the cost of double-walled tanks, when the double-walled tanks are installed to prevent unauthorized discharges or leaks.	100
T-11	Water	Double-walled Piping	The difference between cost of single-walled piping and the cost of double-walled piping, when the double-walled piping is installed to prevent unauthorized discharges or leaks.	100
T-12	Water	Tank Top Sumps	Liquid tight containers to contain leaks or spills that involve tank top fittings and equipment.	100
T-13	Water	Under Dispenser Sumps	Contains leaks and spills from dispensers and pumps.	100
T-14	Water	Sensing Devices	Installed to monitor for product accumulation in secondary containment sumps.	100
T-15	Land/ Water	Concrete Paving Above Underground Tanks and Pipes	Required concrete paving located above underground pipes and tanks. The use determination value is limited to the difference between the cost per square foot of the concrete paving and the cost per square foot of the other paving installed at the service station. This item only applies to service stations.	100

Release Detection for Tanks and Piping

No.	Media	Property	Description	%
T-20	Water	Automatic Tank Gauging	Includes tank gauging probe and control console.	100
T-21	Water	Groundwater or Soil Vapor Monitoring	Observation wells located inside the tank excavation or monitoring wells located outside the tank excavation.	100
T-22	Water	Monitoring of Secondary Containment	Liquid sensors or hydrostatic monitoring systems installed in the interstitial space for tanks or piping.	100
T-23	Water	Automatic Line Leak Detectors	Devices installed at the pump that are designed to detect leaks in underground piping. Mechanical and electronic devices are acceptable.	100
T-24	Water	Under Pump Check Valve	Valve installed to prevent back flow in the fuel dispensing line. This device is only used on suction pump piping systems.	100
T-25	Water	Tightness Testing Equipment	Equipment purchased to comply with tank and/or piping tightness testing requirements.	100

Cathodic Protection

No.	Media	Property	Description	%
T-30	Water	Isolation Fittings	Dielectric bushings and fittings to separate underground piping from aboveground tanks and piping.	100
T-31	Water	Sacrificial Anodes	Magnesium or zinc anodes packaged in low resistivity backfill to provide galvanic protection.	100

T-32	Water	Dielectric Coatings	Factory installed coal-tar epoxies, enamels, fiberglass reinforced plastic, or urethanes on tanks and/or piping. Field installed coatings limited to exposed threads, fittings, and damaged surface areas.	100

Emissions Control Equipment

No.	Media	Property	Description	%
T-40	Air	Stage I or Stage II Vapor Recovery	Includes pressure/vacuum vent relief valves, vapor return piping, stage 2 nozzles, coaxial hoses, vapor processing units, and vacuum- assist units. Used for motor vehicle fuel dispensing facilities. Does not include fuel delivery components of fuel dispensing unit.	100

Figure: 30 TAC §18.25(a)

Tier I Table

The property listed in this table is property that the executive director has determined is used wholly for pollution control purposes when used as shown in the Description section of the table and when no marketable product arises from using the property. The items listed are described in generic terms without the use of brand names or trademarks. The use percentages on all property on the table are established based on standard uses of the pieces of equipment involved. If the executive director determines that the equipment is not being used in a standard manner (*e.g.*, use in production or recovery of a marketable product), the executive director may require that a Tier III application, using the Cost Analysis Procedure, be filed by the applicant to calculate the appropriate use determination percentage. For items where the description limits the use determination to the incremental cost difference, the cost of the property or device with the pollution control feature is compared to a similar device or property without the pollution control feature. The table is a list adopted under Texas Tax Code, §11.31(g).

Air Pollution Control Equipment

Particulate Control Devices

No.	Media	Property	Description	%
A-1	Air	Dust Collection Systems	Structures containing filters, blowers, ductwork - used to remove particulate matter from exhaust gas streams in order to prevent release of particulate matter to ambient air.	100
A-2	Air	Demisters or Mist Eliminators Added	Mesh pads or cartridges - used to remove entrained liquid droplets from exhaust gas streams.	100
A-3	Air	Electrostatic Precipitators	Wet or dry particulate collection created by an electric field between positive or negative electrodes and collection surface.	100
A-4	Air	Dry Cyclone Separators	Single or multiple inertial separators with blowers and ductwork used to remove particulate matter from exhaust gas streams.	100
A-5	Air	Scrubbers	Wet collection device using spray chambers, wet cyclones, packed beds, orifices, venturi, or high- pressure sprays to remove particulates and chemicals from exhaust gas streams. System may include pumps, ductwork, and blowers needed for the equipment to function.	100
A-6	Air	Water/ Chemical Sprays and Enclosures for Particulate Suppression	Spray nozzles, conveyor and chute covers, windshields, piping, and pumps used to reduce fugitive particulate emissions.	100
A-7	Air	Smokeless Ignitors	Installed on electric generating units to control particulate emissions and opacity on start-up.	100

Combustion Based Control Devices

No.	Media	Property	Description	%
A-20	Air	Thermal Oxidizers	Thermal destruction of air pollutants by direct flame combustion.	100
A-21	Air	Catalytic Oxidizer	Thermal destruction of air pollutants that uses a catalyst to promote oxidation.	100

A-22	Air	Flare/Vapor Combustor	Stack, burner, flare tip, and blowers used to destroy air contaminants in a vent gas stream.	100

Non-Volatile Organic Compounds Gaseous Control Devices

No.	Media	Property	Description	%
A-40	Air	Molecular Sieve	Microporous filter used to remove hydrogen sulfide (H_2S) or nitrogen oxides (NO_X) from a waste gas stream.	100
A-41	Air	Strippers Used in Conjunction with Final Control Device	Stripper, with associated pumps, piping - used to remove contaminants from a waste gas stream or waste liquid stream.	100

Monitoring and Sampling Equipment

No.	Media	Property	Description	%
A-60	Air	Fugitive Emission Monitors	Organic vapor analyzers - used to discover leaking piping components.	100
A-61	Air	Continuous & Noncontinuous Emission Monitors	Monitors, analyzers, buildings, air conditioning equipment, and optical gas imaging instruments used to demonstrate compliance with emission limitations of regulated air contaminants, (including flow and diluent gas monitors and dedicated buildings).	100
A-62	Air	Monitoring Equipment on Final Control Devices	Temperature monitor or controller, flow-meter, pH meter, and other meters for a pollution control device. Monitoring of production equipment or processes is not included.	100
A-63	Air	On or Off-Site Ambient Air Monitoring Facilities	Towers, structures, analytical equipment, sample collectors, monitors, and power supplies used to monitor for levels of contaminants in ambient air.	100
A-64	Air	Noncontinuous Emission Monitors, Portable	Portable monitors, analyzers, structures, trailers, air conditioning equipment, and optical gas imaging instruments used to demonstrate compliance with emission limitations.	100
A-65	Air	Predictive Emission Monitors	Monitoring of process and operational parameters that are used solely to calculate or determine compliance with emission limitations.	100
A-66	Air	Sampling Ports	Construction of stack or tower sampling ports used for emission sampling or for the monitoring of process or operational parameters that are used to calculate or determine compliance with emission limitations.	100

Nitrogen Oxides Controls

No.	Media	Property	Description	%
A-80	Air	Selective Catalytic and Non-catalytic Reduction Systems	Catalyst bed, reducing agent injection and storage, monitors - used to reduce nitrogen oxides (NO_X) emissions from combustion sources. Non-catalytic systems use a reducing agent without a catalyst.	100
A-81	Air	Catalytic Converters for Stationary Sources	Used to reduce NO_X emissions from internal combustion engines.	100
A-82	Air	Air/Fuel Ratio Controllers for Piston- Driven Internal Combustion Engines	Used to control the air/fuel mixtures and reduce NO_X formation for fuel injected, naturally aspirated, or turbocharged engines.	100

A-83	Air	Flue Gas Recirculation	Ductwork and blowers used to redirect part of the flue gas back to the combustion chamber for reduction of NO_X formation. May include fly ash collection in coal fired units.	100
A-84	Air	Water/Steam Injection	Piping, nozzles, and pumps to inject water or steam into the burner flame of utility or industrial burners or the atomizer ports for gas turbines, used to reduce NO_X formation.	100
A-85	Air	Over-fire Air & Combination of asymmetric over-fire air with the injection of anhydrous ammonia or other pollutant-reducing agents	The asymmetric over- fire air layout injects preheated air through nozzles through a series of ducts, dampers, expansion joints, and valves also anhydrous ammonia or other pollutant-reducing agent injection is done at the same level.	100
A-86	Air	Low-NO_X Burners	Installation of low-NO_X burners. The eligible portion is the incremental cost difference. For a replacement burner, the incremental cost difference is calculated by comparing the cost of the new burner with the cost of the existing burner. For new installations, the incremental cost difference is calculated by comparing the cost of the new burner to the cost of a similarly sized burner without NOx controls from the most recent generation of burners.	100
A-87	Air	Water Lances	Installed in the fire box of boilers and industrial furnaces to eliminate hot spots, thereby reducing NO_X formation.	100
A-88	Air	Electric Power Generation Burner Retrofit	Retrofit of existing burners on electric power generating units with components for reducing NO_X including directly related equipment.	100
A-89	Air	Wet or Dry Sorbent Injection Systems	Use of a sorbent for flue gas desulfurization or NOx control.	100

Volatile Organic Compounds (VOC) Control

No.	Media	Property	Description	%
A-110	Air	Carbon Adsorption Systems	Carbon beds or liquid-jacketed systems, blowers, piping, condensers - used to remove VOC emissions and odors from exhaust gas streams.	100
A-111	Air	Storage Tank Secondary Seals and Internal Floating Roofs	Used to reduce VOC emissions caused by evaporation losses from aboveground storage tanks.	100
A-112	Air	Replacement of Existing Pumps, Valves, or Seals in Piping Service	The incremental cost difference between the cost of the original equipment and the replacement equipment is eligible only when the replacement of these parts is done for the sole purpose of eliminating fugitive emissions of VOCs. New systems do not qualify for this item.	100
A-113	Air	Welding of Pipe Joints in VOC Service (Existing Pipelines)	Welding of existing threaded or flanged pipe joints to eliminate fugitive emission leaks.	100
A-114	Air	Welding of Pipe Joints in VOC Service (New Construction)	The incremental cost difference between the cost of using threaded or flanged joints and welding of pipe joints in VOC service.	100
A-115	Air	External Floating Roofs	Used to reduce VOC emissions caused by evaporation losses from aboveground storage tanks. Must be installed to meet or exceed §115.112 of this title (relating to Control Requirements).	100

Mercury Control

No.	Media	Property	Description	%
A-130	Air	Sorbent Injection Systems	Sorbents sprayed into the flue gas that chemically react to absorb mercury. The sorbents are then removed by a particulate removal device. Equipment may include pumps, tanks, blowers, nozzles, ductwork, hoppers, and particulate collection devices needed for the equipment to function.	100
A-131	Air	Fixed Sorbent Systems	Equipment, such as stainless steel plate with a gold coating that is installed in the flue gas to absorb mercury.	100
A-132	Air	Mercury Absorbing Filters	Filters that absorb mercury such as those using the affinity between mercury and metallic selenium.	100
A-133	Air	Oxidation Systems	Equipment used to change elemental mercury to oxidized mercury. This can be catalysts (similar to Selective Catalytic Reduction (SCR) catalyst) or chemical additives that can be added to the flue gas or directly to the fuel.	100
A-134	Air	Photochemical Oxidation	Use of an ultraviolet light from a mercury lamp to provide an excited state mercury species in flue gas, leading to oxidation of elemental mercury. These units are only eligible if mercury is removed from flue gas.	100
A-135	Air	Chemical Injection Systems	Equipment used to inject chemicals into the combustion zone or flue gas that chemically bonds mercury to the additive, which is then removed in a particulate removal device.	100

Sulfur Oxides Controls

No.	Media	Property	Description	%
A-160	Air	Wet and Dry Scrubbers	Circulating fluid bed and moving bed technologies using a dry sorbent or various wet scrubber designs that inject a wet sorbent into the scrubber.	100
A-161	Air	Selective Catalytic and Non-catalytic Reduction Systems	Catalyst bed, reducing agent injection and storage, monitors - used to reduce sulfur oxide emissions from combustion sources. Non-catalytic systems use a reducing agent without a catalyst.	100

Miscellaneous Control Equipment

No.	Media	Property	Description	%
A-180	Air	Hoods, Duct and Collection Systems connected to Final Control Devices	Piping, headers, blowers, hoods, and ducts used to collect air contaminants and route them to a control device.	100
A-181	Air	Stack Modifications	Construction of stack extensions to meet a permit requirement.	100
A-182	Air	New Stack Construction	The incremental cost difference between the stack height required for production purposes and the stack height required for pollution control purposes.	100
A-183	Air	Stack Repairs	Repairs made to an existing stack for that stack to provide the same level of pollution control as was previously provided.	100
A-184	Air	Vapor/Liquid Recovery Equipment (for venting to a control device)	Piping, blowers, vacuum pumps, and compressors used to capture a waste gas or liquid stream and vent to a control device, including those used to eliminate emissions associated with loading tank trucks, rail cars, and barges.	100
A-185	Air	Paint Booth Control Devices	Pollution control equipment associated with the paint booth - including the items such as the control device, water curtain, filters, or other devices to capture paint fumes.	100

A-186	Air	Particulate Control Device Connected to a Blast Cleaning System	Particulate control device.	100
A-187	Air	Amine or Chilled Ammonia Scrubber	Installed to provide post combustion capture of pollutants (including carbon dioxide upon the effective date of a final rule adopted by the United States Environmental Protection Agency (EPA) regulating carbon dioxide as a pollutant).	100
A-188	Air	Catalyst-based Systems	Installed to allow the use of catalysts to reduce pollutants in emission streams.	100
A-189	Air	Enhanced Scrubbing Technology	Installed to enhance scrubber performance, including equipment that promotes the oxidation of elemental mercury in the flue gas prior to entering the scrubber.	100

Water and Wastewater Pollution Control Equipment

Solid Separation and De-watering

No.	Media	Property	Description	%
W-1	Water	API Separator	Separates oil, water, and solids by settling and skimming.	100
W-2	Waste water	CPI Separator	Mechanical oil, water, and solids separator.	100
W-3	Waste water	Dissolved Air Flotation	Mechanical oil, water, and solids separator.	100
W-4	Waste water	Skimmer	Used to remove hydrocarbon from process wastewater.	100
W-5	Waste water	Decanter	Used to decant hydrocarbon from process wastewater.	100
W-6	Waste water	Belt Press, Filter Press, or Plate and Frame	Mechanical de-watering devices.	100
W-7	Water	Centrifuge	Separation of liquid and solid waste by centrifugal force, typically a rotating drum.	100
W-8	Water	Settling Basin	Simple tank or basin for gravity separation of suspended solids.	100
W-9	Water	Equalization	Tank, sump, or headbox used to settle solids and equilibrate process wastewater streams.	100
W-10	Water	Clarifier	Circular settling basins usually containing surface skimmers and sludge removal rakes.	100

Disinfection

No.	Media	Property	Description	%
W-20	Water	Chlorination	Wastewater disinfection treatment using chlorine.	100
W-21	Water	De-chlorination	Equipment for removal of chlorine from water or wastewater.	100
W-22	Water	Electrolytic Disinfection	Disinfect water by the use of electrolytic cells.	100
W-23	Water	Ozonization	Equipment that generates ozone for the disinfection of wastewater.	100
W-24	Water	Ultraviolet	Disinfection of wastewater by the use of ultraviolet light.	100
W-25	Water	Mixed Oxidant Solution	Solution of chlorine, chlorine dioxide, and ozone to replace chlorine for disinfection.	100

Biological Systems

No.	Media	Property	Description	%
W-30	Water	Activated Sludge	Wastewater treatment using microorganisms to metabolize biodegradable organic matter in aqueous waste streams. Can include tanks, aeration equipment, clarifiers, and equipment used to handle sludge.	100
W-31	Water	Adsorption	Use of activated carbon to remove organic contaminants from wastewater.	100
W-32	Water	Aeration	Passing air through wastewater to increase oxygen available for bacterial activities that remove contaminants.	100
W-33	Water	Rotary Biological Contactor	Use of large rotating discs that contain a bio- film of microorganisms that promote biological purification of the wastewater.	100
W-35	Water	Trickling Filter	Fixed bed of highly permeable media in which wastewater passes through and forms a slime layer to remove contaminants.	100
W-36	Water	Wetlands and Lagoons (artificial)	Artificial marsh, swamp, or pond that uses vegetation and natural microorganisms as bio- filters to remove sediment and other pollutants from wastewater or stormwater.	100
W-37	Water	Digester	Enclosed, heated tanks for treatment of sludge that is broken down by bacterial action.	100

Other Equipment

No.	Media	Property	Description	%
W-50	Water	Irrigation	Equipment that is used to disburse treated wastewater through irrigation on the site.	100
W-51	Water	Outfall Diffuser	Device used to diffuse effluent discharge from an outfall.	100
W-52	Water	Activated Carbon Treatment	Use of carbon media such as coke or coal to remove organics and particulate from wastewater. May be used in either fixed or fluidized beds.	100
W-53	Water	Oxidation Ditches and Ponds	Process of pumping air bubbles into a pond to assist in oxidizing organic and mineral pollution.	100
W-54	Water	Filters: Sand, Gravel, or Microbial	Passing wastewater through a sand or gravel bed to remove solids and reduce bacteria.	100
W-55	Water	Chemical Precipitation	Process used to remove heavy metals from wastewater.	100
W-56	Water	Ultra-filtration	Use of semi-permeable membrane and hydrostatic pressure to filter solids and high molecular weight solutes from wastewater.	100
W-57	Water	Conveyances, Pumps, Sumps, Tanks, Basins	Used to segregate storm water from process water, control storm water runoff, or convey contaminated process water.	100
W-58	Water	Wastewater Treatment Facility/Plant	New wastewater treatment facilities (including on-site septic systems) constructed to process wastewater generated on site.	100
W-59	Water	High-Pressure Reverse Osmosis	The passing of a contaminated water stream over a permeable membrane at high pressure to collect contaminants.	100
W-60	Water	Hydro-cyclone Vapor Extraction	An air-sparged hydro-cyclone for the removal of VOCs from a wastewater stream.	100
W-61	Water	Chemical Oxidation	Use of hydrogen peroxide or other oxidants for wastewater treatment.	100

W-62	Water	Storm Water Containment Systems	Structures or liners used for containment of runoff from rainfall. The land that is actually occupied by the containment structure is eligible for a positive use determination.	100
W-63	Water	Wastewater Impoundments	Ponds used for the collection of water after use and before circulation.	100
W-64	Water	Oil/Water Separator	Mechanical device used to separate oils from storm water.	100

Control/Monitoring Equipment

No.	Media	Property	Description	%
W-70	Water	pH Meter, Dissolved Oxygen Meter, or Chart Recorder	Used for wastewater operations control and monthly reporting requirements.	100
W-71	Water	On-line Analyzer	Device that conducts chemical analysis on sample streams for wastewater operations control.	100
W-72	Water	Neutralization	Control equipment used to adjust pH of wastewater treatment components.	100
W-73	Water	Respirometer	Device used to measure oxygen uptake or carbon dioxide (CO_2) release in wastewater treatment systems.	100
W-74	Water	Diversion	Structures used for the capture and control of storm water and process wastewater or emergency diversion of process material. Land means only land that is actually occupied by the diversion or storage structure.	100
W-76	Water	Building	Used for housing wastewater control and monitoring equipment.	100
W-77	Water	De-foaming Systems	Systems consisting of nozzles, pilings, spray heads, and piping used to reduce surface foam.	100

Solid Waste Management Pollution Control Equipment

Solid Waste Management

No.	Media	Property	Description	%
S-1	Land/ Water	Stationary Mixing and Sizing Equipment	Immobile equipment used for solidification, stabilization, or grinding of self-generated waste material for the purpose of disposal.	100
S-2	Land/ Water	Decontamination Equipment	Equipment used to remove waste contamination or residues from vehicles that leave the facility.	100
S-3	Land/ Water	Solid Waste Incinerator (not used for energy recovery and export or material recovery)	Solid waste incinerators, feed systems, ash handling systems, and controls.	100
S-4	Land/ Water/Air	Monitoring and Control Equipment	Alarms, indicators, and controllers, for high liquid level, pH, temperature, or flow in waste treatment system. Does not include fire alarms.	100
S-5	Land/ Water	Solid Waste Treatment Vessels	Any vessel used for waste treatment.	100
S-6	Land/ Water	Secondary Containment	External structure or liner used to contain and collect liquids released from a primary containment device and/or ancillary equipment. Main purpose is to prevent groundwater or soil contamination.	100

S-7	Land/ Water	Liners (Noncommercial Landfills and Impoundments)	A continuous layer or layers of natural and/or man-made materials that restrict downward or lateral escape of wastes or leachate in an impoundment or landfill.	100
S-8	Land/ Water	Leachate Collection and Removal Systems	A system capable of collecting leachate or liquids, including suspended solids, generated from percolation through or drainage from a waste. Systems for removal of leachate may include sumps, pumps, and piping.	100
S-9	Land/ Water	Leak Detection Systems	A system capable of detecting the failure of a primary or secondary containment structure or the presence of a liquid or waste in a containment structure.	100
S-10	Land/ Water	Final Cover Systems for Landfills (Noncommercial)	A system of liners and materials to provide drainage, erosion prevention, infiltration minimization, gas venting, and a biotic barrier.	100
S-11	Land/ Water	Lysimeters	An unsaturated zone monitoring device used to monitor soil-pore liquid quality at a waste management unit (e.g., below the treatment zone of a land treatment unit).	100
S-12	Water	Groundwater Monitoring Well and Systems	A groundwater well or system of wells designed to monitor the quality of groundwater at a waste management unit (e.g., detection monitoring systems or compliance monitoring systems).	100
S-13	Air	Fugitive Emission Monitors	A monitoring device used to monitor or detect fugitive emissions from a waste management unit or ancillary equipment.	100
S-14	Land/ Water	Slurry Walls/Barrier Walls	A pollution control method using a barrier to minimize lateral migration of pollutants in soils and groundwater.	100
S-15	Water	Groundwater Recovery or Remediation System	A groundwater remediation system used to remove or treat pollutants in contaminated groundwater or to contain pollutants (e.g., pump-and-treat systems).	100
S-16	Water	Noncommercial Injection Wells (Including Saltwater Disposal Wells) and Ancillary Equipment	Injection well, pumps, collection tanks and piping, pretreatment equipment, and monitoring equipment.	100
S-17	Land/ Water	Noncommercial Landfills (used for disposal of self - generated waste materials) and Ancillary Equipment	Excavation, clay and synthetic liners, leak detection systems, leachate collection and treatment equipment, monitor wells, waste hauling equipment, decontamination facilities, security systems, and equipment used to manage the disposal of waste in the landfill.	100
S-18	Land/ Water	Resource Conservation Recovery Act Containment Buildings (used for storage or treatment of hazardous waste)	Pads, structures, solid waste treatment equipment used to meet the requirements of §335.431 of this title (relating to Purpose, Scope, and Applicability).	100
S-19	Land/ Water	Surface Impoundments and Ancillary Equipment (Including Brine Disposal Ponds)	Excavation, ponds, clay and synthetic liners, leak detection systems, leachate collection and treatment equipment, monitor wells, and pumps.	100
S-20	Land/ Water	Waste Storage Used to Collect and/or Store Waste Prior to Treatment or Disposal	Tanks, containers and ancillary equipment such as pumps, piping, secondary containment, and vent controls (e.g., Resource Conservation Recovery Act Storage Tanks, 90-Day Storage Facilities, Feed Tanks to Treatment Facilities).	100

S-21	Air	Fugitive Emission Containment Structures	Structures or equipment used to contain or reduce fugitive emissions or releases from waste management activities (e.g., coverings for conveyors, chutes, enclosed areas for loading and unloading activities).	100
S-22	Water	Double-Hulled Barge	If double-hulled to reduce chance of leakage into public waters, calculate the incremental cost difference between a single-hulled barge and a double-hulled barge.	100
S-23	Land	Composting Equipment	Used to compost material where the compost will be used on site. (Does not include commercial composting facilities.)	100
S-24	Land	Compost Application Equipment	Equipment used to apply compost that has been generated on-site.	100
S-25	Land	Vegetated Compost Sock	Put in place as part of a facility's permanent Best Management Plan (BMP).	100
S-26	Air	Foundry Sand Reclamation Systems for Foundries	Components of a sand reclamation system that provide specific pollution control. Includes hooding over shaker screens vented to a dust collector, conveyor covers, and emission control devices at other points.	100
S-27	Land	Fencing installed for the control of windblown trash or access control.	Fencing installed at landfills, solid waste transfer stations, or storage/treatment areas located at hazardous waste management facilities to meet environmental regulations.	100

Miscellaneous Pollution Control Equipment

No.	Media	Property	Description	%
M-1	Air/ Land/ Water	Spill Response/ Cleanup Equipment Pre-positioned and Stored for Addressing Future Emergencies	Boats, barges, booms, skimmers, trawls, pumps, power units, packaging materials and containers, vacuum trailers, storage sheds, diversion basins, tanks, and dispersants.	100
M-2	Air/ Land	Hazardous Air Pollutant Abatement Equipment - required removal material contaminated with asbestos, lead, or some other hazardous air pollutant	High-Efficiency Particulate Arresting (HEPA) Vacuum Equipment, Negative Air Pressure Enclosures, Glove Bags, and Disposal Containers.	100
M-3	Air/ Land/ Water	Vacuum Trucks, Street Sweepers and Watering Trucks	Mobile Surface Cleaning Equipment - used exclusively to control particulate matter on plant roads. (Does not include sweepers or scrubbers used to control particulate matter within buildings.)	100
M-4	Land	Compactors, Barrel Crushers, Balers, Shredders	Compactors and similar equipment used to change the physical format of waste material for on-site disposal of facility-generated waste.	100
M-5	Air	Environmental Paving Located at Industrial Facilities	Paving of outdoor vehicular traffic areas in order to meet or exceed an adopted air quality rule, regulation, or law. Does not include paving of parking areas or driveways for convenience purposes or storm water control. Does not include dirt or gravel. Value of the paving must be stated on a square foot basis with a plot plan provided that shows the paving in question.	100
M-6	Air/ Land/ Water	Sampling Equipment	Equipment used to collect samples of exhaust gas, wastewater, soil, or other solid waste to be analyzed for specific contaminants or pollutants.	100
M-7	Water	Dry Stack Building for Poultry Litter	A pole-barn type structure used to temporarily store poultry litter in an environmentally safe manner.	100

M-8	Land/ Water	Poultry Incinerator	Incinerators used to dispose of poultry carcasses.	100
M-9	Land/ Water	Structures, Enclosures, Containment Areas, Pads for Composting Operations	Required to meet 'no exposure' storm water regulations.	100
M-10	Air	Methane Capture Equipment	Equipment used to capture methane generated by the decomposition of waste material on site. Methane must be sent to a control device rather than used.	100
M-11	Land	Drilling Mud Recycling System	Consisting of only the Shaker Tank System, Shale Shakers, Desilter, Desander, and Degasser.	100
M-12	Land	Drilling Rig Spill Response Equipment	Includes only the Ram Type Blowout Preventers, Closing Units, and Choke Manifold Systems.	100
M-13	Air	Odor Neutralization and Chemical Treatment Systems	Carbon adsorption, zeolite adsorption, and other odor neutralizing and chemical treatment systems to meet local ordinance or to prevent/correct nuisance odors at off-site receptors.	100
M-14	Air	Odor Dispersing and Removal Systems	Electrostatic precipitators, vertical dispersing fans, stack extensions, and other physical control equipment used to dilute, disperse, or capture nuisance odor vent streams.	100
M-15	Air	Odor Detectors	Olfactometers, gas chromatographs, and other analytical instrumentation used specifically for detecting and measuring ambient odor, either empirically or chemical specific.	100
M-16	Land	Cathodic Protection	Cathodic protection installed to prevent corrosion of metal tanks and piping.	100
M-17	Water	Fish and Other Aquatic Organism Protection Equipment	Equipment installed to protect fish and other aquatic organisms from entrainment or impingement in an intake cooling water structure. Equipment includes: Aquatic Filter Barrier Systems, Fine-Mesh Traveling Intake Screens, Fish Return Buckets, Sprays, Flow-Altering Louvers, Fish Trough, Fish Behavioral Deterrents, and Wetland Creation.	100
M-18	Water/ Land	Double-walled Piping	The difference between cost of single walled piping and the cost of double-walled piping, when the double-walled piping is installed to prevent unauthorized discharges.	100
M-19	Water/ Land	Double-walled Tanks	The difference between cost of single walled tanks and the cost of double-walled tanks, when the double-walled tanks are installed to prevent unauthorized discharges.	100

Equipment Located at Tank Installations including Service Stations

Spill and Overfill Prevention Equipment

No.	Media	Property	Description	%
T-1	Water	Tight Fill Fittings	Liquid tight connections between the delivery hose and fill pipe.	100
T-2	Water	Spill Containers	Spill containment manholes equipped with either a bottom drain valve to return liquids to the tank or a hand pump for liquid removal.	100
T-3	Water	Automatic Shut-off Valves	Flapper valves installed in the fill pipe to automatically stop the flow of product.	100
T-4	Water	Overfill Alarms	External signaling device attached to an automatic tank gauging system.	100

T-5	Water	Vent Restriction Devices	Float vent valves or ball float valves to prevent backflow through vents.	100

Secondary Containment

No.	Media	Property	Description	%
T-10	Water	Double-walled Tanks	The difference between cost of single-walled tanks and the cost of double-walled tanks, when the double-walled tanks are installed to prevent unauthorized discharges or leaks.	100
T-11	Water	Double-walled Piping	The difference between cost of single-walled piping and the cost of double-walled piping, when the double-walled piping is installed to prevent unauthorized discharges or leaks.	100
T-12	Water	Tank Top Sumps	Liquid tight containers to contain leaks or spills that involve tank top fittings and equipment.	100
T-13	Water	Under Dispenser Sumps	Contains leaks and spills from dispensers and pumps.	100
T-14	Water	Sensing Devices	Installed to monitor for product accumulation in secondary containment sumps.	100
T-15	Land/ Water	Concrete Paving Above Underground Tanks and Pipes	Required concrete paving located above underground pipes and tanks. The use determination value is limited to the difference between the cost per square foot of the concrete paving and the cost per square foot of the other paving installed at the service station. This item only applies to service stations.	100

Release Detection for Tanks and Piping

No.	Media	Property	Description	%
T-20	Water	Automatic Tank Gauging	Includes tank gauging probe and control console.	100
T-21	Water	Groundwater or Soil Vapor Monitoring	Observation wells located inside the tank excavation or monitoring wells located outside the tank excavation.	100
T-22	Water	Monitoring of Secondary Containment	Liquid sensors or hydrostatic monitoring systems installed in the interstitial space for tanks or piping.	100
T-23	Water	Automatic Line Leak Detectors	Devices installed at the pump that are designed to detect leaks in underground piping. Mechanical and electronic devices are acceptable.	100
T-24	Water	Under Pump Check Valve	Valve installed to prevent back flow in the fuel dispensing line. This device is only used on suction pump piping systems.	100
T-25	Water	Tightness Testing Equipment	Equipment purchased to comply with tank and/or piping tightness testing requirements.	100

Cathodic Protection

No.	Media	Property	Description	%
T-30	Water	Isolation Fittings	Dielectric bushings and fittings to separate underground piping from aboveground tanks and piping.	100
T-31	Water	Sacrificial Anodes	Magnesium or zinc anodes packaged in low resistivity backfill to provide galvanic protection.	100

T-32	Water	Dielectric Coatings	Factory installed coal-tar epoxies, enamels, fiberglass reinforced plastic, or urethanes on tanks and/or piping. Field installed coatings limited to exposed threads, fittings, and damaged surface areas.	100

Emissions Control Equipment

No.	Media	Property	Description	%
T-40	Air	Stage I or Stage II Vapor Recovery	Includes pressure/vacuum vent relief valves, vapor return piping, stage 2 nozzles, coaxial hoses, vapor processing units, and vacuum- assist units. Used for motor vehicle fuel dispensing facilities. Does not include fuel delivery components of fuel dispensing unit.	100

Figure: 30 TAC §335.1(140)(D)(iv)

TABLE 1

	Use Constituting Disposal S.W. Def. (D)(i)(1)	Energy Recovery/Fuel S.W. Def. (D)(ii)(2)	Reclamation S.W. Def. (D)(iii)(3)[2]	Speculative Accumulation S.W. Def. (D)(iv)(4)
Spent materials (listed hazardous and not listed characteristically hazardous)	*	*	*	*
Spent materials (nonhazardous)[1]	*	*	*	*
Sludges (listed hazardous in 40 CFR §261.31 or §261.32)	*	*	*	*
Sludges (not listed characteristically hazardous)	*	*		*
Sludges (nonhazardous)[1]	*	*		*
By-products (listed hazardous in 40 CFR §261.31 or §261.32)	*	*	*	*
By-products (not listed characteristically hazardous)	*	*		*
By-products (nonhazardous)[1]	*	*		*
Commercial chemical products (listed, not listed characteristically hazardous, and nonhazardous)	*	*		
Scrap metal that is not excluded under §335.1(140)(A)(iv) [§335.1(138)(A)(iv)] of this title (hazardous)	*	*	*	*
Scrap metal other than excluded scrap metal (see §335.17(9) of this title) (nonhazardous)[1]	*	*	*	*

NOTE: The terms "spent materials," "sludges," "by-products," "scrap metal," and "excluded scrap metal" are defined in §335.17 of this title (relating to Special Definitions for Recyclable Materials and Nonhazardous Recyclable Materials).

[1] These materials are governed by the provisions of §335.24(h) of this title only.
[2] Except as provided in 40 CFR §261.4(a)(17) for mineral processing secondary materials.

Figure: 31 TAC §57.981(c)(5)

Species	Daily Bag	Minimum Length (Inches)	Maximum Length (Inches)
Amberjack, greater.	1	34	No limit
Bass: Largemouth, smallmouth, spotted and Guadalupe bass.	5 (in any combination)		
Largemouth and smallmouth bass.		14	No limit
Bass, striped, its hybrids, and subspecies.	5 (in any combination)	18	No limit
Bass, white.	25	10	No limit
Catfish: channel and blue catfish, their hybrids, and subspecies.	25 (in any combination)	12	No limit
Catfish, flathead.	5	18	No limit
Catfish, gafftopsail.	No limit	14	No limit
Cobia.	2	37	No limit
Crappie: white and black crappie, their hybrids, and subspecies.	25 (in any combination)	10	No limit
Drum, black.	5	14	30*
*Special Regulation: One black drum over 52 inches may be retained per day as part of the five-fish bag limit.			
Drum, red.	3*	20	28*
*Special Regulation: During a license year, one red drum over the stated maximum length limit may be retained when affixed with a properly executed Red Drum Tag, a properly executed Exempt Red Drum Tag or with a properly executed Duplicate Exempt Red Drum Tag and one red drum over the stated maximum length limit may be retained when affixed with a properly executed Bonus Red Drum Tag. Any fish retained under authority of a Red Drum Tag, an Exempt Red Drum Tag, a Duplicate Exempt Red Drum Tag, or a Bonus Red Drum Tag may be retained in addition to the daily bag and possession limit as stated in this section.			
Flounder: all species, their hybrids, and subspecies.	5*	14	No limit
*Special Regulation: During the month of November, lawful means are restricted to pole-and-line only and the bag and possession limit for flounder is two. For the first 14 days in December, the bag and possession limit is two, and flounder may be taken by any legal means.			
Gar, alligator.*	1	No limit	No limit

*Special Regulation: Between May 1 and May 31 no person shall take alligator gar in that portion of Lake Texoma encompassed within the boundaries of the Hagerman National Wildlife Refuge or that portion of Lake Texoma from the U.S. 377 bridge (Willis Bridge) upstream to the I.H. 35 bridge.			
Grouper, gag.	2	22	No limit
Grouper, goliath.	0		
Mackerel, king.	2	27	No limit
Mackerel, Spanish.	15	14	No limit
Marlin, blue.	No limit	131	No limit
Marlin, white.	No limit	86	No limit
Mullet: all species, their hybrids, and subspecies.	No limit	No limit	*
*Special Regulation: During the period October through January, no mullet more than 12 inches in length may be taken from public waters or possessed on board a vessel.			
Sailfish.	No limit	84	No limit
Saugeye.	3	18	No limit
Seatrout, spotted*	5	15	25**
*Exception: From F.M. 457 in Matagorda County northward to the Louisiana border, the daily bag limit is 10 and the possession limit is 20. **Special Regulation: One spotted seatrout greater than 25 inches may be retained per day. Limit of Effectiveness: If the provisions of this subsection governing spotted seatrout are not amended or repealed before August 31, 2019, the bag, possession, and length limits for spotted seatrout are as follows:			
Seatrout, spotted.	10	15	25*
All waters of the lower Laguna Madre south of marker 21.	5**	15	25*
*Special Regulation: One spotted seatrout greater than 25 inches may be retained per day. **Special Regulation: The daily bag limit of 5 is the possession limit allowed for spotted seatrout.			
Shark: all species, their hybrids, and subspecies other than Atlantic sharpnose, blacktip, and bonnethead sharks.	1*	64*	No limit
Atlantic sharpnose, blacktip, and bonnethead sharks.	1*	24	No limit
*Special Regulation: The take of the following species of sharks from the waters of this			

state is prohibited and they may not be possessed on board a vessel at any time: Atlantic angel, Basking, Bigeye sand tiger, Bigeye sixgill, Bigeye thresher, Bignose, Caribbean reef, Caribbean sharpnose, Dusky, Galapagos, Longfin mako, Narrowtooth, Night, Sandbar, Sand tiger, Sevengill, Silky, Sixgill, Smalltail, Whale, and White.			
Sheepshead.	5	15	No limit
Snapper, lane.	No limit	8	No limit
Snapper, red.	4*	15	No limit
*Special Regulation: Red snapper may be taken using pole and line, but it is unlawful to use any kind of hook other than a circle hook baited with natural bait.			
Snapper, vermilion.	No limit	10	No limit
Snook.	1	24	28
Tarpon.	1	85	No limit
Triggerfish, gray.	20	16	No limit
Trout: rainbow and brown trout, their hybrids, and subspecies.	5 (in any combination)	No limit	No limit
Tripletail.	3	17	No limit
Walleye.	5*	No limit	No limit
*Special Regulation: Two walleye of less than 16 inches may be retained per day.			

Figure: 31 TAC §57.981(d)(1)

Species and Location (County)	Daily Bag	Minimum Length (Inches)	Special Regulation
Bass: largemouth, smallmouth, spotted and Guadalupe bass, their hybrids, and subspecies.			
In all waters in the Lost Maples State Natural Area (Bandera).	0	No limit	Catch and release only.
Bass: largemouth and spotted.			
Lake Alan Henry.	5	No limit	It is unlawful to retain more than two bass of less than 18 inches in length.
Caddo Lake (Marion and Harrison).	8 (in any combination with spotted bass)	14 - 18 inch slot limit (largemouth bass); no limit for spotted bass.	It is unlawful to retain largemouth bass between 14 and 18 inches. No more than 4 largemouth bass 18 inches or longer may be retained. Possession limit is 10.
Sabine River (Newton and Orange) from Toledo Bend dam to I.H. 10 bridge and Toledo Bend Reservoir (Newton, Sabine, and Shelby).	8 (in any combination with spotted bass)	14 (largemouth bass); no limit for spotted bass.	Possession limit is 10.
Bass: largemouth.			
Conroe (Montgomery and Walker), Granbury (Hood), Possum Kingdom (Palo Pinto, Stephens, Young), and Ratcliff (Houston).	5	16	
Lakes Kurth (Angelina) and Nacogdoches (Nacogdoches).	5		It is unlawful to retain largemouth bass of 16 inches or greater in length. Largemouth bass 24 inches or greater in length may be retained in a live well or other aerated holding

			device for purposes of weighing, but may not be removed from the immediate vicinity of the lake. After weighing, the bass must be released immediately back into the lake unless the department has instructed that the bass be kept for donation to the ShareLunker Program.
Lakes Bellwood (Smith), Braunig (Bexar), Bright (Williamson), Brushy Creek (Williamson), Bryan (Brazos), Calaveras (Bexar), Casa Blanca (Webb), Cleburne State Park (Johnson), Cooper (Delta and Hopkins), Fairfield (Freestone), Gilmer (Upshur), Marine Creek Reservoir (Tarrant), Meridian State Park (Bosque), Naconiche (Nacogdoches), Old Mount Pleasant City (Titus), Pflugerville (Travis), Rusk State Park (Cherokee), and Welsh (Titus).	5	18	
Buck Lake (Kimble), Lake Kyle (Hays), and Nelson Park Lake (Taylor).	0	No limit	Catch and release and only.
Lake Jacksonville (Cherokee) and O.H. Ivie Reservoir (Coleman, Concho, and Runnels).	5	No limit	It is unlawful to retain more than two bass of less than 18 inches in length.
Purtis Creek State Park Lake (Henderson and Van Zandt), and Raven (Walker).	0	No limit	Catch and release only except that any bass 24 inches or greater in length may be retained in a live well or other aerated holding device for purposes of

			weighing, but may not be removed from the immediate vicinity of the lake. After weighing, the bass must be released immediately back into the lake unless the department has instructed that the bass be kept for donation to the ShareLunker Program.
Lakes Bridgeport (Jack and Wise), Burke-Crenshaw (Harris), Davy Crockett (Fannin), Grapevine (Denton and Tarrant), Georgetown (Williamson), Madisonville (Madison), San Augustine City (San Augustine), and Sweetwater (Nolan).	5	14 - 18 inch slot limit	It is unlawful to retain largemouth bass between 14 and 18 inches in length.
Lakes Athens (Henderson), Bastrop (Bastrop), Buescher State Park (Bastrop), Houston County (Houston), Joe Pool (Dallas, Ellis, and Tarrant), Lady Bird (Travis) Mill Creek (Van Zandt), Murvaul (Panola), Pinkston (Shelby), Timpson (Shelby), Walter E. Long (Travis) and Wheeler Branch (Somervell).	5	14 - 21 inch slot limit	It is unlawful to retain largemouth bass between 14 and 21 inches in length. No more than 1 bass 21 inches or greater in length may be retained each day.
Lakes Fayette County (Fayette), Gibbons Creek Reservoir (Grimes), and Monticello (Titus).	5	14 - 24 inch slot limit	It is unlawful to retain largemouth bass between 14 and 24 inches in length. No more than 1 bass 24 inches or greater in length may be retained each day.
Lake Fork (Wood, Rains and Hopkins).	5	16 - 24 inch slot limit	It is unlawful to retain largemouth bass between 16 and 24 inches in length. No

			more than 1 bass 24 inches or greater in length may be retained each day.
Bass: smallmouth.			
Lakes O. H. Ivie (Coleman, Concho, and Runnels), Devil's River (Val Verde) from State Highway 163 bridge crossing near Juno downstream to Dolan Falls, and Wheeler Branch (Somervell).	3	18	
Lake Meredith (Hutchinson, Moore, and Potter).	3	12 - 15 inch slot limit	It is unlawful to retain smallmouth bass between 12 and 15 inches in length.
Bass: striped and white bass, their hybrids, and subspecies.			
Sabine River (Newton and Orange) from Toledo Bend dam to I.H. 10 bridge and Toledo Bend Reservoir (Newton, Sabine, and Shelby).	5	No limit	No more than 2 striped bass 30 inches or greater in length may be retained each day.
Lake Texoma (Cooke and Grayson).	10 (in any combination)	No limit	No more than 2 striped or hybrid striped bass 20 inches or greater in length may be retained each day. Striped or hybrid striped bass caught and placed on a stringer, in a live well or any other holding device become part of the daily bag limit and may not be released. Possession limit is 20.
Red River (Grayson) from Denison Dam downstream to and including Shawnee Creek (Grayson).	5 (in any combination)	No limit	Striped bass caught and placed on a stringer, in a live well or any other holding device become part of the daily bag limit and may not be released.

Trinity River (Polk and San Jacinto) from the Lake Livingston dam downstream to the F.M. 3278 bridge.	2 (in any combination)	18	
Bass: white.			
Lakes Caddo (Harrison and Marion), Texoma (Cooke and Grayson) and Toledo Bend (Newton, Sabine, and Shelby), and Sabine River (Newton and Orange) from Toledo Bend dam to I.H. 10 bridge.	25	No limit	
Carp: common.			
Lady Bird Lake (Travis).	No limit	No limit	It is unlawful to retain more than one common carp of 33 inches or longer per day.
Catfish: blue.			
Lakes Lewisville (Denton), Richland-Chambers (Freestone and Navarro), and Waco (McLennan).	25 (in any combination with channel catfish)	30-45-inch slot limit	It is unlawful to retain blue catfish between 30 and 45 inches in length. No more than one blue catfish 45 inches or greater in length may be retained each day.
Catfish: channel and blue catfish, their hybrids, and subspecies.			
Lake Kyle (Hays)	0	No limit	Catch and release and only.
Lake Livingston (Polk, San Jacinto, Trinity, and Walker).	50 (in any combination)	12	
Trinity River (Polk and San Jacinto) from the Lake Livingston dam downstream to the F.M. 3278 bridge.	10 (in any combination)	12	No more than 2 channel or blue catfish 24 inches or greater in length may be retained each day.
Lakes Kirby (Taylor) and Palestine (Cherokee, Anderson, Henderson, and Smith).	50 (in any combination)	No limit	No more than five catfish 20 inches or greater in length may be retained each day. Possession limit is 50.

Lakes Caddo (Harrison and Marion) and Toledo Bend (Newton, Sabine, and Shelby), and Sabine River (Newton and Orange) from Toledo Bend dam to I.H. 10 bridge.	50 (in any combination)	No limit	No more than five catfish 30 inches or greater in length may be retained each day. Possession limit is 50.
Lake Texoma (Cooke and Grayson).	15 (in any combination)	12	No more than one blue catfish 30 inches or greater in length may be retained each day.
Canyon Lake Project #6 (Lubbock), North Concho River (Tom Green) from O.C. Fisher Dam to Bell Street Dam, and South Concho River (Tom Green) from Lone Wolf Dam to Bell Street Dam.	5 (in any combination)	No limit	
Community fishing lakes.	5 (in any combination)	No limit	
Bellwood (Smith), Dixieland (Cameron), and Tankersley (Titus).	5 (in any combination)	12	
Catfish: flathead.			
Lake Texoma (Cooke and Grayson) and the Red River (Grayson) from Denison Dam to and including Shawnee Creek (Grayson).	5	20	
Lakes Caddo (Harrison and Marion), Toledo Bend (Newton, Sabine, and Shelby), and Sabine River (Newton and Orange) from Toledo Bend dam to the I.H. 10 bridge.	10	18	Possession limit is 10.
Crappie: black and white crappie, their hybrids and subspecies.			
Caddo Lake (Harrison and Marion), Toledo Bend Reservoir (Newton, Sabine, and Shelby), and Sabine River (Newton and Orange) from	25 (in any combination)	No limit	

Toledo Bend dam to the I.H. 10 bridge.			
Lake Fork (Wood, Rains, and Hopkins) and Lake O' The Pines (Camp, Harrison, Marion, Morris, and Upshur).	25 (in any combination)	10	From December 1, through the last day in February, there is no minimum length limit. All crappie caught during this period must be retained.
Lake Texoma (Cooke and Grayson).	37 (in any combination)	10	Possession limit is 50.
Drum, red.			
Lakes Braunig and Calaveras (Bexar), and Coleto Creek Reservoir (Goliad and Victoria), Fairfield (Freestone).	3	20	No maximum length limit.
Shad, gizzard and threadfin.			
The Trinity River below Lake Livingston in Polk and San Jacinto Counties.	500 (in any combination)	No limit	Possession limit 1,000 in any combination.
Sunfish: all species			
Lake Kyle (Hays)	0	No limit	Catch and release and only.
Trout: rainbow and brown trout, their hybrids, and subspecies.			
Guadalupe River (Comal) from the second bridge crossing on the River Road upstream to the easternmost bridge crossing on F.M. 306.	1	18	
Guadalupe River (Comal) from the easternmost bridge crossing on F.M. 306 upstream to 800 yards below the Canyon Lake dam.	5	12 - 18 inch slot limit	It is unlawful to retain trout between 12 and 18 inches in length. No more than one trout 18 inches or greater in length may be retained each day.
Walleye.			
Lake Texoma (Cooke and Grayson).	5	18	

Figure: 31 TAC §57.981(d)(2)

Species	Daily Bag	Minimum Length (Inches)	Special Regulation
Seatrout, spotted.			
All inside waters from F.M. 457 northward to the Louisiana border.	10	15	25*
*Special Regulation: One spotted seatrout greater than 25 inches may be retained per day.			

Figure: 40 TAC §15.410(d)(2)

Minors	**Total Staff**	**RN**	**RN or LVN**	**RN, LVN or Direct Care staff**
1	1	1		
2-6	2	1		1
7-9	3	1	1	1
10-12	4	1	1	2
13-15	5	2	1	2
16-18	6	2	1	3
19-21	7	2	2	3
22-24	8	2	2	4
25-27	9	3	2	4
28-30	10	3	2	5
31-33	11	3	3	5
34-36	12	3	3	6
37-39	13	4	3	6
40-42	14	4	3	7
43-45	15	4	4	7
46-48	16	4	4	8
49-51	17	5	4	8
52-54	18	5	4	9
55-57	19	5	5	9
58-60	20	5	5	10

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Texas Department of Agriculture

Request for Applications: 2014 GO TEXAN Partner Program, Round 3

The Texas Department of Agriculture (TDA) is accepting proposals for the GO TEXAN Partner Program (GOTEPP). GOTEPP is designed to provide matching funds for Tier 2 or higher GO TEXAN members to market and promote their Texas agricultural products. TDA has been authorized to award $1 million in grants over the 2014 and 2015 state fiscal years. TDA anticipates three application periods over this time frame and awards of approximately $300,000 - $350,000 each cycle. This is the third of three application cycles.

Eligibility.

GO TEXAN Membership: An eligible applicant must be a **current** GO TEXAN Program Tier 2, 3, or sponsorship member in good standing. Only proposals from applicants with a GO TEXAN membership in approved account status in good standing at the time of the GOTEPP proposal submission deadline will be considered. Please note: a GO TEXAN membership application takes 2 - 3 weeks to process and membership upgrades cannot be performed online. Full payment for membership fees must be received prior to submission of a GOTEPP proposal. For questions or to check on membership status, please contact (877) 99-GOTEX or gotexan@TexasAgriculture.gov. NO EXCEPTIONS WILL BE MADE.

Only project requests submitted by applicants physically located in Texas or that have a principal place of business in Texas shall be funded. An eligible applicant must be a current GO TEXAN Program Tier 2, 3, or sponsorship member **and** be:

(1) a state or regional organization or board that promotes the marketing and sale of Texas agricultural products and does not stand to profit directly from specific sales of agricultural commodities;

(2) a cooperative organization, consisting of a group of five or more individuals who produce or market agricultural products in the state and associate to achieve common goals by registering with the Secretary of State's Office;

(3) a state agency or board that promotes the marketing and sale of agricultural commodities;

(4) a national organization or board that represents Texas producers and promotes the marketing and sale of Texas agricultural products;

(5) a small business - a legal agricultural entity, including a corporation, partnership, or sole proprietorship that:

(A) is formed for the purpose of making a profit; and

(B) has fewer than 50 full-time employees or less than $1 million in annual gross receipts.

(6) any other entity or business, other than a business meeting the definition of small business, that promotes the marketing and sale of Texas agricultural products;

(7) retailer/distributors, if:

(A) 70% of their agricultural products are sourced from Texas;

(B) 70% of their products are sourced from GO TEXAN members; or

(C) 70% of their participating businesses, companies, or members and/or vendors are GO TEXAN members, other than associate or retail members.

Funding Parameters. Selected projects will receive funding on a cost reimbursement basis. Funds will not be advanced to grantees. Selected applicants must have the financial capacity to pay all costs up-front.

Budgets will be reviewed in the competitive evaluation process. Applicants may request up to $50,000 in GOTEPP funding for activities promoting the sale of Texas agricultural products. Combined with Applicant matching funds, a total of no more than $100,000 must be identified in a detailed budget.

Projects are required to meet a 1:1 match minimum. For every GOTEPP dollar requested, the applicant must show at least an equal amount of Applicant Matching Funds.

Awards are subject to the availability of funds. If no funds are appropriated or collected for this program, applicants will be informed accordingly.

Applicants selected for funding may receive a maximum of $50,000 over the 2014-2015 biennium.

Application Requirements. To be considered, applications must be complete and include all of the required information. Application and information can be downloaded from TDA's website at: www.gotexan.org and click on the GOTEPP link.

For questions regarding submission of the proposal and/or TDA requirements, please contact the Grants Office at (512) 463-6695, or by e-mail at Grants@TexasAgriculture.gov.

Deadline for Submission of Responses. The complete application packet, including the proposal with signatures, must be received by Monday, September 15, 2014. It is the applicant's responsibility to submit all materials necessary for evaluation early enough to ensure timely delivery. Electronic, hand-delivered or mailed applications must be RECEIVED by TDA by close of business (5:00 p.m.) on Monday, September 15, 2014. Applicants may not supplement or amend the application after the deadline.

Texas Public Information Act. Once submitted, all applications shall be deemed to be the property of the TDA and are subject to the Texas Public Information Act, Texas Government Code, Chapter 552.

TRD-201403768
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Filed: August 11, 2014

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Request for Applications: National Organic Certification Cost-Share Program

Statement of Purpose. Pursuant to Texas Agriculture Code, §12.002, the Texas Department of Agriculture (TDA) hereby requests applica-

tions for the National Organic Certification Cost Share Program designed to assist Texas producers with the cost of organic certification.

Program Authority. The Farm Security and Rural Investment Act of 2002 (2002 Farm Bill) (7 U.S.C. 7901 note) authorized the Department of Agriculture (USDA) to provide cost share assistance to organic producers and handlers who participate in the National Organic Certification Cost Share Program (NOCCSP).

Section 10301 of the Food, Conservation, and Energy Act of 2008 (2008 Farm Bill) (7 U.S.C. 8701 note) amended the 2002 Farm Bill and authorized USDA to provide grants to States from 2008 through 2012 to encourage participation in organic food production. The American Taxpayer Relief Act of 2012 (26 U.S.C. 1 note) extended the 2008 Farm Bill for one year until September 30, 2013, but did not provide funding for the NOCCSP. Section 10004(c) of the Agriculture Act of 2014 (2014 Farm Bill) (Pub. L. 113-79) amended the Food, Conservation, and Energy Act of 2008 and authorized the USDA to provide 11.5M to assist producers and handlers of agricultural products in obtaining certification under the National Organic Program.

Eligibility. Applicants must be a Texas-based business that produces organic crops. Operations must possess current USDA organic certification to be eligible to receive reimbursements. This means operations either must have successfully received their initial USDA organic certification from a USDA-accredited certifying agent, or must have incurred expenses related to the renewal of their USDA organic certification from a USDA-accredited certifying agent between October 1, 2013 and September 30, 2014. Operations with suspended or revoked certifications are ineligible for reimbursement. The applicable NOP regulations and resources for certification are available on the NOP website at www.ams.usda.gov/nop.

Organic producers (crops, wild crops, and/or livestock) and/or handlers are eligible to participate in the NOCCSP.

Funding Parameters. Applications must be complete and have all required documentation to be considered. Applications missing documentation or otherwise deemed incomplete will not be considered for funding until sufficient information has been received by TDA. Information not received by the application deadline will not be considered.

Payments are limited to 75% (seventy-five percent) of an individual producer's certification costs, up to a maximum of $750 (seven hundred and fifty dollars) per certificate or category of certification, per year.

Eligible operations may receive one reimbursement per year per certificate or category of certification (if one certificate includes multiple categories). Each certificate may be reimbursed separately. Likewise, each category of certification may be reimbursed separately.

Application Requirements. Applications will be accepted beginning August 2014, and must be submitted on the form provided by TDA. The application (GTBD-167) is available on TDA's website at www.TexasAgriculture.gov, or available upon request from TDA by calling (512) 463-9932. Applications must be submitted to TDA headquarters in Austin, Texas. If mailing the application, please make sure it is in a properly addressed envelope, bearing sufficient postage. To be considered, applications must be signed/certified by the applicant and include required supporting documentation.

Submission of Responses. A complete application packet including signatures must be RECEIVED by TDA by close of business (5:00 p.m.) on **Friday, October 31, 2014.** It is the applicant's responsibility to submit all materials necessary early enough to ensure timely delivery. Applications may be submitted electronically, hand-delivered or mailed. Late or incomplete applications will not be accepted.

Mailing Address: Texas Department of Agriculture, Grants Office, Organic Cost Share Program, P.O. Box 12847 Austin, Texas 78711.

Physical Address for overnight delivery: Texas Department of Agriculture, Grants Office, Organic Cost Share Program, 1700 North Congress Ave, 11th floor Austin, Texas 78701.

Electronic Submissions: E-mail: Grants@TexasAgriculture.gov; Fax: (888) 223-9048

An electronic version will be accepted as long as all sections of the application are complete, including signature of applicant. The e-mail or fax cover page subject line must contain the RFA title and applicant name (Ex: 2014 Organic Cost - Share - ABC Inc.) The respondent is solely responsible for ensuring that the complete application, regardless of method of delivery, is sent to, and actually received by, TDA in a timely manner and at the proper destination server.

IMPORTANT NOTE: TDA recommends a limit on the attachments to 10MB each. This may result in sending multiple e-mails for the submission of all documentation contained in a response. All submissions must be sent in Microsoft Word or other Word compatible format or as PDF files. Unreadable submissions may be deemed unresponsive and will not be reviewed for funding consideration.

TDA takes no responsibility for electronic bids that are captured, blocked, filtered, quarantined or otherwise prevented from reaching the proper destination server by any TDA anti-virus or other security software.

TDA will send an acknowledgement receipt by e-mail indicating the response was received.

For questions regarding submission of the application and TDA documentation requirements, please contact Mr. Allen Regehr at (512) 463-9932 or by e-mail at Grants@TexasAgriculture.gov.

Texas Public Information Act. Once submitted, all proposals shall be deemed to be the property of the TDA and are subject to the Texas Public Information Act, Texas Government Code, Chapter 552.

TRD-201403774
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Filed: August 11, 2014

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Alamo Area Metropolitan Planning Organization

Request for Qualifications/Proposals

The Alamo Area Metropolitan Planning Organization (MPO) is seeking qualifications/proposals for legal services.

A copy of the Request for Qualifications/Proposals (RFQ/P) may be requested by downloading the RFQ/P from the MPO's website at www.alamoareampo.org or calling Jeanne Geiger, Deputy Director, at (210) 227-8651. Anyone wishing to submit a proposal must do so by 12:00 p.m. (CT), Friday, September 19, 2014 at the MPO office to:

Isidro "Sid" Martinez

Director

Alamo Area Metropolitan Planning Organization

825 South Saint Mary's Street

San Antonio, Texas 78205

The MPO's Executive Committee will review the qualifications/proposals and the contract award will be made by the MPO's Transportation Policy Board.

Funding is contingent upon the availability of Federal transportation planning funds.

TRD-201403775
Jeanne Geiger
Deputy Director
Alamo Area Metropolitan Planning Organization
Filed: August 11, 2014

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Office of the Attorney General

Notice of Settlement of a Texas Water Code Enforcement Action

The State of Texas gives notice of the following proposed resolution of an environmental enforcement action under the Texas Water Code. Before the State may enter into a voluntary settlement agreement, pursuant to §7.110 of the Texas Water Code the State shall permit the public to comment in writing. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreement if the comments disclose facts or considerations indicating that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the law.

Case Title: *United States of America and State of Texas v. Oxy USA, Inc. and Canadianoxy Offshore Production Co.,* CA No. 4:14-cv-00491; In the United States District Court for the Eastern District of Texas, Sherman Division.

Background: This case seeks recovery of damages for injury to natural resources and recovery of costs associated with past assessment of damages and the future oversight of restoration under 42 U.S.C. §9607(a)(4)(C) (CERCLA) and Texas Water Code §26.265(d), at the former Empire Oil Refinery located at 101 County Road 401 in Gainesville, Cooke County, Texas ("Site"). Defendants are the successor in interest to the former owners of the Site. Industrial activities from 1926 to about 1935 left the Site contaminated with hazardous substances. These substances were found in several waste pits and the concrete pads for six crude and/or refined product tanks. This contamination injured surface water, submerged lands and sediments, wetlands habitats, grassland habitats, upland woodlands, avian resources, aquatic biota, and terrestrial wildlife. Specific harm included the deaths of several species of birds and other wildlife at the Site in 2000 because of exposure to hydrocarbons.

Nature of the Settlement: The action by the State of Texas against Oxy, Inc. and Canadianoxy Offshore Production Co., will be settled by a Consent Decree in the United States District Court for the Eastern District of Texas, Sherman Division.

Proposed Settlement: The proposed settlement orders Defendants to pay past assessment and future oversight costs incurred by the Plaintiffs. The proposed settlement also requires the Defendants to fund the restoration of natural resources damaged by the releases at and from the Empire Oil Refinery.

For a complete description of the proposed settlement, the complete proposed Consent Decree Addressing Natural Resource Damages should be reviewed. Requests for copies of the proposed settlement, and written comments on the proposed settlement, should be directed to Jane E. Atwood, Assistant Attorney General, Environmental Protection Division, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0911. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-201403773
Katherine Cary
General Counsel
Office of the Attorney General
Filed: August 11, 2014

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Texas Water Code and Texas Health and Safety Code Settlement Notice

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement lawsuit under the Texas Water Code. Before the State may settle a judicial enforcement action under the Texas Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Code.

Case Title and Court: *Ector County, Texas, and State of Texas, acting by and through the Texas Commission on Environmental Quality v. SKM Recycling, Inc.,* Cause No. D-1-GV-13-000226; in the 250th Judicial District Court, Travis County, Texas.

Nature of Defendant's Operations: Defendant SKM Recycling, Inc. owns and operates a recycling facility at 3023 E I-20 Business and 2267 West County Road South, Odessa, Ector County (the Site). Ector County initiated this suit to enforce Texas statutes and rules governing solid waste disposal and storage. In October 2011, Ector County personnel discovered piles of solid waste at the Site, including trash, tires and other materials. The unauthorized waste has been removed.

Proposed Agreed Final Judgment: The proposed Agreed Final Judgment assesses civil penalties against Defendant in the amount of $15,400, to be divided equally between Ector County and the State of Texas. In addition, the Agreed Final Judgment awards attorney's fees and investigative costs in the amount of $7,000 to Ector County and $2,000 to the State of Texas. Defendant shall pay all costs of court.

For a complete description of the proposed settlement, the complete proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgment, and written comments on the proposed settlement, should be directed to Sireesha Chirala, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, MC 066, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0911. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-201403667
Katherine Cary
General Counsel
Office of the Attorney General
Filed: August 11, 2014

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Cancer Prevention and Research Institute of Texas

Request for Applications C-15-ESTCO-2 Established Company Product Development Award

The Cancer Prevention and Research Institute of Texas (CPRIT) seeks applications from Texas-based companies for the research and development of innovative products addressing critically important needs re-

lated to diagnosis, prevention, and/or treatment of cancer and the product development infrastructure needed to support these efforts.

The goal of the Established Company Product Development Award is to finance the research and development of innovative products, services, and infrastructure with significant potential impact on patient care. These investments will provide companies or limited partnerships located and headquartered in Texas with the opportunity to further the research and development of new products for the diagnosis, treatment, or prevention of cancer; to establish infrastructure that is critical to the development of a robust industry; or to fill a treatment or research gap. This award is intended to support companies that will be staffed with a majority of Texas-based employees, including C-level executives. The long-term objective of this award is to support the research and development of commercially-oriented therapeutic and medical technology products, diagnostic- or treatment-oriented information technology products, diagnostics, tools, services, and infrastructure projects. Eligible products or services include - but are not limited to - therapeutics (e.g., small molecules and biologics), diagnostics, devices, and potential breakthrough technologies, including software and research discovery techniques. Eligible stages of research and development include translational research, proof-of-concept studies, preclinical studies, and Phase I or Phase II clinical trials. By exception, Phase III clinical trials and later stage product development projects will be considered where circumstances warrant CPRIT investment.

To be eligible for the three (3) year funding award, company applicants must have already received at least one round of professional institutional investment and must have or must commit to headquartering registering in Texas; the majority of staff residing in or relocating to Texas; and use of Texas-based subcontractors and suppliers, unless adequate justification is provided for the use of out-of-state entities. CPRIT's contribution to a program will not be greater than $20 million. Funding will be tranched and will be tied to the achievement of contract-specified milestones. Funds may be used for salary and fringe benefits, research supplies, equipment, clinical trial expenses, intellectual property protection, external consultants and service providers, and other appropriate development costs, subject to certain limitations set forth by Texas state law.

A detailed Request for Applications (RFA) is available online at www.cprit.state.tx.us. Applications will be accepted beginning at 7:00 a.m. Central Time on August 25, 2014, through 3:00 p.m. Central Time on September 29, 2014, and must be submitted via the CPRIT Application Receipt System (www.CPRITGrants.org). CPRIT will not accept applications that are not submitted via the CPRIT Application Receipt System.

TRD-201403582
Heidi McConnell
Chief Operating Officer
Cancer Prevention and Research Institute of Texas
Filed: August 7, 2014

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Request for Applications C-15-NEWCO-2 New Company Product Development Award

The Cancer Prevention and Research Institute of Texas (CPRIT) seeks applications from Texas-based companies for the research and development of innovative products addressing critically important needs related to diagnosis, prevention, and/or treatment of cancer and the product development infrastructure needed to support these efforts.

The goal of the New Company Product Development Award is to support the formation and establishment of new start-up companies in Texas undertaking research and development activities for products and services that have the potential to significantly impact cancer care. These companies must be Texas-based or be willing to relocate to and remain in Texas for a specified period upon funding. Eligible products or services include, but are not limited to, therapeutics (e.g., small molecules and biologics), diagnostics, devices, and potential breakthrough technologies, including software and research discovery techniques. Eligible stages of research and development include translational research, proof-of-concept studies, preclinical studies, and Phase I or Phase II clinical trials. By exception, Phase III clinical trials and later stage product development projects will be considered where circumstances warrant CPRIT investment.

To be eligible for the three (3) year funding award, a company applicant must be an early-stage, start-up company with no previous rounds of professional institutional investment (i.e., has not yet received Series A financing.) Successful applicants must commit to headquarters or substantial business functions of the company in Texas; personnel sufficient to operate the Texas-based research and/or development activities of the company, along with appropriate management, relocated to or hired from within Texas. CPRIT's contribution to the program will not be greater than $20 million. Funding will be tranched and will be tied to the achievement of contract-specified milestones. Funds may be used for salary and fringe benefits, research supplies, equipment, clinical trial expenses, intellectual property protection, external consultants and service providers, and other appropriate development costs, subject to certain limitations set forth by Texas state law.

A detailed Request for Applications (RFA) is available online at www.cprit.state.tx.us. Applications will be accepted beginning at 7:00 a.m. Central Time on August 25, 2014, through 3:00 p.m. Central Time on September 29, 2014, and must be submitted via the CPRIT Application Receipt System (www.CPRITGrants.org). CPRIT will not accept applications that are not submitted via the CPRIT Application Receipt System.

TRD-201403583
Heidi McConnell
Chief Operating Officer
Cancer Prevention and Research Institute of Texas
Filed: August 7, 2014

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Request for Applications C-15-RELCO-2 Company Relocation Product Development Award

The Cancer Prevention and Research Institute of Texas (CPRIT) seeks applications from existing oncology-focused companies or limited partnerships that are willing to relocate to Texas. The award will support the research and development of innovative products addressing critically important needs related to diagnosis, prevention, and/or treatment of cancer and the product development infrastructure needed to support these efforts.

The goal of the Company Relocation Award is to attract industry partners in the field of cancer care to advance economic development and cancer care efforts in the state by recruiting to Texas companies with proven management teams who are focused on exceptional product opportunities to improve cancer care. CPRIT expects outcomes of supported research and development activities to directly and indirectly benefit subsequent cancer research efforts, cancer public health policy, or the continuum of cancer care - from prevention to treatment and cure. To fulfill this vision, applications may address any product development topic or issue related to cancer biology, causation, prevention, detection or screening, treatment, or cure. The overall goal of this award program is to improve outcomes of patients with cancer by increasing the availability of Food and Drug Administration (FDA) -

approved therapeutic interventions with a primary focus on Texas-centric programs. Eligible products or services include - but are not limited to - therapeutics (e.g., small molecules and biologics), diagnostics, devices, and potential breakthrough technologies, including software and research discovery techniques. Eligible stages of research and development include translational research, proof-of-concept studies, preclinical studies, and Phase I or Phase II clinical trials. By exception, Phase III clinical trials and later stage product development projects will be considered where circumstances warrant investment.

To be eligible for the three (3) year funding award, company applicants must presently be based outside Texas and must have already received at least one round of professional institutional investment (e.g., Series A financing.) In addition, award recipients must commit to headquarters or substantial business functions of the company in Texas; personnel sufficient to operate the Texas-based research and/or development activities of the company, along with appropriate management, relocated to or hired from within Texas; and use of Texas-based subcontractors and suppliers unless adequate justification is provided for the use of out-of-state entities. Financial support will be awarded based upon the breadth and nature of the research and development program proposed. CPRIT's contribution to the program will not be greater than $20 million. Funding will be tranched and will be tied to the achievement of contract-specified milestones. Funds may be used for salary and fringe benefits, research supplies, equipment, clinical trial expenses, intellectual property protection, external consultants and service providers, and other appropriate development costs, subject to limitations set by Texas state law.

A detailed Request for Applications (RFA) is available online at www.cprit.state.tx.us. Applications will be accepted beginning at 7:00 a.m. Central Time on August 25, 2014, through 3:00 p.m. Central Time on, September 29, 2014, and must be submitted via the CPRIT Application Receipt System (www.CPRITGrants.org). CPRIT will not accept applications that are not submitted via the CPRIT Application Receipt System.

TRD-201403584
Heidi McConnell
Chief Operating Officer
Cancer Prevention and Research Institute of Texas
Filed: August 7, 2014

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Comptroller of Public Accounts

Notice of Contract Award

Pursuant to Chapter 403, Chapter 2254, Subchapter A of the Texas Government Code, and Chapter 111, Subchapter A, §111.0045 of the Texas Tax Code, the Texas Comptroller of Public Accounts ("Comptroller") announces this notice of contract awards.

The Comptroller's Request for Qualifications 207L ("RFQ") related to these contract awards was published in the April 11, 2014, issue of the *Texas Register* (39 TexReg 2975).

The examiners will provide Professional Contract Examination Services as authorized by Subchapter A, Chapter 111, §111.0045 of the Texas Tax Code as described in the Comptroller's RFQ.

The Comptroller announces that four (4) contracts were awarded as follows:

Wayne A. Powe, 5501 Independence Parkway, Suite 107, Plano, Texas 75023. Examinations will be assigned in $60,000 - $90,000 examination packages per individual examiner but no contract examiner shall have examination packages totaling more than $180,000 in fees during any one state fiscal year during the contract term. The term of the contract is September 1, 2014 through August 31, 2015 with two (2) one (1) year options to renew.

Willie L. Sullivan, Jr., 4530 Brookren Court, Pearland, Texas 77584. Examinations will be assigned in $60,000 - $90,000 examination packages per individual examiner but no contract examiner shall have examination packages totaling more than $180,000 in fees during any one state fiscal year during the contract term. The term of the contract is September 1, 2014 through August 31, 2015 with two (2) one (1) year options to renew.

Frederick Drew Nixon, 1333 Sunny Glen Drive, Dallas, Texas 75232. Examinations will be assigned in $60,000 - $90,000 examination packages per individual examiner but no contract examiner shall have examination packages totaling more than $180,000 in fees during any one state fiscal year during the contract term. The term of the contract is September 1, 2014 through August 31, 2015 with two (2) one (1) year options to renew.

State and Local Tax Group, LLC, 308 Cooper Drive, Hurst, Texas 76053. Examinations will be assigned in $60,000 - $90,000 examination packages per individual examiner but no contract examiner shall have examination packages totaling more than $180,000 in fees during any one state fiscal year during the contract term. The term of the contract is September 1, 2014 through August 31, 2015 with two (2) one (1) year options to renew.

The four (4) contracts above are the final awards that the Comptroller will make under this RFQ.

TRD-201403572
Jette Withers
Deputy General Counsel for Contracts
Comptroller of Public Accounts
Filed: August 6, 2014

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Notice of Contract Award

The Comptroller of Public Accounts announces this notice of award for consulting services for the Financial Allocation Study for Texas (FAST) under Request for Proposals 208a ("RFP"). The RFP was published in the April 11, 2014, issue of the *Texas Register* (39 TexReg 2974).

The contract was awarded to Lori L. Taylor, Ph.D, 4723 Johnson Creek Loop, College Station, Texas 77845. The total amount of the contract is not to exceed $18,000.00. The term of the contract is July 17, 2014 through August 31, 2015, with option to renew for two (2) additional one-year periods through August 31, 2017.

TRD-201403815
Jason C. Frizzell
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: August 13, 2014

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Notice of Contract Award

The Comptroller of Public Accounts announces this notice of award for consulting services for a Texas Treasury Safekeeping Trust Company Employee Compensation Study under Request for Proposals 210a ("RFP"). The RFP was published in the May 16, 2014, issue of the *Texas Register* (39 TexReg 3887).

The contract was awarded to CBIZ Benefits & Insurance Services, Inc. dba CBIZ Human Capital Services, 625 Maryville Centre Drive, Suite 200, St. Louis, Missouri 63141. The total amount of the contract is not to exceed $21,300.00. The term of the contract is August 1, 2014, through September 30, 2014.

TRD-201403816
Jason C. Frizzell
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: August 13, 2014

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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 and §303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 08/18/14 - 08/24/14 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 08/18/14 - 08/24/14 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-201403795
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: August 12, 2014

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East Texas Council of Governments

Public Notice

An announcement was published earlier that the East Texas Council of Governments (ETCOG) as the Administrative unit for the Workforce Solutions East Texas Board, is soliciting proposals for the operation and management of Temporary Assistance for Needy Families (TANF) Basic Education and Literacy Projects for a period beginning October 1, 2014 and extending through September 30, 2015 with the availability of three, one-year additional options.

Two important changes to this solicitation of proposals are announced in response to significant changes in the way the TANF Basic Education and Literacy Project participants impact Texas Workforce Commission (TWC) performance requirements:

The due date for the request for proposals is changed from August 12, 2014 to **August 25, 2014 at 5:00 p.m.**

Proposer is expected to implement overall program strategies which will contribute to meeting the contracted performance measure for the East Texas Workforce Development Area. Proposer will be held contractually liable for its portion of the program year 2014 TWC contracted measures, based upon enrollments and outcomes.

The purpose of this Request for Proposals is to provide basic education, literacy services and/or work preparedness for Temporary Assistance for Needy Families (TANF) program participants, former TANF Program participants and/or individuals who are at-risk of becoming TANF participants. Proposers are encouraged to incorporate into their proposals a component offering "work-related soft skills" training in conjunction with basic education and literacy training in partnership with area employer(s).

Counties comprising the East Texas Workforce Development Areas are: Anderson, Camp, Cherokee, Gregg, Harrison, Henderson, Marion, Panola, Rains, Rusk, Smith, Upshur, Van Zandt, and Wood.

The Workforce Solutions East Texas Board is making approximately $190,231 available through this RFP. Proposals are limited to $75,000. The amount of funds available is subject to change. Persons or organizations wanting to receive a Request for Proposals (RFP) package, should submit a request by letter, fax, or e-mail to the East Texas Council of Governments, 3800 Stone Road, Kilgore, Texas 75662, Attn: Gary Allen (903) 218-6429 or (800) 735-2989 (TD) and 7-1-1 (Voice). The fax number for ETCOG is (903) 983-1440 or e-mail gary.allen@etcog.org. Questions concerning the RFP process should also be addressed by letter, e-mail or fax to Gary Allen.

The deadline for receipt of proposals is Monday August 25, 2014 at 5:00 p.m. CDT.

Historically Underutilized Businesses (HUBs) are encouraged to apply. ETCOG is an equal opportunity employer. The TANF Basic Education and Literacy Program is an Equal Opportunity Program. Individuals needing assistance may call (800) 735-2989 (TD) and 7-1-1 (Voice).

TRD-201403801
David Cleveland
Executive Director
East Texas Council of Governments
Filed: August 12, 2014

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ, agency or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **September 22, 2014.** 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. September 22, 2014.** 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 com-

ment 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: Beacon Estates Water Supply Corporation; DOCKET NUMBER: 2014-0471-MWD-E; IDENTIFIER: RN101917573; LOCATION: Brookshire, Waller County; TYPE OF FACILITY: wastewater treatment facility; RULES VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0014963001, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limits; and 30 TAC §§305.125(1), 319.1, 319.4, and 319.5(b), and TPDES Permit Number WQ0014963001, Monitoring and Reporting Requirements Number 1, by failing to collect and analyze effluent samples for *Escherichia coli;* PENALTY: $6,600; ENFORCEMENT COORDINATOR: Katelyn Samples, (512) 239-4728; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(2) COMPANY: Burton Grocers, Incorporated dba Stop N Save 3; DOCKET NUMBER: 2014-0735-PST-E; IDENTIFIER: RN101499796; LOCATION: Austin, Travis County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide corrosion protection for the underground storage tank system; PENALTY: $2,438; ENFORCEMENT COORDINATOR: Rebecca Boyett, (512) 239-2503; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753, (512) 339-2929.

(3) COMPANY: Carolyn Maxey dba Channel Oaks Water System; DOCKET NUMBER: 2014-0554-PWS-E; IDENTIFIER: RN101210391; LOCATION: Marble Falls, Burnet County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.45(b)(1)(C)(i) and Texas Health and Safety Code, §341.0315(c), by failing to provide a minimum well capacity of 0.6 gallons per minute per connection; 30 TAC §290.46(f)(2) and (3)(B)(iv), by failing to provide water system records to commission personnel at the time of the investigation; and 30 TAC §290.41(c)(3)(K), by failing to provide a well casing vent with an opening that is covered with a 16-mesh or finer corrosion resistant screen, facing downward, elevated, and located as to minimize the drawing of contaminants into the well; PENALTY: $170; ENFORCEMENT COORDINATOR: Epifanio Villarreal, (361) 825-3425; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753, (512) 339-2929.

(4) COMPANY: CCP Composites US LLC; DOCKET NUMBER: 2014-0724-AIR-E; IDENTIFIER: RN100692219; LOCATION: Houston, Harris County; TYPE OF FACILITY: chemical manufacturing; RULES VIOLATED: 30 TAC §117.340(a) and §122.143(4), Texas Health and Safety Code (THSC), §382.085(b), and Federal Operating Permit (FOP) Number O3330, Special Terms and Conditions Number 1.A., by failing to maintain and operate totalizing fuel flow meters; 30 TAC §122.143(4) and §122.146(2), THSC, §382.085(b), and FOP Number O3330, General Terms and Conditions (GTC), by failing to submit the Permit Compliance Certification no later than 30 days after the end of the certification period; and 30 TAC §122.143(4) and §122.145(2)(C), THSC, §382.085(b), and FOP Number O3330, GTC, by failing to submit a deviation report no later than 30 days after the end of the reporting period; PENALTY: $22,538; ENFORCEMENT COORDINATOR: Farhaud Abbaszadeh, (512) 239-0779; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(5) COMPANY: CHARTWELL PROPERTIES, LP; DOCKET NUMBER: 2014-0633-WQ-E; IDENTIFIER: RN106430762; LOCATION: Georgetown, Williamson County; TYPE OF FACILITY: airport terminal services; RULES VIOLATED: 30 TAC §281.25(a)(4) and 40 Code of Federal Regulations §122.26(c), by failing to obtain authorization to discharge storm water associated with industrial activities under Texas Pollutant Discharge Elimination System Multi-Sector General Permit Number TXR050000; PENALTY: $1,125; ENFORCEMENT COORDINATOR: Alejandro Laje, (512) 239-2547; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753, (512) 339-2929.

(6) COMPANY: CHCA MAINLAND, L.P. dba Mainland Medical Center; DOCKET NUMBER: 2013-1466-PST-E; IDENTIFIER: RN101901809; LOCATION: Texas City, Galveston County; TYPE OF FACILITY: medical center with a gasoline powered emergency generator system; RULES VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to renew a previously issued underground storage tank (UST) delivery certificate by submitting a properly completed UST registration and self-certification form at least 30 days before the expiration date; and 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the UST; PENALTY: $12,115; ENFORCEMENT COORDINATOR: Michael Pace, (817) 588-5933; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(7) COMPANY: City of Bishop; DOCKET NUMBER: 2014-0547-MWD-E; IDENTIFIER: RN101920684; LOCATION: City of Bishop, Nueces County; TYPE OF FACILITY: wastewater treatment plant; RULES VIOLATED: 30 TAC §305.125(1) and (5) and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0010427001, Operational Requirements Number 1, by failing to properly operate and maintain all facilities and systems of treatment and control installed or used by the permittee to achieve compliance with the permit conditions at all times; 30 TAC §305.125(9) and TPDES Permit Number WQ0010427001, Monitoring and Reporting Requirements Number 7.a, by failing to notify the TCEQ Regional Office within 24 hours of becoming aware of a noncompliance; PENALTY: $10,188; ENFORCEMENT COORDINATOR: Jason Fraley, (512) 239-2552; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(8) COMPANY: COUNTRY SIDE INCORPORATED dba Country Mart; DOCKET NUMBER: 2013-2115-PST-E; IDENTIFIER: RN102034725; LOCATION: Paris, Lamar County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(C) and (5)(A), by failing to obtain a underground storage tank (UST) delivery certificate by submitting a properly completed UST registration and self-certification form; 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; 30 TAC §334.50(b)(1)(A) and TWC, §26.3475 and (c)(1), by failing to monitor the USTs for releases at a frequency of at least once every month; and 30 TAC §334.50 (b)(2) and TWC, §26.3475(a), by failing to provide release detection for the pressurized piping associated with the UST system; PENALTY: $8,900; ENFORCEMENT COORDINATOR: Tiffany Maurer, (512) 239-2696; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(9) COMPANY: DCP Midstream, LP; DOCKET NUMBER: 2014-0381-AIR-E; IDENTIFIER: RN100220052; LOCATION: Dumas, Moore County; TYPE OF FACILITY: natural gas compressor station; RULE VIOLATED: 30 TAC §§116.115(c), 122.143(4), and 101.20(1) and (3), Texas Health and Safety Code, §382.085(b), 40 Code of Federal Regulations §60.18(c)(1), New Source Review Permit Numbers 83193 and PSDTX1104, Special Conditions Numbers 1 and 17C, and Federal Operating Permit Number O2568, Special Terms and

Conditions Number 8, by failing to prevent unauthorized emissions; PENALTY: $112,500; ENFORCEMENT COORDINATOR: Farhaud Abbaszadeh, (512) 239-0779; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(10) COMPANY: E & M Equity Holdings, LLC.; DOCKET NUMBER: 2014-0183-PWS-E; IDENTIFIER: RN102323557; LOCATION: Pearland, Brazoria County; TYPE OF FACILITY: day care with a public water supply; RULES VIOLATED: 30 TAC §290.110(e)(4)(A) and (f)(3), by failing to submit a Disinfectant Level Quarterly Operating Report to the executive director each quarter by the tenth day of the month following the end of each quarter; 30 TAC §290.106(e) and §290.113(e), by failing to provide the results of annual nitrate and Stage 1 Disinfectant Byproduct contaminant sampling to the executive director; 30 TAC §290.106(e) and §290.107(e), by failing to provide the results of triennial cyanide, synthetic organic chemical (SOC) contaminants Group 5 and SOC contaminants (methods 504, 515 and 531) sampling to the executive director; and 30 TAC §290.51(a)(6) and TWC, §5.702, by failing to pay Public Health Service fees and associated late fees for TCEQ Financial Administration Account Number 90200509 for Fiscal Years 2012 - 2014; PENALTY: $1,947; ENFORCEMENT COORDINATOR: Katy Montgomery, (210) 403-4016; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(11) COMPANY: Evve D. Kuykendall; DOCKET NUMBER: 2014-0930-OSS-E; IDENTIFIER: RN106639222; LOCATION: Barnhart, Irion County; TYPE OF FACILITY: on-site sewage facility; RULES VIOLATED: 30 TAC §285.3(a) and (b)(1) and Texas Health and Safety Code, §366.051(a), by failing to obtain authorization prior to constructing, installing, and operating an on-site sewage facility; PENALTY: $625; ENFORCEMENT COORDINATOR: Lanae Foard, (512) 239-2554; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7035, (325) 655-9479.

(12) COMPANY: FML Sand, LLC; DOCKET NUMBER: 2014-0605-OSS-E; IDENTIFIER: RN105156624; LOCATION: Voca, McCulloch County; TYPE OF FACILITY: on-site sewage facility; RULE VIOLATED: 30 TAC §285.3(a) and (b)(1) and Texas Health and Safety Code, §366.051, by failing to obtain authorization prior to constructing, installing and operating an on-site sewage facility; PENALTY: $168; ENFORCEMENT COORDINATOR: Jason Fraley, (512) 239-2552; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7035, (325) 655-9479.

(13) COMPANY: HAYS CITY CORPORATION dba Tex Con Oil; DOCKET NUMBER: 2013-1792-PST-E; IDENTIFIER: RN102958014; LOCATION: Austin, Travis County; TYPE OF FACILITY: fuel distributor; RULE VIOLATED: 30 TAC §334.5(b)(1)(A) and TWC, §26.3467(d), by failing to verify that the owner or operator of an underground storage tank (UST) system possessed a valid, current TCEQ delivery certificate prior to depositing a regulated substance into the UST system; PENALTY: $3,857; ENFORCEMENT COORDINATOR: Michael Pace, (817) 588-5933; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753, (512) 339-2929.

(14) COMPANY: Junction Builders, LLC; DOCKET NUMBER: 2014-0860-WQ-E; IDENTIFIER: RN107230310; LOCATION: Abliene, Taylor County; TYPE OF FACILITY: residential construction; RULE VIOLATED: 30 TAC §281.25 (a)(4), by failing to obtain a construction general permit (stormwater); PENALTY: $875; ENFORCEMENT COORDINATOR: Remington Burklund, (512) 239-2611; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(15) COMPANY: Lucite International, Incorporated; DOCKET NUMBER: 2014-0423-IHW-E; IDENTIFIER: RN102736089; LOCATION: Nederland, Jefferson County; TYPE OF FACILITY: a hydrogen cyanide unit, acetone cyanohydrin unit, methyl methacrylate unit, and sulfuric acid recovery unit within the Dupont Beaumont Works Industrial Park; RULE VIOLATED: 30 TAC §335.2(a) and 40 Code of Federal Regulations §270.1(c), by failing to prevent unauthorized storage of hazardous waste; PENALTY: $7,500; ENFORCEMENT COORDINATOR: Rebecca Boyett, (512) 239-2503; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(16) COMPANY: Lumbini Enterprise LLC dba NEIGHBORHOOD FOOD MART; DOCKET NUMBER: 2014-0787-PST-E; IDENTIFIER: RN102269818; LOCATION: Cedar Park, Williamson County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum underground storage tanks (USTs); and 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide corrosion protection for the UST system; PENALTY: $6,011; ENFORCEMENT COORDINATOR: Jason Fraley, (512) 239-2552; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753, (512) 339-2929.

(17) COMPANY: Midwest Engine Incorporated; DOCKET NUMBER: 2014-1045-WQ-E; IDENTIFIER: RN107235731; LOCATION: Seagoville, Dallas County; TYPE OF FACILITY: retail sales of truck parts; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain a Multi-Sector General Permit (stormwater); PENALTY: $875; ENFORCEMENT COORDINATOR: Alex Laje, (512) 239-2547; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(18) COMPANY: Nhu Kim Quach dba DDS Express Mart; DOCKET NUMBER: 2014-0831-PST-E; IDENTIFIER: RN104502778; LOCATION: College Station, Brazos County; TYPE OF FACILITY: retail convenience facility; 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 35 days between each monitoring); PENALTY: $3,375; ENFORCEMENT COORDINATOR: Michael Meyer, (512) 239-4492; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(19) COMPANY: Palo Pinto County; DOCKET NUMBER: 2014-0548-MWD-E; IDENTIFIER: RN101524429; LOCATION: Palo Pinto, Palo Pinto County; TYPE OF FACILITY: wastewater treatment plant; RULES VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0011698001, Effluent Limitations and Monitoring Requirements Number 2, by failing to comply with permitted effluent limits; 30 TAC §305.125(1) and (5), and TPDES Permit Number WQ0011698001, Operational Requirements Number 1, by failing to ensure that the facility and all its systems of collection, treatment, and disposal are properly operated and maintained; 30 TAC §305.125(1) and TPDES Permit Number WQ0011698001, Monitoring and Reporting Requirements Number 5, by failing to accurately calibrate all automatic flow measuring or recording devices and all totalizing meters for measuring flows by a trained person at facility start-up and as often thereafter as necessary to ensure accuracy, but not less often than annually unless authorized by the executive director for a longer period; 30 TAC §305.125(1) and (11)(C), and §319.7(a), and TPDES Permit Number WQ0011698001, Monitoring and Reporting Requirements Number 3.c, by failing to properly document moni-

toring activities; and 30 TAC §305.65 and §305.125(1), and TPDES Permit Number WQ0011698001, Permit Conditions Number 4.c, by failing to timely apply for an amendment or renewal at least 180 days prior to the expiration of the existing permit in order to continue a permitted activity after the expiration date of the permit; PENALTY: $2,850; ENFORCEMENT COORDINATOR: Christopher Bost, (512) 239-4575; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(20) COMPANY: RIP GRIFFIN TRUCK SERVICE CENTER, INCORPORATED dba Griffin Transportation; DOCKET NUMBER: 2014-0828-PST-E; IDENTIFIER: RN100589092; LOCATION: Lubbock, Lubbock County; TYPE OF FACILITY: a fuel distributor; RULES VIOLATED: 30 TAC §334.5(b)(1)(A) and TWC, §26.3467(d), by failing to allegedly have deposited a regulated substance into a regulated underground storage tank system that was not covered by a valid, current TCEQ delivery certificate; PENALTY: $6,670; ENFORCEMENT COORDINATOR: Margarita Dennis, (817) 588-5892; REGIONAL OFFICE: 5012 50th Street, Suite 100, Lubbock, Texas 79414-3421, (806) 796-7092.

(21) COMPANY: Robert J. Crawford and Carolyn Crawford dba LITTLE TEXANS PUBLIC WATER SYSTEM; DOCKET NUMBER: 2014-0475-PWS-E; IDENTIFIER: RN102903911; LOCATION: Bertram, Burnet County; TYPE OF FACILITY: daycare with a public water supply; RULES VIOLATED: 30 TAC §290.109(c)(2)(A)(i) and Texas Health and Safety Code, §341.033(d), by failing to collect routine distribution water samples for coliform analysis for the months of December 2013 and January 2014; 30 TAC §290.116(b)(2), by failing to complete corrective action or be in compliance with an approved corrective action plan and schedule within 120 days of receiving notification from a laboratory of a fecal indicator-positive raw groundwater source sample; and 30 TAC §290.117(c)(2) and (i)(1), by failing to collect lead and copper tap samples at the required five sample sites, have the samples analyzed at an approved laboratory, and submit the results to the executive director; PENALTY: $1,282; ENFORCEMENT COORDINATOR: Katie Hargrove, (512) 239-2569; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753, (512) 339-2929.

(22) COMPANY: Rocio Hernandez; DOCKET NUMBER: 2014-0609-MSW-E; IDENTIFIER: RN106922305; LOCATION: Socorro, El Paso County; TYPE OF FACILITY: property with an unauthorized municipal solid waste disposal site; RULE VIOLATED: 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of municipal solid waste; PENALTY: $1,312; ENFORCEMENT COORDINATOR: Allyson Plantz, (512) 239-4593; REGIONAL OFFICE: 401 East Franklin Avenue, Suite 560, El Paso, Texas 79901-1206, (915) 834-4949.

(23) COMPANY: S & K KHAIRANI CORPORATION dba Time Saver Food Store; DOCKET NUMBER: 2014-0790-PST-E; IDENTIFIER: RN103935227; LOCATION: Highlands, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to timely renew a previously issued underground storage tank (UST) delivery certificate by submitting a properly completed UST registration and self-certification form at least 30 days before the expiration date; 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the UST; 30 TAC §115.242(3) and Texas Health and Safety Code (THSC), §382.085(b), by failing to maintain the Stage II vapor recovery system in proper operating condition, as specified by the manufacturer and/or any applicable California Air Resources Board Executive Order, and free of defects that would impair the effectiveness of the system, including but not limited to the absence or disconnection of any component that is part of the approved system; and 30 TAC §115.246(4) and THSC, §382.085(b), by failing to maintain Stage II records at the station and make them immediately available for review upon request by agency personnel; PENALTY: $9,752; ENFORCEMENT COORDINATOR: Mike Pace, (817) 588-5933; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(24) COMPANY: Sidney Dewayne Walley; DOCKET NUMBER: 2014-0984-MLM-E; IDENTIFIER: RN107236705; LOCATION: Barnhart, Irion County; TYPE OF FACILITY: on-site sewage; RULES VIOLATED: 30 TAC §285.61(4), by failing to ensure that an authorization to construct had been issued prior to beginning construction of an on-site sewage facility (OSSF); and 30 TAC §30.5(a), by failing to obtain a required OSSF occupational license; PENALTY: $350; ENFORCEMENT COORDINATOR: Remington Burklund, (512) 239-2611; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7035, (325) 655-9479.

(25) COMPANY: Sig-Longmire, LLC; DOCKET NUMBER: 2014-0770-WQ-E; IDENTIFIER: RN107130981; LOCATION: Conroe, Montgomery County; TYPE OF FACILITY: residential construction and development; RULE VIOLATED: 30 TAC §281.25 (a)(4), by failing to obtain a construction general permit (stormwater); PENALTY: $875; ENFORCEMENT COORDINATOR: Remington Burklund, (512) 239-2611; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

TRD-201403788
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: August 12, 2014

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Enforcement Orders

An agreed order was entered regarding Premier Powerlines and Telecommunications, Inc. dba Jensen Express Mart, Docket No. 2012-0222-PST-E on August 4, 2014, assessing $5,200 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Ryan Rutledge, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Rosey International Inc. dba Sunshine Groceries, Docket No. 2012-0232-PST-E on August 4, 2014, assessing $2,641 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jim Sallans, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding MAVERICK TUBE CORPORATION dba Tenaris Conroe, Docket No. 2012-1273-IWD-E on August 4, 2014, assessing $3,600 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Joel Cordero, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Robert M. Smith dba Oak Terrace Estates Water System, Docket No. 2012-1478-PWS-E on August 4, 2014, assessing $734 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jeffrey J. Huhn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding DALLAS TRADING ENTERPRISES, INC. dba Kuick Check, Docket No. 2013-0404-PST-E on August 4, 2014, assessing $5,129 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Ryan Rutledge, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Kevin J. Wilson, Docket No. 2013-0452-MSW-E on August 4, 2014, assessing $262 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Joel Cordero, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding J. L. H. LAND INVESTMENTS, CORP., Docket No. 2013-0565-OSS-E on August 4, 2014, assessing $525 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Joel Cordero, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Sharps Environmental Services, Inc., Docket No. 2013-0743-AIR-E on August 4, 2014, assessing $1,125 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Elizabeth Lieberknecht, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding MD Golden Tree Maintenance, LLC, Docket No. 2013-0869-MLM-E on August 4, 2014, assessing $6,579 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jeffrey J. Huhn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Aziz Momin and Nadia Momin, Docket No. 2013-0909-PST-E on August 4, 2014, assessing $5,100 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jess Robinson, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding HT BELLS FOOD LLC dba Bells Market, Docket No. 2013-0920-PST-E on August 4, 2014, assessing $3,693 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Ryan Rutledge, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding David Singh dba Happy Stop, Docket No. 2013-0984-PST-E on August 4, 2014, assessing $3,375 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting J. Amber Ahmed, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding NZ LLC dba Jeffry's Food Mart, Docket No. 2013-1249-PST-E on August 4, 2014, assessing $3,000 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting David A. Terry, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding JAM Investments, Inc., Docket No. 2013-1300-PST-E on August 4, 2014, assessing $3,937 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jess Robinson, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding HAMEEDA INVESTMENTS INC dba Peachtree Food & Beer Wine, Docket No. 2013-1301-PST-E on August 4, 2014, assessing $5,412 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Ryan Rutledge, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding JRP Oil Co., Inc. dba Buffalo Stop 1, Docket No. 2013-1565-PST-E on August 4, 2014, assessing $2,567 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting J. Amber Ahmed, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Alykar, Inc. dba SPEEDY PAC-EXXON, Docket No. 2013-1691-PST-E on August 4, 2014, assessing $2,567 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jess Robinson, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Jipu, Inc. dba Save N Go Fuel Stop, Docket No. 2013-1766-PST-E on August 4, 2014, assessing $3,375 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Meaghan M. Bailey, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Tho Qui Hang dba Francis Mini Mart, Docket No. 2013-1779-PST-E on August 4, 2014, assessing $7,442 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Meaghan M. Bailey, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding El Paso Electric Company, Docket No. 2013-1826-PST-E on August 4, 2014, assessing $3,459 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jeffrey J. Huhn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding UNIVERSAL ENTERPRISES, INC. dba Handi Plus 12, Docket No. 2013-1828-PST-E on August 4, 2014, assessing $2,888 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Tammy Mitchell, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding S&S Mehta, Inc. dba S & S M, Docket No. 2013-1977-PST-E on August 4, 2014, assessing $3,000 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Meaghan M. Bailey, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-201403811
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: August 13, 2014

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Notice of Application and Opportunity to Request a Public Meeting for a New Municipal Solid Waste Facility Registration Application Number 40276

Application. Piney Woods Sanitation, Inc., 5002 Business 50 West, Jefferson City, Missouri 65109, has applied to the Texas Commission on Environmental Quality (TCEQ) for proposed Registration No. 40276, to change the owner and operator and to expand an existing Type V municipal solid waste transfer station. The facility, formerly East Texas Sanitation proposed to be renamed Piney Woods Sanitation, Inc., is located at 140 County Road 250 Nacogdoches, Texas 75965-0580, approximately 100 feet from the intersection of U.S. Highway 59 and County Road 250, in Nacogdoches County. The Applicant is requesting authorization to transfer municipal solid waste which includes municipal household and commercial solid waste, and residential construction debris. The registration application is available for viewing and copying at the Nacogdoches Public Library, 1112 North Street, Nacogdoches, Texas 75961 and may be viewed online at http://pineywoodssanitation.com/location-application/. The following link to an electronic map of the site or facility's general location is provided as a public courtesy and is not part of the application or notice: http://www.tceq.texas.gov/assets/public/hb610/index.html?lat=31.705&lng=-94.635833&zoom=13&type=r. For exact location, refer to application.

Public Comment/Public Meeting. Written public comments or written requests for a public meeting must be submitted to the Office of Chief Clerk at the address included in the information section below. If a public meeting is held, comments may be made orally at the meeting or submitted in writing by the close of the public meeting. A public meeting will be held by the executive director if requested by a member of the legislature who represents the general area where the development is to be located, or if there is a substantial public interest in the proposed development. The purpose of the public meeting is for the public to provide input for consideration by the commission, and for the applicant and the commission staff to provide information to the public. A public meeting is not a contested case hearing. The executive director will review and consider public comments and written requests for a public meeting submitted during the comment period. The comment period shall begin on the date this notice is published and end 60 calendar days after this notice is published. The comment period shall be extended to the close of any public meeting. The executive director is not required to file a response to comments.

Executive Director Action. The executive director shall, after review of an application for registration, determine if the application will be approved or denied in whole or in part. If the executive director acts on an application, the chief clerk shall mail or otherwise transmit notice of the action and an explanation of the opportunity to file a motion to overturn the executive director's decision. The chief clerk shall mail this notice to the owner and operator, the public interest counsel, to adjacent landowners as shown on the required land ownership map and landowners list, and to other persons who timely filed public comment in response to public notice. Not all persons on the mailing list for this notice will receive the notice letter from the Office of the Chief Clerk.

Information. Written public comments or requests to be placed on the permanent mailing list for this application should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087 or electronically submitted to http://www14.tceq.texas.gov/epic/eComment/. If you choose to communicate with the TCEQ electronically, please be aware that your e-mail address, like your physical mailing address, will become part of the agency's public record. For information about this application or the registration process, individual members of the general public may call the TCEQ Public Education Program at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at http://www.tceq.texas.gov/. Further information may also be obtained from Piney Woods Sanitation, Inc. at the address stated above or by calling Mr. Jerod Morris, P.E., Everett Griffith, Jr. & Associates, Inc. at (936) 634-5528.

TRD-201403809
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: August 13, 2014

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Notice of Application and Opportunity to Request a Public Meeting for a New Municipal Solid Waste Facility Registration Application Number 40277

Application. Pro Star Waste, LLC, has applied to the Texas Commission on Environmental Quality (TCEQ) for proposed Registration No. 40277, to construct and operate a Type V municipal solid waste transfer station. The proposed facility, Pro Star Waste, LLC, will be located at 7118 U.S. Hwy. 59 South; 1/4 mile north of FM 1988 and inside city limits of Goodrich, in Polk County, Texas 77335. The Applicant is requesting authorization to process, transfer, and recycle municipal solid waste which includes construction or demolition waste and municipal solid waste. The registration application is available for viewing and copying at the City Hall of City of Goodrich, 1003 State Hwy. Loop 393, Goodrich, Polk County, Texas 77335 and may be viewed online at http://prostarwaste.com. The following link to an electronic map of the site or facility's general location is provided as a public courtesy and is not part of the application or notice: http://www.tceq.texas.gov/assets/public/hb610/index.html?lat=30.61262&lng=-94.94432&zoom=13&type=r. For exact location, refer to application.

Public Comment/Public Meeting. Written public comments or written requests for a public meeting must be submitted to the Office of

Chief Clerk at the address included in the information section below. If a public meeting is held, comments may be made orally at the meeting or submitted in writing by the close of the public meeting. A public meeting will be held by the executive director if requested by a member of the legislature who represents the general area where the development is to be located, or if there is a substantial public interest in the proposed development. The purpose of the public meeting is for the public to provide input for consideration by the commission, and for the applicant and the commission staff to provide information to the public. A public meeting is not a contested case hearing. The executive director will review and consider public comments and written requests for a public meeting submitted during the comment period. The comment period shall begin on the date this notice is published and end 60 calendar days after this notice is published. The comment period shall be extended to the close of any public meeting. The executive director is not required to file a response to comments.

Executive Director Action. The executive director shall, after review of an application for registration, determine if the application will be approved or denied in whole or in part. If the executive director acts on an application, the chief clerk shall mail or otherwise transmit notice of the action and an explanation of the opportunity to file a motion to overturn the executive director's decision. The chief clerk shall mail this notice to the owner and operator, the public interest counsel, to adjacent landowners as shown on the required land ownership map and landowners list, and to other persons who timely filed public comment in response to public notice. Not all persons on the mailing list for this notice will receive the notice letter from the Office of the Chief Clerk.

Information. Written public comments or requests to be placed on the permanent mailing list for this application should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087 or electronically submitted to http://www14.tceq.texas.gov/epic/eComment/. If you choose to communicate with the TCEQ electronically, please be aware that your e-mail address, like your physical mailing address, will become part of the agency's public record. For information about this application or the registration process, individual members of the general public may call the TCEQ Public Education Program at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at http://www.tceq.texas.gov/. Further information may also be obtained from Pro Star Waste, LLC at the address stated above or by calling Mr. James R. Hubbard, Facility Manager, at (936) 365-4210.

TRD-201403810
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: August 13, 2014

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Notice of Public Hearing on Proposed Revisions to 30 TAC Chapter 335

The Texas Commission on Environmental Quality (commission) will conduct a public hearing to receive testimony regarding proposed amendments to 30 Texas Administrative Code (TAC) Chapter 335, Industrial Solid Waste and Municipal Hazardous Waste, §§335.1, 335.29, 335.155, 335.211, 335.261, 335.431, 335.503, and 335.504, under the requirements of the Texas Government Code, Chapter 2001, Subchapter B.

The proposed rulemaking would update 30 TAC Chapter 335 to include federal rule changes that are optional and are set forth in parts of the United States Environmental Protection Agency's (EPA) Resource Conservation and Recovery Act Clusters XXI-XXIII. The proposed amendments would establish an alternative land disposal treatment standard for carbamate wastes; make two technical corrections to the hazardous waste regulations in final rules previously published in the Federal Register; revise the definition of "solid waste" to conditionally exclude solvent-contaminated wipes that are cleaned and reused; and revise the definition of "hazardous waste" to conditionally exclude solvent-contaminated wipes that are disposed; exclude hazardous carbon dioxide streams from the definition of "hazardous waste" provided they are captured from emission sources and injected into Underground Injection Control Class VI wells for purposes of geologic sequestration. Finally, this rulemaking initiative will include corrections to existing rules in Chapter 335. These changes will revise language and correct typographical errors, incorrect or outdated citations, and omissions as recommended by the EPA.

The commission will hold a public hearing on this proposal in Austin on September 16, 2014, at 10:00 a.m., in Building E, Room 201S, at the commission's central office, located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members 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 Sandy Wong, Office of Legal Services, at (512) 239-1802. Requests should be made as far in advance as possible.

Written comments may be submitted to Bruce McAnally, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 or faxed to (512) 239-4808. Electronic comments may be submitted at *http://www5.tceq.texas.gov/rules/ecomments/*. File size restrictions may apply to comments being submitted via the *eComments* system. All comments should reference Rule Project Number 2014-019-335-WS. The comment period closes September 22, 2014. Copies of the proposed rulemaking can be obtained from the commission's Web site at *http://www.tceq.texas.gov/nav/rules/propose_adopt.html*. For further information, please contact Cynthia Palomares, Industrial Hazardous Waste Permits Unit, (512) 239-6079.

TRD-201403599
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: August 8, 2014

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Notice of Water Quality Applications

The following notices were issued August 1, 2014, through August 8, 2014.

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

E.I. DU PONT DE NEMOURS AND COMPANY which operates an organic and inorganic chemical manufacturing plant, has applied for a major amendment to Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0000475000 to relocate the point of compliance to Outfall 001; revise the monitoring methodology for parameters

regulated at Outfall 001; establish new internal Outfall 301 to regulate the discharge of domestic wastewater as an authorized wastestream to the cooling water system and eventually discharged via final Outfall 001; establish limitations at internal Outfall 101 to regulate the discharge of process wastewater as an authorized wastestream eventually discharged via final Outfall 001; and replace the chlorination/disinfection requirement (current Other Requirement No. 5) with appropriate effluent limitations for Enterococci bacteria at new internal Outfall 301. The current permit authorizes the discharge of storm water runoff and previously monitored effluent from Outfalls 101 [recirculated non-contact cooling water, storm water, and utility wastewaters (including boiler blowdown and emergency firewater washdown) on an intermittent and flow variable basis] and 201 [treated process wastewater, utility wastewater (cooling tower blowdown, boiler blowdown, and water softener demineralizer regeneration effluent), treated laboratory wastewater, steam condensate, clarifier effluent, domestic wastewater, and non-contact cooling water at a daily average flow not to exceed 16,000,000 gallons per day] via Outfall 001 on a continuous and flow variable basis. The facility is located on Farm-to-Market Road 1006, approximately three miles southwest of the City of Orange, Orange County, Texas 77631.

CITY OF LUFKIN has applied for a major amendment to TCEQ Permit No. WQ0004585000. The proposed amendment requests to increase the sludge application rate for the three fields at the permitted site. The current permit authorizes the land application of sewage sludge for beneficial use on 150 acres. This permit will not authorize a discharge of pollutants into waters in the State. The sewage sludge land application site is located approximately 1.25 miles east of the intersection of State Highway 287 and Farm-to-Market Road 325, approximately 2.25 miles east of the City of Lufkin in Angelina County, Texas 75901.

JBS PACKING COMPANY INC which operates Plant 1 - Houston Avenue Facility, a shrimp processing facility, has applied for new TPDES Permit No. WQ0005021000 to authorize the discharge of shrimp processing wastewater and facility rinse water at a combined daily average flow not to exceed 400,000 gallons per day via Outfall 001 and Outfall 002. The facility is located at 101 Houston Avenue, Port Arthur, Jefferson County, Texas 77640. The TCEQ Executive Director has reviewed this action for consistency with the Texas Coastal Management Program (CMP) goals and policies in accordance with the regulations of the General Land Office and has determined that the action is consistent with the applicable CMP goals and policies.

CITY OF COLORADO CITY has applied for a renewal of TCEQ Permit No. WQ0010077001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 1,120,000 gallons per day via surface irrigation of 318.4 acres of non-public access hay and grass fields. The wastewater treatment facility and disposal site are located approximately 1.7 miles south-southeast of the intersection of East Central Avenue and Washington Street along State Highway 163 and 1.7 miles east of the intersection of State Highway 163 and Farm-to-Market Road 1229 in Mitchell County, Texas 79512.

FORT BEND COUNTY WCID NO 2 has applied for a renewal of TPDES Permit No. WQ0010086002, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 4,000,000 gallons per day. The facility will be located at 300 South Cravens Road, Missouri City, approximately 3300 feet southeast of the intersection of Cravens Road and U.S. Highway 90 in Fort Bend County, Texas 77489.

CITY OF MARFA has applied for a renewal of TCEQ Permit No. WQ0010109001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 120,000 gallons per day via surface irrigation of 62 acres of non-public access agricultural land. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site are located within the easement, approximately 3,000 feet southeast of the intersection of U.S. Highway 90 and U.S. Highway 67 in Presidio County, Texas 79843.

CITY OF COLEMAN has applied for a renewal of TPDES Permit No. WQ0010150001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 800,000 gallons per day. The facility is located east of the City of Coleman on the south side of Hords Creek and approximately 0.75 mile northwest of the intersection of Farm-to-Market Road 568 and U.S. Highway 84 in Coleman County, Texas 76834.

CITY OF TEXLINE has applied for a renewal of TCEQ Permit No. WQ0011029001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 45,300 gallons per day via surface irrigation of 33 acres of non-public access pastureland. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site are located 0.77 mile northeast of the intersection of Farm-to-Market Road 296 and US Highway 87, Texline, in Dallam County, Texas 79087.

BELL COUNTY WATER CONTROL AND IMPROVEMENT DISTRICT NO 2 has applied for a renewal of TPDES Permit No. WQ0011091001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 160,000 gallons per day. The facility is located approximately 0.4 mile south of the intersection of South Evans Street and West Main Street (Farm-to-Market Road 436) in Bell County, Texas 76554.

MOUNT HOUSTON ROAD MUNICIPAL UTILITY DISTRICT has applied for a major amendment to TPDES Permit No. WQ0011154001 to authorize relocation of the existing point of discharge to a point approximately 100 meters downstream. The current permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 950,000 gallons per day, and the applicant is not proposing to increase the volume of water discharged. The facility is located at 2265 Stuebner Park Lane, Houston, approximately 1.3 miles northwest of the intersection of State Highway 249 and Veterans Memorial Drive, on the east bank of Halls Bayou in Harris County, Texas 77038.

SUNBELT FRESH WATER SUPPLY DISTRICT has applied to the Texas Commission on Environmental Quality (TCEQ) for a renewal of TPDES Permit No. WQ0011791001, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 1,225,000 gallons per day. The facility is located 1.2 miles west of U.S. Highway 59, on the south side of Greens Bayou in Harris County, Texas 77039.

CITY OF STERLING CITY has applied for a renewal of TCEQ Permit No. WQ0012147001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 116,000 gallons per day via surface irrigation of 35 acres of non-public access agricultural land. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site are located approximately 650 feet southwest of the intersection of U.S. Highway 87 and State Highway 158 in Sterling County, Texas 76951.

HARRIS COUNTY MUNICIPAL UTILITY DISTRICT NO 122 has applied for a renewal of TPDES Permit No. WQ0012250001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 250,000 gallons per day. The facility is located at 760 North Cravens Road, Missouri City in Harris County, Texas 77489.

CITY OF ROBERT LEE has applied for a renewal of TPDES Permit No. WQ0013901001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 121,000 gallons

per day. The facility is located at 101 West 1st Street in Coke County, Texas 76945.

AQUA DEVELOPMENT INC has applied for a renewal of TPDES Permit No. WQ0014061001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 490,000 gallons per day. The facility is located approximately 2.0 miles east of the intersection of Farm-to-Market Road 973 and Blake Manor Road in Travis County, Texas 78653.

CITY OF WEATHERFORD MUNICIPAL UTILITY BOARD OF TRUSTEES has applied for a major amendment to TPDES Permit No. WQ0014198001 to authorize an increase in the discharge of treated filter backwash effluent from a water treatment plant from a daily average flow not to exceed 636,000 gallons per day to an annual average flow not to exceed 1,000,000 gallons per day. The facility is located at 400 East Lake Drive, approximately 1,400 feet east and 2,100 feet south of the pump station at the dam of Lake Weatherford in the City of Weatherford, Parker County, Texas 76087.

UNITED STATES DEPARTMENT OF THE NAVY which operates the Naval Weapons Industrial Reserve Plant McGregor, has applied for a renewal of TPDES Permit No. WQ0002335000, which authorizes the discharge of treated groundwater from Area M and other groundwater on an intermittent and variable flow basis. The facility is located at 1701 Bluebonnet Parkway, just west of State Highway 317, bounded on the south by Farm-to-Market Road 2671 and on the north by the St. Louis Southwestern Railway, southwest of the City of McGregor, Coryell County, Texas, 76657.

The following do not require publication in a newspaper. Written comments or requests for a public meeting may be submitted to the Office of the Chief Clerk, at the address provided in the information section above, WITHIN (30) DAYS OF THE ISSUED DATE OF THE NOTICE.

THE TEXAS COMMISSION ON ENVIRONMENTAL QUALITY (TCEQ) has initiated a minor amendment of TPDES Permit No. WQ0010134002 issued to City of Pearland to correct and change BOD5 to CBOD5. The existing permit authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 4,500,000 gallons per day. The facility is located on Pearland Parkway, 500 feet north of the intersection of Pearland Parkway and Barry Rose Road in Brazoria County, Texas 77581.

If you need more information about these permit applications or the permitting process, please call the TCEQ Public Education Program, Toll Free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.TCEQ.texas.gov. Si desea información en español, puede llamar al 1-800-687-4040.

TRD-201403808
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: August 13, 2014

♦ ♦ ♦

General Land Office

Notice of Approval of Coastal Boundary Survey

Pursuant to §33.136 of the Texas Natural Resources Code, notice is hereby given that Jerry Patterson, Commissioner of the General Land Office, approved a coastal boundary survey described as follows:

A Coastal Boundary Survey, dated May 20, 2014, by David L. Nesbitt, Licensed State Land Surveyor, delineating the line of Mean High Water along the western shore of Copano Bay and State Submerged Land Tracts 89 and 90, same line, being a portion of the littoral boundary of the Joseph F. Smith Survey, Abstract 270. The survey is in support of aquatic vegetation planting and offshore breakwater construction, proposed under Texas General Land Office lease No. SL20140017 and is located at the City of Bayside public park and fishing pier (coordinates N 28° 05' 30", W 97° 12' 45", WGS84) and extends northerly and southerly approximately 500 feet.

This survey is intended to provide pre-project baseline information related to an erosion response activity on coastal public lands. An owner of uplands adjoining the project area is entitled to continue to exercise littoral rights possessed prior to the commencement of the erosion response activity, but may not claim any additional land as a result of accretion, reliction, or avulsion resulting from the erosion response activity.

For a copy of this survey or more information on this matter, contact Bill O'Hara, Director of the Survey Division, Texas General Land Office, by phone at (512) 463-5212, email bill.o'hara@glo.texas.gov, or fax (512) 463-5223.

TRD-201403817
Larry L. Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Filed: August 13, 2014

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Notice of Approval of Coastal Boundary Survey

Pursuant to §33.136 of the Texas Natural Resources Code, notice is hereby given that Jerry Patterson, Commissioner of the General Land Office, approved a coastal boundary survey described as follows:

A Coastal Boundary Survey, dated March 11, 2014, by J. L. Brundrett, Jr., Registered Professional Land Surveyor and duly elected County Surveyor for Aransas County, delineating the line of Mean Higher High Water along a portion of the southern shore of Goose Island State Park, situated in Aransas Bay, Submerged Land Tracts 67 and 68 near the southern tip of Lamar Peninsula, in support of proposed bulkhead construction authorized by General Land Office lease no. CL20010005 and installed by the Texas Parks and Wildlife Department (project no. 127383). The site is located between existing concrete bulkheads along the eastern leg of Park Road 13 approximately 850 feet southeasterly from the South Palmetto Street entrance to the park, coordinates N28° 07' 34", W96° 59' 02" (WGS84).

This survey is intended to provide pre-project baseline information related to an erosion response activity on coastal public lands. An owner of uplands adjoining the project area is entitled to continue to exercise littoral rights possessed prior to the commencement of the erosion response activity, but may not claim any additional land as a result of accretion, reliction, or avulsion resulting from the erosion response activity.

For a copy of this survey or more information on this matter, contact Bill O'Hara, Director of the Survey Division, Texas General Land Office, by phone at (512) 463-5212, email bill.o'hara@glo.texas.gov, or fax (512) 463-5223.

TRD-201403819
Larry L. Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Filed: August 13, 2014

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Notice of Approval of Coastal Boundary Survey

Pursuant to §33.136 of the Texas Natural Resources Code, notice is hereby given that Jerry Patterson, Commissioner of the General Land Office, approved a coastal boundary survey described as follows:

Being a Coastal Boundary Survey, dated January and November 2013, by James M. Naismith, Licensed State Land Surveyor, delineating the line of Mean High Water along the northerly shore of Corpus Christi Bay and submerged lands described in Patent No. 106 (Refugio Scrip, SF-1930), from the State of Texas, same line being a portion of the littoral boundary of the C. W. Egery Survey, A-111. The survey is in support of a proposed shoreline protection project, consisting of rock groin and breakwater construction, under Coastal Erosion Planning and Response Act (CEPRA) project No. 1527. The site is situated at the Philip Dimitt Municipal Fishing Pier on Indian Point (coordinates N 27° 51' 02", W 97° 21' 16", WGS84) and extends both westward to the right-of-way of US Highway No. 181 and easterly along the shore approximately 2000 feet.

This survey is intended to provide pre-project baseline information related to an erosion response activity on coastal public lands. An owner of uplands adjoining the project area is entitled to continue to exercise littoral rights possessed prior to the commencement of the erosion response activity, but may not claim any additional land as a result of accretion, reliction, or avulsion resulting from the erosion response activity.

For a copy of this survey or more information on this matter, contact Bill O'Hara, Director of the Survey Division, Texas General Land Office, by phone at (512) 463-5212, email bill.o'hara@glo.texas.gov or fax (512) 463-5223.

TRD-201403822
Larry L. Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Filed: August 13, 2014

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Notice of Approval of Coastal Boundary Survey

Pursuant to §33.136 of the Texas Natural Resources Code, notice is hereby given that Jerry Patterson, Commissioner of the General Land Office, approved a coastal boundary survey described as follows:

Being a Coastal Boundary Survey, dated January and March 31, 2014, by Stephen C. Blaskey, Licensed State Land Surveyor, delineating the line of Mean Higher High Water along the shore of Galveston Bay and submerged lands of Chambers & Liberty Co Navigation District, Abstract 680. The survey is in support of a proposed marsh creation under Texas Parks and Wildlife Department, Project No. 444784, is located at Houston Point, near the confluence of Trinity Bay, the San Jacinto River and Galveston Bay (coordinates N 29° 39' 41", W 94° 55' 31", WGS84) and extends easterly, to near Center Point Road, then northwesterly approximately 3600 feet.

This survey is intended to provide pre-project baseline information related to an erosion response activity on coastal public lands. An owner of uplands adjoining the project area is entitled to continue to exercise littoral rights possessed prior to the commencement of the erosion response activity, but may not claim any additional land as a result of accretion, reliction, or avulsion resulting from the erosion response activity.

For a copy of this survey or more information on this matter, contact Bill O'Hara, Director of the Survey Division, Texas General Land Office, by phone at (512) 463-5212, email bill.o'hara@glo.texas.gov, or fax (512) 463-5223.

TRD-201403823
Larry L. Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Filed: August 13, 2014

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Texas Health and Human Services Commission

Notice of Public Hearing on Proposed Community First Choice State Plan Amendment

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on Wednesday, September 3, 2014, at 2:00 p.m. to receive public comment on transmittal number 14-026 to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendment would implement the Community First Choice (CFC) program. The public hearing will be held in the Public Hearing Room of the John H. Winters Building, located at 701 West 51st Street, Austin, Texas. Entry is through Security at the front of the building facing 51st Street.

Proposal. HHSC proposes to implement the Community First Choice (CFC) program under section 1915(k) of the Social Security Act. CFC services would be provided at an enhanced federal match rate to individuals who have a physical or intellectual disability, who meet categorical coverage requirements for Medicaid or meet financial eligibility for home and community-based services, and who meet an institutional level of care. The requested effective date for the proposed amendment is March 1, 2015.

Methodology and Justification. Texas Government Code §534.152(a)(1), adopted in 2013, §1.01, requires HHSC to "implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with disabilities under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs." See Act of May 26, 2013, 83d Leg., R.S., ch. 1310, §1.01, 2013 Tex. Gen. Laws 3409, 3416. Texas Government Code §534.152(a)(2) requires voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program. CFC is available under federal law and lets states provide home and community-based attendant services to Medicaid enrollees with disabilities under their State Plan. See 42 U.S.C. §1396n(k). This option became available on October 1, 2011, and provides a six percent increase in the Federal Medical Assistance Percentage for expenditures related to this option. The Final Rule was issued May 7, 2012, and regulations are in effect as of July 6, 2012. See 42 C.F.R. pt. 441, subpt. K.

Briefing Package. A briefing package describing the proposed amendment will be available at http://www.hhsc.state.tx.us/medicaid/about/state-plan/ by August 29, 2014. Interested parties may also obtain a copy of the proposed amendment prior to the hearing by contacting Policy Development Support by telephone at (512) 728-1932; by fax at (512) 730-7472; or by e-mail at beren.dutra@hhsc.state.tx.us. The proposed amendment also will be available at the public hearing.

Written Comments. Written comments regarding the proposed amendment may be submitted in lieu of, or in addition to, oral testimony. Written comments may be sent by U.S. mail to the Texas Health and Human Services Commission, Policy Development Sup-

port Department, Mail Code H-600, P.O. Box 85200, Austin, Texas 78708-5200; by fax to Policy Development at (512) 730-7472; or by e-mail to beren.dutra@hhsc.state.tx.us. In addition, written comment may be sent by overnight mail or hand delivered to the Texas Health and Human Services Commission, Policy Development Support Department, Mail Code H-600, 4900 North Lamar, Austin, Texas 78751. Persons with disabilities who wish to attend the hearing and require auxiliary aids or services should contact Beren Dutra at (512) 728-1932 at least 72 hours before the hearing so appropriate arrangements can be made.

TRD-201403828
Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Filed: August 13, 2014

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Public Notice

The Texas Health and Human Services Commission (HHSC) announces its intent to submit an amendment to the Texas State Plan for Medical Assistance under Title XIX of the Social Security Act. The proposed amendment is effective September 1, 2014.

The purpose of this amendment is to update the fee schedules in the current state plan by adjusting or implementing fees for:

Early and Periodic Screening, Diagnosis, and Treatment Services; and

Physicians and Other Practitioners

These rate actions comply with applicable adjustments in response to direction from the Texas Legislature as set out in the 2012-2013 General Appropriations Act and the 2014-2015 General Appropriations Act, effective September 1, 2013. Within HHSC's portion of article II, Rider 51 of the current appropriations act directs HHSC to reduce expenditures by, among other things, implementing certain payment adjustments. See General Appropriations Act, 83d Leg., R.S., ch. 1411, art. II, rider 51, at II-100 to II-101, 2013 Tex. Gen. Laws (Health & Hum. Servs. Section, Health & Hum. Servs. Comm'n); General Appropriations Act, 82d Leg., R.S., ch. 1355, art. II, § 16, at II-108, 2011 Tex. Gen. Laws (Health & Hum. Servs. Section, Special Provisions Related to All Health & Hum. Servs. Agencies). All of the proposed adjustments are being made in accordance with 1 TAC §355.201.

The proposed amendment is estimated to result in an annual cost of $121 for federal fiscal year (FFY) 2014, consisting of $71 in federal funds and $50 in state general revenue. For FFY 2015, the estimated annual cost is $800 consisting of $464 in federal funds and $336 in state general revenue. For FFY 2016, the estimated annual cost is $880, consisting of $504 in federal funds and $376 in state general revenue.

To obtain copies of the proposed amendment or to submit written comments, interested parties may contact Dan Huggins, Director of Rate Analysis for Acute Care Services, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 149030, H-400, Austin, Texas 78714-9030; by telephone at (512) 707-6071; by facsimile at (512) 730-7475; or by e-mail at dan.huggins@hhsc.state.tx.us. Copies of the proposal will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-201403824
Jack Stick
Chief Counsel
Texas Health and Human Services Commission
Filed: August 13, 2014

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Department of State Health Services

Licensing Actions for Radioactive Materials

The Department of State Health Services has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "Location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout Texas" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

This notice affords the opportunity for a hearing on written request of a person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A person affected may request a hearing by writing Richard A. Ratliff, Radiation Program Officer, Department of State Health Services, Radiation Material Licensing - Mail Code 2835, P.O. Box 149347, Austin, Texas 78714-9347. For information call (512) 834-6688.

NEW LICENSES ISSUED:

Location of Use/Possession of Material	Name of Licensed Entity	License Number	City of Licensed Entity	Amend-ment Number	Date of Action
Amarillo	BSA Amarillo Diagnostic Clinic Inc.	L06659	Amarillo	00	07/08/14
El Paso	MA X Ray Consultants L.L.C.	L06660	El Paso	00	07/21/14
Throughout Tx	CHI St. Lukes Health Baylor College of Medicine Medical Center	L06661	Houston	00	07/30/14

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location of Use/Possession of Material	Name of Licensed Entity	License Number	City of Licensed Entity	Amend-ment Number	Date of Action
Abilene	Hendrick Medical Center	L02433	Abilene	114	07/18/14
Amarillo	BSA Hospital L.L.C. dba The Don and Sybil Harrington Cancer Center - a Department of Baptist St. Anthony's Hospital	L06556	Amarillo	03	07/25/14
Angleton	Isotherapeutics Group L.L.C.	L05969	Angleton	26	07/25/14
Austin	St. Davids Healthcare Partnership L.P., L.L.P. dba North Austin Medical Center	L04910	Austin	95	07/31/14
Austin	Texas Oncology P.A. dba South Austin Cancer Center	L05108	Austin	31	07/18/14
Austin	Texas Oncology P.A. dba Central Austin Cancer	L06090	Austin	06	07/25/14
Austin	St. Davids Healthcare Partnership L.P., L.L.P. dba St. Davids Medical Center	L06335	Austin	15	07/18/14
Beaumont	Cardiac Imaging Inc.	L06565	Beaumont	02	07/30/14
Conroe	Adnan Afzal M.D., P.A. dba Healing Hearts	L06071	Conroe	05	07/30/14
Dallas	Methodist Hospitals of Dallas Radiology Services	L00659	Dallas	99	07/31/14
Dallas	Crown Imaging L.L.C.	L06223	Dallas	07	07/24/14
Denton	Texas Health Presbyterian Hospital Denton	L04003	Denton	51	07/23/14
El Paso	El Paso Childrens Hospital Corporation	L06452	El Paso	01	07/29/14
Georgetown	Radiation Detection Company	L06647	Georgetown	01	07/31/14
Houston	Memorial Hermann Health System dba Memorial Hermann Memorial City Medical Center	L01168	Houston	148	07/25/14
Houston	Cardinal health	L05536	Houston	44	07/30/14
Houston	MH/USON Radiation Management Company L.L.C.	L06408	Houston	10	07/31/14

AMENDMENTS TO EXISTING LICENSES ISSUED (continued):

Houston	Memorial Hermann Medical Group Department of Radiation Therapy	L06430	Houston	10	07/28/14
Houston	St. Lukes Hospital at the Vintage	L06612	Houston	01	07/29/14
Lufkin	Memorial Medical Center of East Texas	L01346	Lufkin	91	07/31/14
Lufkin	Piney Woods Healthcare System L.P. dba Woodland Heights Medical Center	L01842	Lufkin	61	07/18/14
Midland	Midland County Hospital District dba Midland Memorial Hospital	L00728	Midland	103	07/21/14
Midland	Texas Oncology P.A. dba Allison Cancer Center	L04905	Midland	19	07/23/14
Plano	Columbia Medical Center of Plano Subsidiary L.P. dba Medical Center of Plano	L02032	Plano	99	07/25/14
Round Rock	Texas Oncology P.A.	L06349	Round Rock	10	07/22/14
San Antonio	Cancer Care Network of South Texas P.A. dba Cancer Care Centers of South Texas	L05717	San Antonio	22	07/24/14
San Marcos	Adventist Health System/Sunbelt Inc. dba Central Texas Medical Center	L03133	San Marcos	31	07/31/14
Stafford	Aloki Enterprise Inc.	L06257	Stafford	28	07/25/14
Stephenville	Stephenville Medical And Surgical Clinic	L05309	Stephenville	22	07/21/14
The Woodlands	Pietro Fiorentini USA Inc.	L06592	The Woodlands	05	07/18/14
Throughout Tx	Halliburton Energy Services Inc.	L03284	Alvarado	41	07/23/14
Throughout Tx	Halliburton Energy Services Inc.	L00442	Houston	131	07/31/14
Throughout Tx	Baker Hughes Oilfield Operations Inc. dba Baker Atlas	L00446	Houston	175	07/18/14
Throughout Tx	Aviles Engineering Corporation	L03016	Houston	32	07/18/14
Throughout Tx	GE Oil & Gas Logging Services Inc.	L05262	Houston	50	07/30/14
Throughout Tx	IRISNDT Inc.	L06435	Houston	10	07/22/14
Throughout Tx	Baker Hughes Oilfield Operations Inc.	L06453	Houston	12	07/18/14
Throughout Tx	Texas A&M University Kingsville	L01821	Kingsville	51	07/28/14
Throughout Tx	Acuren Inspection Inc.	L01774	La Porte	283	07/29/14
Throughout Tx	Industrial Nuclear Company Inc.	L04508	La Porte	18	07/17/14
Throughout Tx	Weld Spec Inc.	L05426	Lumberton	101	07/21/14
Throughout Tx	Ace NDT	L06595	Perryton	04	07/29/14
Throughout Tx	Furmanite America Inc.	L06554	Port Lavaca	08	07/17/14
Throughout Tx	All American Inspections Inc.	L01336	San Antonio	73	07/24/14
Throughout Tx	American Electric Power- Public Service Company of Oklahoma	L03481	Vernon	27	07/18/14
Tyler	Mother Frances Hospital Regional Health Care Center	L01670	Tyler	194	07/18/14
Tyler	Mother Frances Hospital Regional Health Care Center	L01670	Tyler	195	07/23/14

RENEWAL OF LICENSES ISSUED:

Location of Use/Possession of Material	Name of Licensed Entity	License Number	City of Licensed Entity	Amend-ment Number	Date of Action
Dallas	Cardinal Health	L05610	Dallas	28	07/30/14
Houston	PACS Construction Laboratories and Testing Services Inc.	L05776	Houston	05	07/23/14
Humble	Mohan Jacob M.D., P.A.	L04442	Humble	10	07/29/14
Stephenville	Tarleton State University	L05612	Stephenville	07	07/24/14
Throughout Tx	Southwest Research Institute	L00775	San Antonio	83	07/31/14

TERMINATIONS OF LICENSES ISSUED:

Location of Use/Possession of Material	Name of Licensed Entity	License Number	City of Licensed Entity	Amend-ment Number	Date of Action
Amarillo	Amarillo Diagnostic Clinic	L04085	Amarillo	25	07/08/14
Conroe	Montgomery County Cardiovascular Associates P.A.	L05151	Conroe	18	07/24/14
El Paso	EP Premier Medical Group P.A. dba Premier Diagnostic Center	L05198	El Paso	11	07/22/14
Houston	St. Lukes Health System Corporation	L00581	Houston	108	07/30/14
Throughout Tx	Delta Tubular International L.P.	L03083	Houston	27	07/18/14
Tyler	Cardiovascular Associates of East Texas P.A.	L04800	Tyler	36	07/24/14

In issuing new licenses, amending and renewing existing licenses, or approving license exemptions, the Department of State Health Services (department), Radiation Safety Licensing Branch, has determined that the applicant has complied with the licensing requirements in Title 25 Texas Administrative Code (TAC), Chapter 289 for the noted action. In granting termination of licenses, the department has determined that the licensee has complied with the applicable decommissioning requirements of 25 TAC, Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC, Chapter 289.

TRD-201403630
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: August 8, 2014

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Houston-Galveston Area Council

Request for Information

The Houston-Galveston Area Council, staff to the Gulf Coast Workforce Board, is requesting information on combined production-related certification and training programs that address core technical competencies required for skilled production occupations in all sectors of manufacturing. H-GAC will not fund contracts from responses to this request for information, but may later issue a request for proposals.

Prospective respondents may download the request from Workforce Solutions www.wrksolutions.com and H-GAC www.h-gac.com web sites beginning at 12:00 noon Central Daylight Time on Thursday, August 14, 2014. HGAC will also fill requests for hard copies of the proposal package beginning at that time; interested parties should contact Carol Kimmick at (713) 627-3200 or carol.kimmick@h-gac.com. Responses are due at H-GAC by 12:00 noon Central Daylight Time on Thursday, August 28, 2014. Mailed responses should be postmarked no later than Monday, August 25, 2014.

TRD-201403807
Jack Steele
Executive Director
Houston-Galveston Area Council
Filed: August 13, 2014

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Texas Lottery Commission

Instant Game Number 1659 "Extreme 8s"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1659 is "EXTREME 8s". The play style is "other".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1659 shall be $5.00 per Ticket.

1.2 Definitions in Instant Game No. 1659.

A. Display Printing - That area of the Instant Game Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Ticket.

C. Play Symbol - The printed data under the latex on the front of the Instant Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37, 39, 40, 8 SYMBOL, EXTREME SYMBOL, $5.00, $10.00, $15.00, $20.00, $40.00, $50.00, $100, $500, $1,000 and $100,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1659 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
29	TWNI
30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
39	TRNI
40	FRTY
8 SYMBOL	WIN
EXTREME SYMBOL	WINALL
$5.00	FIVE$
$10.00	TEN$
$15.00	FIFTN
$20.00	TWENTY
$40.00	FORTY
$50.00	FIFTY
$100	ONE HUND
$500	FIV HUND
$1,000	ONE THOU
$100,000	HUN THOU

E. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Low-Tier Prize - A prize of $5.00, $10.00, $15.00 or $20.00.

G. Mid-Tier Prize - A prize of $50.00, $100 or $500.

H. High-Tier Prize - A prize of $1,000 or $100,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1659), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 075 within each Pack. The format will be: 1659-0000001-001.

K. Pack - A Pack of "EXTREME 8s" Instant Game Tickets contains 075 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The Packs will alternate. One will show the front of Ticket 001 and back of 075 while the other fold will show the back of Ticket 001 and front of 075.

L. Non-Winning Ticket - A Ticket which is not programmed to be a winning Ticket or a Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "EXTREME 8s" Instant Game No. 1659 Ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Ticket validation requirements set forth in Texas Lottery Rule §401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each Instant Ticket. A prize winner in the "EXTREME 8s" Instant Game is determined once the latex on the Ticket is scratched off to expose 40 (forty) Play Symbols. The player must scratch the entire play area to reveal 20 Play Symbols. If a player reveals an "8" Play Symbol, the player wins the prize for that symbol. If a player reveals an "EXTREME" Play Symbol, the player WINS ALL 20 PRIZES instantly! No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game Ticket, all of the following requirements must be met:

1. Exactly 40 (forty) Play Symbols must appear under the Latex Overprint on the front portion of the Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Ticket;

8. The Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Ticket must not be counterfeit in whole or in part;

10. The Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Ticket must not have been stolen, nor appear on any list of omitted Tickets or non-activated Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Ticket must be complete and not miscut and have exactly 40 (forty) Play Symbols under the Latex Overprint on the front portion of the Ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the Ticket;

14. The Serial Number of an apparent winning Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Tickets, and a Ticket with that Serial Number shall not have been paid previously;

15. The Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 40 (forty) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 40 (forty) Play Symbols on the Ticket must be printed in the symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Ticket Serial Numbers must be printed in the serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Ticket. In the event a defective Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Ticket with another unplayed Ticket in that Instant Game (or a Ticket of equivalent sales price from any other current Texas Lottery Instant Game) or refund the retail sales price of the Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive Non-Winning Tickets in a Pack will not have identical play data, spot for spot.

B. No matching non-winning Play Symbols on a Ticket.

C. A non-winning Prize Symbol will never be the same as a winning Prize Symbol.

D. No more than three matching non-winning Prize Symbols on a Ticket.

E. No prize amount in a non-winning spot will correspond with the corresponding Play Symbol (i.e., 20 and $20).

F. The "8" (win) Play Symbol will only appear on intended winning Tickets as dictated by the prize structure.

G. When the "EXTREME" (win all) Play Symbol appears, there will be no occurrence of the "8" (win) Play Symbol appearing.

H. The "EXTREME" (win all) Play Symbol will only appear as dictated by the prize structure.

I. The top Prize Symbol will appear at least once on every Ticket unless restricted by other parameters, play action or prize structure.

2.3 Procedure for Claiming Prizes.

A. To claim a "EXTREME 8s" Instant Game prize of $5.00, $10.00, $15.00, $20.00, $50.00, $100 or $500, a claimant shall sign the back of the Ticket in the space designated on the Ticket and present the winning Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00, $100 or $500 Ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "EXTREME 8s" Instant Game prize of $1,000 or $100,000, the claimant must sign the winning Ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "EXTREME 8s" Instant Game prize, the claimant must sign the winning Ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. A sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "EXTREME 8s" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "EXTREME 8s" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Tickets ordered. The number of actual prizes available in a game may vary based on number of Tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game Ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game Ticket in the space designated, a Ticket shall be owned by the physical possessor of said Ticket. When a signature is placed on the back of the Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Ticket in the space designated. If more than one name appears on the back of the Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game Tickets and shall not be required to pay on a lost or stolen Instant Game Ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 8,040,000 Tickets in the Instant Game No. 1659. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1659 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$5	750,400	10.71
$10	804,000	10.00
$15	214,400	37.50
$20	268,000	30.00
$50	17,755	452.83
$100	23,450	342.86
$500	3,752	2,142.86
$1,000	460	17,478.26
$100,000	14	574,285.71

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 3.86. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1659 without advance notice, at which point no further Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Instant Game closing procedures and the Instant Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing an Instant Game Ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1659, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-201403820
Bob Biard
General Counsel
Texas Lottery Commission
Filed: August 13, 2014

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North Central Texas Council of Governments

Notice of Consultant Contract Award

Pursuant to the provisions of Government Code, Chapter 2254, the North Central Texas Council of Governments publishes this notice of consultant contract award. The consultant request appeared in the May 16, 2014, issue of the *Texas Register* (39 TexReg 3906). The selected consultant will perform Air Quality Technical Assistance for the North Central Texas Council of Governments.

The consultant selected for this project is Providence Engineering and Environmental Group, LLC., 1200 West Walnut Hill Lane, Suite 1000, Irving, Texas 75038. The amount of the contract is not to exceed $159,924.

TRD-201403806
R. Michael Eastland
Executive Director
North Central Texas Council of Governments
Filed: August 12, 2014

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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 August 5, 2014, for retail electric provider (REP) certification, pursuant to §39.352 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of Agera Energy LLC for a Retail Electric Provider Certificate, Docket Number 42725.

Applicant's requested service area is in a 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 telephones (TTY) may contact the commission at (512) 936-7136 or through Relay Texas by dialing 7-1-1. All inquiries should reference Docket Number 42725.

TRD-201403586
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 7, 2014

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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 August 11, 2014, for an amendment to certificated service area for a service area exception within Roberts County, Texas.

Docket Style and Number: Application of North Plains Electric Cooperative, Inc. to Amend a Certificate of Convenience and Necessity for Electric Service Area Exception within Roberts County. Docket Number 42748.

The Application: North Plains Electric Cooperative, Inc. (NPEC) filed an application for a service area exception to allow NPEC to provide service to a specific customer located within the certificated service area of Southwestern Public Service Company (SPS). SPS 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 August 29, 2014 by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission through Relay Texas by dialing 7-1-1. All comments should reference Docket Number 42748.

TRD-201403825
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 13, 2014

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Public Notice

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of a petition filed on August 8, 2014, seeking to determine whether certain markets of the company with populations of less than 100,000 in Texas should remain regulated.

Docket Style and Number: Petition of Verizon Southwest to Determine Whether Certain Markets with Populations Less than 100,000 Should Remain Regulated. Docket Number 42745.

The Application: GTE Southwest Incorporated d/b/a Verizon Southwest (Verizon) filed a petition seeking to determine whether certain markets of the company with populations of less than 100,000 in Texas should remain regulated. The commission has jurisdiction over the petition pursuant to Public Utility Regulatory Act (PURA) §65.052. Verizon claims that 15 of its local exchange markets meet the criteria for deregulation set out in PURA §65.052(b)(2). In making a determination, PURA §65.052(b)(2) provides that the Commission may not determine that a market should remain regulated if the population in the area included in the market is less than 100,000 and, in addition to the incumbent local exchange company (ILEC), there are at least two competitors operating in all or part of the market that are unaffiliated with the ILEC and provide voice communications service without regard to the delivery technology.

The 15 exchanges affected are: Bangs, Bells-Savoy, Bishop, Caddo Mills, DFW Airport, East Bernard, Grand Saline, Hallsville, La Vernia, Mount Vernon, Rice, Shepherd, Taft, Venus and Winters.

Pursuant to PURA §65.052(a) the commission shall issue a final order no later than 90 days after the petition is filed. The 90th day in this case is November 6, 2014.

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 (888) 782-8477 as soon as possible as a deadline to intervene will be established. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission through Relay Texas by dialing 7-1-1. All comments should reference Docket Number 42745.

TRD-201403829
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 13, 2014

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Request for Comments

The staff of the Public Utility Commission of Texas (commission) requests comments in Project Number 42647, *ERCOT Planning and System Costs Associated with Renewable Resources and New Large DC Ties*. This project has been established to review topics related to ERCOT transmission, including prospective system upgrades, ancillary services, the transmission planning process related to renewable resources, imports/exports on new large DC Ties, and challenges arising from the Competitive Renewable Energy Zones (CREZ). The commission requests that interested parties file comments to the attached questions (Attachment 1).

Comments may be filed by submitting 16 copies to the commission's Filing Clerk, Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326. Initial comments are due by Friday, September 12, 2014, and reply comments are due by Friday, September 19, 2014. All comments should reference Project Number 42647.

Questions concerning this notice should be referred to Liz Kayser, Section Director, Competitive Markets Division, (512) 936-7390. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission through Relay Texas by dialing 7-1-1.

Attachment 1 – Proposed Questions

RENEWABLE RESOURCES	
FUNCTION	**ISSUE**
Transmission Planning	Is the production cost savings test required by Substantive Rule §25.101(b)(3)(A)(i) generally appropriate for analyzing the benefits of transmission projects, especially projects to address transmission limitations and voltage stability mitigation that will be needed to address a system heavily weighted with wind generation with a production cost of zero?
	For purposes of this section, assume that transmission projects are long-lived assets and the capital investment decisions of generators are at least somewhat influenced by transmission planning policy. i. Is it appropriate for any production cost savings analysis to focus on short-run marginal production costs (where installed capacity is assumed to be fixed)? i. If not, should long-run marginal production costs (wherein capital investment costs are assumed to be variable) or other considerations be applied to any production cost savings analysis, especially with respect to renewable resources? ii. What, if any, production costs should be assigned to renewable resources?
Investment in Transmission System	To the extent that renewable resources impact grid stability, as the transmission system grows how should the cost of maintaining grid stability be allocated?
	Should renewable resources help fund further investment in the transmission system? What mechanisms and methodologies should be used to determine and assign those costs? i. Can the Commission implement these mechanisms and methodologies under existing law?
Market	What ancillary services costs are incurred specifically due to the employment of renewable resources in the ERCOT generation mix? i. Are these costs disproportionately large as compared to other causes? Explain? ii. How can incremental increases in ancillary services costs be identified and quantified as the installed capacity of variable renewable resources increases? iii. How should any assignment or allocation of ancillary services costs be properly designed to reflect any costs incurred due to the nature of renewable resources?
	What effect has the increased deployment of renewable resources had on market prices in the ERCOT system?
	What effect, if any has the increased deployment of renewable resources had on Peaker Net Margin as used in Substantive Rule §25.505(g)?

DC TIES	
FUNCTION	**ISSUE**
Transmission Planning	How should the uncertainty of whether DC Ties will be exporting or importing be addressed in transmission planning?
	What relationship exists between ownership of transmission equipment (including converter stations) and cost responsibility for transmission upgrades? What relationship, if any, should exist?
	What potential grid stability problems might occur with the construction of additional DC Ties? If such grid stability problems could occur, what mitigation measures should be undertaken? Estimate the cost of such mitigation.
	Has a ceiling on the number or size of DC Tie installations been identified below which the existing ERCOT grid can accommodate DC Tie installations without major upgrades by transmission service providers (TSPs) and without changes in ERCOT operational practices?
	Under current ERCOT Protocols, DC Ties are not currently dispatchable and therefore the load on DC Ties cannot be changed by Security Constrained Economic Dispatch (SCED). Should the ERCOT Protocols be rewritten to allow DC Ties to be dispatchable?
Investment in Transmission System	To what extent, if at all, should a DC Tie owner be required to bear cost responsibility for transmission upgrades by TSPs that are required to accommodate power flows over the DC Tie?
	The current ERCOT Most Severe Single Contingency (MSSC) is at about 1375 MW. If DC Ties greater than 1375 MW were installed, it is expected that the ERCOT MSSC would likely increase. Assuming this happens and that this increase would require a larger operating Responsive Reserve Service (RSS), who should pay for the increased costs of the RRS? How should increased costs be recovered?
Market	If DC Tie owners are required to bear some portion of the costs of transmission system investments to accommodate power flows over the DC Tie, what mechanisms and methodologies should be used to determine and assign those costs? Can the Commission implement these mechanisms and methodologies under existing law?
Registration	Should in-state DC Ties owners (who are not public utilities/transmission service providers) be required to register with the PUC or ERCOT? Explain why or why not.
	Does a TSP in ERCOT have an obligation to serve a merchant DC Tie under federal or state law?
	Does Public Utility Regulatory Act enable the Commission to regulate merchant DC Ties and the provision of transmission service to those ties?
	How should the Commission regulate merchant DC Ties and the provision of transmission service to those ties?

TRD-201403827
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: August 13, 2014

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Texas Department of Transportation

Aviation Division - Request for Qualifications for Professional Architectural/Engineering Services

The City of Brady, through its agent, the Texas Department of Transportation (TxDOT), intends to engage an Aviation Professional Engineering Firm for services pursuant to Chapter 2254, Subchapter A, of the Government Code. The TxDOT Aviation Division will solicit and receive qualifications for professional aviation engineering design services for the current project as described below.

Current Project: City of Brady; TxDOT CSJ No.: 15HGBRADY.

Scope: Provide engineering/design services to construct a new Hangar.

The DBE goal for the design of the current project is 10%. The goal will be re-set for the construction phase. The TxDOT Project Manager is Robert Johnson.

The following is a listing of proposed projects at Curtis Field during the course of the next five years through multiple grants.

Future scope work items for engineering/design services within the next five years may include the following: pavement rehabilitation; rehabilitate Runway 17-35; mark Runway 17-35; rehabilitate partial parallel taxiway; rehabilitate apron and ag apron; extend Runway 17-35; extend partial taxiway to full parallel taxiway; upgrade and extend runway lighting.

The City of Brady 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 qualification statement preparation the criteria, 5010 drawing, project diagram, and most recent Airport Layout Plan are available online at http://www.txdot.gov/inside-txdot/division/aviation/projects.html by selecting "Curtis Field." The qualification statement should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Qualifications for Aviation Architectural/Engineering Services". The form may be requested from TxDOT, Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at http://www.txdot.gov/inside-txdot/division/aviation/projects.html. 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. Qualifications shall not exceed the number of pages in the AVN-550 template. The AVN-550 consists of eight 8 1/2" x 11" pages of data plus one optional illustration page. The optional illustration page shall be no larger than 11" x 17" and may be folded to an 8 1/2" x 11" size. A prime provider may only submit one AVN-550. If a prime provider submits more than one AVN-550, that provider will be disqualified. AVN-550s shall be stapled but not bound or folded in any other fashion. AVN-550s 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 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 October 7, 2014, 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 Beverly Longfellow.

The consultant selection committee will be composed of local government representatives. The final selection by the committee will generally be made following the completion of review of AVN-550s. The committee will review all AVN-550s and rate and rank each. The Evaluation Criteria for Engineering Qualifications can be found at http://www.txdot.gov/inside-txdot/division/aviation/projects.html under the Notice to Consultants link. 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 Beverly Longfellow, Grant Manager. For technical questions, please contact Robert Johnson, Project Manager.

TRD-201403813
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: August 13, 2014

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Public Notice - Overall Disadvantaged Business Enterprise Goal for Federal Transit Authority, Fiscal Years 2014 through 2016

In accordance with Title 49 Code of Federal Regulations (C.F.R.), Part 26, recipients of federal-aid funds authorized by the Transportation Equity Act for the 21st Century (TEA 21) are required to establish Disadvantaged Business Enterprise (DBE) programs. Title 49 C.F.R. §26.45 requires the recipients of federal funds, including the Texas Department of Transportation (department), to set an overall goal for DBE participation in U.S. Department of Transportation assisted contracts. As part of this goal-setting process, the department is publishing this notice to inform the public of the proposed overall goal, and to provide instructions on how to obtain copies of documents explaining the rationale for the goal.

The proposed overall FTA DBE goal for Fiscal Years 2015-2017 is 4.57 percent. The proposed goal and goal-setting methodology are available for inspection between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, for 30 days following the date this notice is published. The information may be viewed in the office of the Texas Department of Transportation, Office of Civil Rights, 200 East Riverside Drive, Austin, Texas 78704. Any questions concerning inspection of the DBE goal and methodology should be directed to the Office of Civil Rights by calling (512) 416-4700.

The department will accept written comments on the DBE goal until October 6, 2014. Written comments should be submitted to Eli Lopez, Office of Civil Rights, 125 E. 11th Street, Austin, Texas 78701; Fax: (512) 416-4711; Email: eli.lopez@txdot.gov.

TRD-201403814
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: August 13, 2014

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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 39 (2014) is cited as follows: 39 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 "39 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 39 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)***

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