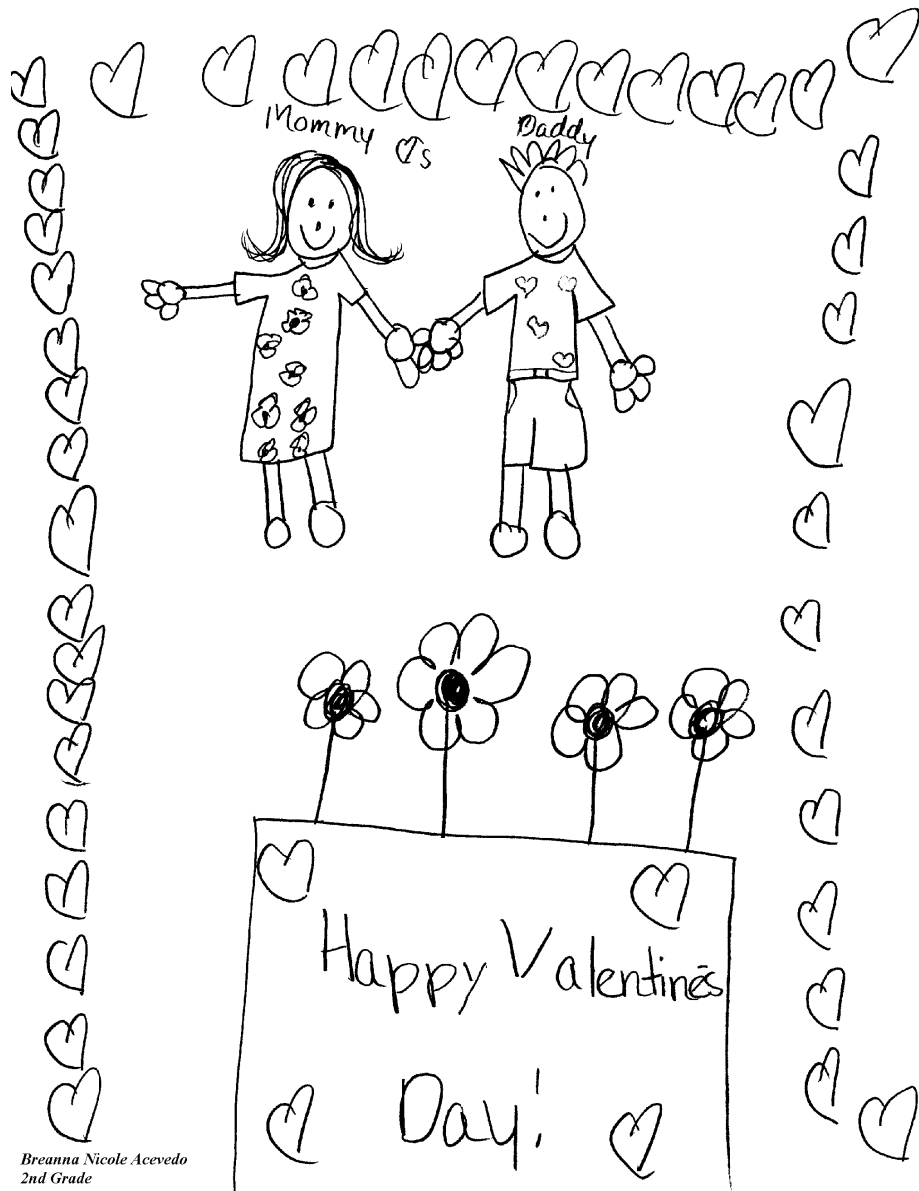


TEXAS REGISTER

Volume 30 Number 7

February 18, 2005

Pages 773-944



Breanna Nicole Acevedo
2nd 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*.

Texas Register, (ISSN 0362-4781), is published weekly, 52 times a year. Issues will be published by the Office of the Secretary of State, 1019 Brazos, Austin, Texas 78701. Subscription costs: printed, one year \$200. First Class mail subscriptions are available at a cost of \$300 per year. Single copies of most issues for the current year are available at \$10 per copy in printed format.

Material in the *Texas Register* is the property of the State of Texas. However, it may be copied, reproduced, or republished by any person without permission of the *Texas Register* Director, provided no such republication shall bear the legend *Texas Register* or "Official" without the written permission of the director.

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

POSTMASTER: Send address changes to the *Texas Register*, P.O. Box 13824, Austin, TX 78711-3824.

TEXAS REGISTER

a section of the
Office of the Secretary of State
P.O. Box 13824
Austin, TX 78711-3824
(800) 226-7199
(512) 463-5561
FAX (512) 463-5569
<http://www.sos.state.tx.us>
subadmin@sos.state.tx.us

Secretary of State –
Roger Williams
Director - Dan Procter

Staff
Ada Aulet
Leti Benavides
Dana Blanton
Carla Carter
Kris Hogan
Roberta Knight
Jill S. Ledbetter
Juanita Ledesma
Diana Muniz
Shadrock Roberts

IN THIS ISSUE

GOVERNOR

Appointments779

ATTORNEY GENERAL

Opinions781

PROPOSED RULES

TEXAS DEPARTMENT OF AGRICULTURE

PESTICIDES

4 TAC §7.52, §7.53783

TEXAS HIGHER EDUCATION COORDINATING BOARD

AGENCY ADMINISTRATION

19 TAC §1.15784

RULES APPLYING TO ALL PUBLIC INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

19 TAC §4.25785

19 TAC §§4.151 - 4.160.....786

RULES APPLYING TO PUBLIC UNIVERSITIES AND/OR HEALTH-RELATED INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

19 TAC §5.6787

19 TAC §5.23, §5.24788

19 TAC §5.44, §5.50788

PRIVATE AND OUT-OF-STATE PUBLIC POSTSECONDARY EDUCATIONAL INSTITUTIONS OPERATING IN TEXAS

19 TAC §7.7, §7.9789

PROGRAM DEVELOPMENT IN PUBLIC TWO-YEAR COLLEGES

19 TAC §9.93, §9.96795

CAREER SCHOOLS AND COLLEGES

19 TAC §12.21796

FINANCIAL PLANNING

19 TAC §§13.120 - 13.130.....796

STATE BOARD OF DENTAL EXAMINERS

DENTAL BOARD PROCEDURES

22 TAC §107.103800

22 TAC §107.103800

22 TAC §107.110802

DENTAL LABORATORIES

22 TAC §116.10802

TEXAS BOARD OF PROFESSIONAL ENGINEERS

LICENSING

22 TAC §133.31803

22 TAC §133.53805

22 TAC §133.65805

22 TAC §133.81806

COMPLIANCE AND PROFESSIONALISM

22 TAC §137.13807

TEXAS BOARD OF PROFESSIONAL LAND SURVEYING

GENERAL RULES OF PROCEDURES AND PRACTICES

22 TAC §661.100807

22 TAC §661.102808

22 TAC §661.104809

TEXAS PARKS AND WILDLIFE DEPARTMENT

WILDLIFE

31 TAC §§65.190, 65.191, 65.193, 65.198, 65.199, 65.201810

TEXAS STATE SOIL AND WATER CONSERVATION BOARD

AGRICULTURAL AND SILVICULTURAL WATER QUALITY MANAGEMENT

31 TAC §523.6816

TEXAS YOUTH COMMISSION

PROGRAM SERVICES

37 TAC §91.99816

37 TAC §91.99817

GENERAL PROVISIONS

37 TAC §99.90818

WITHDRAWN RULES

TEXAS EDUCATION AGENCY

BUDGETING, ACCOUNTING, AND AUDITING

19 TAC §109.1002821

ADOPTED RULES

OFFICE OF THE SECRETARY OF STATE

ELECTIONS

1 TAC §81.176823

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

REIMBURSEMENT RATES

1 TAC §355.8063823

MEDICAID ESTATE RECOVERY PROGRAM

1 TAC §§373.101, 373.103, 373.105	832
1 TAC §§373.201, 373.203, 373.205, 373.207, 373.209, 373.211, 373.213, 373.215, 373.217, 373.219	832
1 TAC §§373.301, 373.303, 373.305, 373.307	834

TEXAS HIGHER EDUCATION COORDINATING BOARD

RULES APPLYING TO ALL PUBLIC INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

19 TAC §4.7	834
-------------------	-----

RULES APPLYING TO PUBLIC UNIVERSITIES AND/OR HEALTH-RELATED INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

19 TAC §5.45, §5.46	835
---------------------------	-----

PRIVATE AND OUT-OF-STATE PUBLIC POSTSECONDARY EDUCATIONAL INSTITUTIONS OPERATING IN TEXAS

19 TAC §7.4	835
-------------------	-----

CAMPUS PLANNING

19 TAC §17.3	836
19 TAC §17.12	838
19 TAC §17.30	840

GRANT AND SCHOLARSHIP PROGRAMS

19 TAC §22.112	842
----------------------	-----

TEXAS EDUCATION AGENCY

ASSESSMENT

19 TAC §§101.2003, 101.2005, 101.2007, 101.2011, 101.2013	842
---	-----

STATE BOARD OF DENTAL EXAMINERS

DENTAL BOARD PROCEDURES

22 TAC §107.101	845
22 TAC §107.102	845

TEXAS BOARD OF PROFESSIONAL ENGINEERS

ORGANIZATION AND ADMINISTRATION

22 TAC §131.81	846
----------------------	-----

LICENSING

22 TAC §133.13	846
22 TAC §133.21	846

COMPLIANCE AND PROFESSIONALISM

22 TAC §137.17	847
22 TAC §137.73	847

TEXAS BOARD OF PROFESSIONAL LAND SURVEYING

GENERAL RULES OF PROCEDURES AND PRACTICES

22 TAC §661.41	847
22 TAC §661.95	848
22 TAC §661.99	848

STANDARDS OF RESPONSIBILITY AND RULES OF CONDUCT

22 TAC §663.8	848
22 TAC §663.20	849

STATE BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

22 TAC §741.65	850
22 TAC §741.141	853
22 TAC §741.161, §741.162	853
22 TAC §741.181	853
22 TAC §741.195	854

TEXAS DEPARTMENT OF INSURANCE

HEALTH MAINTENANCE ORGANIZATIONS

28 TAC §11.1, §11.2	869
28 TAC §11.101	872
28 TAC §§11.201 - 11.206	873
28 TAC §§11.301 - 11.303	874
28 TAC §§11.502 - 11.506, 11.508, 11.509, 11.512	876
28 TAC §11.602, §11.603	881
28 TAC §§11.801 - 11.803, 11.806, 11.810	882
28 TAC §§11.901, 11.902, 11.904	883
28 TAC §11.1001	885
28 TAC §§11.1301 - 11.1306	886
28 TAC §§11.1401 - 11.1404	887
28 TAC §11.1500	888
28 TAC §§11.1600 - 11.1602, 11.1604 - 11.1607	889
28 TAC §§11.1702 - 11.1704	892
28 TAC §§11.1801 - 11.1806	893
28 TAC §11.1901, §11.1902	894
28 TAC §§11.2101 - 11.2103	898
28 TAC §§11.2200, 11.2201, 11.2203, 11.2204, 11.2207, 11.2208	899
28 TAC §§11.2303, 11.2311, 11.2314	903
28 TAC §§11.2402, 11.2405, 11.2406	904
28 TAC §§11.2501 - 11.2503	905

28 TAC §11.2601, §11.2602.....	906	Texas Health and Human Services Commission	
HEALTH MAINTENANCE ORGANIZATIONS		Public Notice Statement.....	929
28 TAC §11.1101, §11.1102.....	907	Texas Department of Housing and Community Affairs	
28 TAC §11.1608.....	907	2005 Housing Tax Credit Program.....	930
28 TAC §§11.2001 - 11.2006.....	907	Houston-Galveston Area Council	
TEXAS STATE SOIL AND WATER CONSERVATION BOARD		Public Meeting Notice.....	930
GENERAL PROCEDURES		Texas Department of Insurance	
31 TAC §518.5.....	908	Notice of Public Hearing.....	931
TEXAS YOUTH COMMISSION		Third Party Administrator Applications.....	931
PROGRAM SERVICES		Texas Lottery Commission	
37 TAC §91.94.....	908	Instant Game Number 543 "Cashword".....	931
TEXAS BOARD OF OCCUPATIONAL THERAPY EXAMINERS		Manufactured Housing Division	
PROVISION OF SERVICES		Notice of Administrative Hearing.....	936
40 TAC §372.1.....	910	Texas Parks and Wildlife Department	
SUPERVISION		Notice of Hearing and Opportunity for Public Comment.....	936
40 TAC §373.3.....	911	Public Utility Commission of Texas	
TABLES AND GRAPHICS		Notice of Application for Amendment to Certificated Service Area Boundary.....	937
.....	913	Notice of Application for Amendment to Service Provider Certificate of Operating Authority.....	937
IN ADDITION		Notice of Application for Certificate of Convenience and Necessity for a Proposed Transmission Line in Wood County, Texas.....	937
Automobile Theft Prevention Authority		Notice of Application for Designation as an Eligible Telecommunications Carrier Pursuant to P.U.C. Substantive Rule §26.418.....	937
Request for Applications Under the Automobile Theft Prevention Authority Fund.....	921	Notice of Application to Amend Certificated Service Area Boundaries.....	938
Coastal Coordination Council		Notice of Application to Amend Certificated Service Area Boundaries.....	938
Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program.....	921	Notice of Application to Amend Certificated Service Area Boundaries.....	938
Office of Consumer Credit Commissioner		Notice of Petition for Waiver of Denial of Request for NXX Code.....	938
Notice of Rate Ceilings.....	923	Notice of Petition for Waiver of Denial of Request for NXX Code.....	939
Texas Education Agency		Public Notice of Workshop on Pro-Forma Delivery Service Tariff Issues and Request for Redlines.....	939
Notice of Texas Education Agency Security Environment (TEASE) Access Required for Even Start Family Literacy Program eGrant Application.....	923	Texas Department of Transportation	
Texas Commission on Environmental Quality		Public Notice - Availability of Draft Environmental Impact Statement.....	939
Enforcement Orders.....	924	Request for Proposal Addendum 1 - Collin County Regional Airport.....	940
Notice of Water Quality Applications.....	926	Request for Proposal for Aviation Engineering Services.....	940
Notice of Water Rights Application.....	927	Texas Workers' Compensation Commission	
Proposed Enforcement Orders.....	928	Invitation to Apply to the Medical Advisory Committee (MAC)....	941
Golden Crescent Workforce Development Board			
Public Notice.....	929		

Open Meetings

A notice of a meeting filed with the Secretary of State by a state governmental body or the governing body of a water district or other district or political subdivision that extends into four or more counties is posted at the main office of the Secretary of State in the lobby of the James Earl Rudder Building, 1019 Brazos, Austin, Texas.

Notices are published in the electronic *Texas Register* and available on-line. <http://www.sos.state.tx.us/texreg>

To request a copy of a meeting notice by telephone, please call 463-5561 if calling in Austin. For out-of-town callers our toll-free number is (800) 226-7199. Or fax your request to (512) 463-5569.

Information about the Texas open meetings law is available from the Office of the Attorney General. The web site is <http://www.oag.state.tx.us>. Or phone the Attorney General's Open Government hotline, (512) 478-OPEN (478-6736).

For on-line links to information about the Texas Legislature, county governments, city governments, and other government information not available here, please refer to this on-line site. <http://www.state.tx.us/Government>



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 GOVERNOR

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

Appointments

Appointments for February 1, 2005

Appointed to be Commissioner of the Railroad Commission of Texas for a term until the next General Election and until her successor shall be duly elected and qualified, Elizabeth Ames Jones of San Antonio. Ms. Jones is replacing Commissioner Charles Matthews who resigned.

Appointments for February 7, 2005

Appointed to the State Cemetery Committee for a term to expire February 1, 2011, James Coley Cowden of Austin. Mr. Cowden is replacing Ralph Wayne whose term expired.

Appointed to the Texas Building and Procurement Commission for a term to expire January 31, 2011, Betty Pinckard Reinbeck of Sealy. Ms. Reinbeck is being reappointed.

Appointed to the Texas Racing Commission for a term to expire February 1, 2007, Louis Edward Sturns of Fort Worth. Mr. Sturns is replacing Comer Cottrell who resigned.

Appointed to the Texas Workforce Commission for a term to expire February 1, 2011, Ronald Gene Congleton of Austin. Mr. Congleton is being reappointed.

Appointed to the State Securities Board for a term to expire January 20, 2011, Bryan K. Brown of Pearland. Mr. Brown is being reappointed.

Appointed to the Office of Rural Community Affairs for a term to expire February 1, 2011, Michael Cooper Waters of Abilene. Mr. Waters is being reappointed.

Rick Perry, Governor

TRD-200500582



THE ATTORNEY GENERAL

Under provisions set out in the Texas Constitution, the Texas Government Code, Title 4, §402.042, and numerous statutes, the attorney general is authorized to write advisory opinions for state and local officials. These advisory opinions are requested by agencies or officials when they are confronted with unique or unusually difficult legal questions. The attorney general also determines, under authority of the Texas Open Records Act, whether information requested for release from governmental agencies may be held from public disclosure. Requests for opinions, opinions, and open records decisions are summarized for publication in the *Texas Register*. The attorney general responds to many requests for opinions and open records decisions with letter opinions. A letter opinion has the same force and effect as a formal Attorney General Opinion, and represents the opinion of the attorney general unless and until it is modified or overruled by a subsequent letter opinion, a formal Attorney General Opinion, or a decision of a court of record. You may view copies of opinions at <http://www.oag.state.tx.us>. To request copies of opinions, please fax your request to (512) 462-0548 or call (512) 936-1730. To inquire about pending requests for opinions, phone (512) 463-2110.

Opinions

Opinion No. GA-0298

The Honorable Robert E. Talton
Chair, Urban Affairs Committee
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Re: Whether a Texas inmate violates the Texas forfeiture statute by selling his artwork on an Internet website (RQ-0252-GA)

S U M M A R Y

Article 59.01(7)(B) of the Code of Criminal Procedure provides for forfeiture of certain income from "the sale of tangible property the value of which is increased by the notoriety gained from the conviction of an offense by the person accused or convicted of the crime." TEX. CODE CRIM. PROC. ANN. art. 59.01(7)(B) (Vernon Supp. 2004-05). Whether such income constitutes proceeds subject to forfeiture depends upon the resolution of fact questions.

Opinion No. GA-0299

The Honorable Bruce Isaacks
Denton County Criminal District Attorney
127 North Woodrow Lane
Denton, Texas 76205

Re: Whether a bail bond surety who is convicted of violating section 1704.304(c) of the Occupations Code has committed a crime of moral turpitude for purposes of section 1704.302(c) thereof (RQ-0259-GA)

S U M M A R Y

A bail bond surety who is convicted of soliciting clients inside an area prohibited by section 1704.304(c) of the Occupations Code has not committed a crime of "moral turpitude" for purposes of section 1704.302(c) of the Occupations Code.

Opinion No. GA-0300

The Honorable Robert E. Talton
Chair, House Committee on Urban Affairs
Texas House of Representatives

Post Office Box 2910

Austin, Texas 78711-2910

Re: Whether payment for accumulated vacation time, paid as salary under an employment contract, is creditable compensation for purposes of determining Teacher Retirement System benefits (RQ-0251-GA)

S U M M A R Y

A payment for accumulated vacation time, paid as salary under an employment contract, is not creditable compensation for purposes of determining Teacher Retirement System benefits.

Opinion No. GA-0301

The Honorable Richard J. Miller
Bell County Attorney
Post Office Box 1127
Belton, Texas 76513

Re: Whether Health and Safety Code section 691.023(b) prohibits a commissioners court from adopting an order authorizing cremation as a means of disposing of the remains of a deceased pauper (RQ-0263-GA)

S U M M A R Y

Health and Safety Code section 694.002 authorizes a commissioners court to dispose of a pauper's remains by donation, cremation, or burial and allows a county to specify by rule how it normally will determine the manner of disposition. Health and Safety Code section 691.023(b) requires a county to pay the costs of preparing a pauper's remains for disposition if the remains are not needed by the State Anatomical Board and does not prohibit a commissioners court from adopting an order authorizing cremation to dispose of a pauper's remains.

Opinion No. GA-0302

The Honorable Craig D. Caldwell
Cherokee County Attorney
Post Office Box 320
Rusk, Texas 75785

Re: Whether Texas or New Jersey law applies to the payment of late fees on a contract between a Texas county and an out-of-state vendor (RQ-0266-GA)

S U M M A R Y

A county that is expressly authorized to enter into a contract impliedly has authority to negotiate the terms of the contract. The scope of that implied authority does not include a choice of law provision that imports the law of another state that effectively overrides or negates the provisions of chapter 2251 of the Texas Government Code.

Opinion No. GA-0303

The Honorable Ronald D. Hankins

Somervell County Attorney

Post Office Box 1335

Glen Rose, Texas 76043

Re: Whether an elected county official may close his office on a day declared by the Governor of Texas to be an "official day of mourning" (RQ-0267-GA)

S U M M A R Y

A Somervell County official is authorized to set the hours that his office will be open as well as his employees' working conditions. He may

close the office and allow the employees to take the day off, assuming that there is a public purpose for the closing. The Somervell County Justice of the Peace, Precinct Two, was authorized to close his office on June 11, 2004 for the official day of mourning honoring former President Ronald Reagan and to allow his clerk to take the day off. The Somervell County Auditor has a ministerial duty to approve payment of the clerk's salary for the official day of mourning as a regular work day and may not charge it to leave time.

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200500572

Nancy S. Fuller

Assistant Attorney General

Office of the Attorney General

Filed: February 7, 2005



PROPOSED RULES

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

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

TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 7. PESTICIDES

SUBCHAPTER E. REGULATED HERBICIDES

4 TAC §7.52, §7.53

The Texas Department of Agriculture (the department) proposes amendments to §7.52, concerning counties regulated and §7.53, concerning county special provisions for the use of regulated herbicides. The amendments are proposed to make changes to the regulations necessitated by an order entered by the county commissioner court of a county subject to the regulations.

Proposed amendment to §7.52 will add Moore County to the list of counties regulated. Proposed amendment to §7.53 will make changes to the county special provisions by adding county special provisions for Moore County.

Phil Tham, assistant commissioner for pesticides, has determined that for the five-year period the amendments are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections, as amended.

Mr. Tham also has determined that for each year of the first five years the amendments are in effect, the public benefit anticipated as a result of enforcing the sections will be increased efficiency and effectiveness in the use of regulated herbicides in regulated counties. There will be no effect on micro-businesses, small or large businesses. There is no anticipated economic cost to persons who are required to comply with the sections as proposed.

Comments on the proposal may be submitted to Phil Tham, Assistant Commissioner for Pesticide Programs, Texas Department of Agriculture, P.O. Box 12847, Austin, Texas 78711. 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 §76.144, which provides that the Texas Department of Agriculture with the authority to adopt rules concerning the use of regulated herbicides in a county in which the commissioner court has entered an order in accordance with the Texas Agriculture Code §76.144(a).

The Texas Agriculture Code, Chapter 76, is affected by the proposal.

§7.52. *Counties Regulated.*

The following counties shall be subject to the provisions of the Act, Subchapter G, unless specifically excepted by provisions of §7.53 of

this title (relating to County Special Provisions): Aransas, Austin, Bailey, Baylor, Bexar, Brazoria, Brazos, Briscoe, Burlleson, Calhoun, Cochran, Collin, Collingsworth, Culberson, Dallas, Dawson, Deaf Smith, Delta, Dickens, Donley, El Paso, Falls, Foard, Fort Bend, Gaines, Galveston, Hall, Harris, Haskell, Hidalgo, Hudspeth, Hunt, Jackson, King, Knox, Lamar, Lamb, Loving, McLennan, Martin, Matagorda, Midland, Milam, Moore, Motley, Parmer, Refugio, Robertson, Rockwall, Runnels, San Patricio, Waller, Ward, Wharton and Wilbarger.

§7.53. *County Special Provisions.*

(a) - (gg) (No change.)

(hh) Moore.

(1) The use of all ester formulations of regulated herbicides is prohibited from May 1 through September 30 each year.

(2) A permit is required for the application of all other formulations of regulated herbicides from May 1 through September 30 of each year.

(3) No permit is required for the application of regulated herbicides during the period beginning October 1 and ending April 30 of the following year.

(ii) ~~[(hh)]~~ Motley. No permit is required for the period of November 1 to May 14 of the following year.

(ij) ~~[(ii)]~~ Parmer. No permit is required in Parmer County for applications of regulated herbicides between November 1 and March 31 of the following year. However, the application of all ester formulations of 2,4-D is prohibited between the dates of April 15 and October 1 of each year.

(kk) ~~[(jj)]~~ Refugio.

(1) The application of the ester formulations of 2,4-D by any means is prohibited between the period of March 1 and September 15 of each year. The application of the amine formulations of 2,4-D is prohibited between the period of March 10 and September 15 of each year except by permit.

(2) No permit is required for the application of regulated herbicides during the period of September 16 and ending the last day of February of the following year.

(ll) ~~[(kk)]~~ Robertson.

(1) Persons in that portion of Robertson County, east of State Highway 6, are exempted from requirements of the Act, Subchapter G and regulations adopted thereunder.

(2) A permit is required for the application of regulated herbicides in that portion of Robertson County, west of State Highway 6 between the dates of April 1 and September 15 each year.

(mm) [(H)] Runnels. That portion of Runnels County beginning on the west county line at the point of intersection with the Colorado River, east-southeasterly along the Colorado River to its intersection with U.S. Highway 83, thence north along U.S. Highway 83 to its intersection with the north county line, thence westerly along the north Runnels County line to the northwest corner of the county, thence southerly along the west county line to the Colorado River, the point of beginning, is regulated by the Act, Subchapter G and regulations adopted thereunder. In regulated areas, no permit is required from October 1 through May 25 of the following year. The application of ester formulations of regulated herbicides is prohibited from May 26 through September 30 of each year. The application of other regulated herbicides will be allowed beginning May 26 through September 30 of each year provided that a spray permit is obtained prior to each application.

(nn) [(mm)] San Patricio. No permit is required during the period beginning September 1 and ending March 1 of the following year. Application of regulated herbicides during the period of March 2 through August 31 must be in compliance with the Act, Subchapter G and regulations adopted thereunder. Only boom-type equipment can be used, for ground applications with nozzle height not to exceed 24 inches and maximum pressure not to exceed 20 pounds per square inch. The use of 2,4-D amine herbicides must meet the following requirements for both ground and aerial applications:

- (1) wind velocity of 0-5 mph downwind within 16 rows and upwind 8 rows;
- (2) wind velocity of 6-10 mph downwind 1/8 mile and upwind 8 rows.

(oo) [(mm)] Wharton.

(1) The aerial application of all formulations of 2,4-D is prohibited in that portion of Wharton County east of the Colorado River between March 10 and September 15 of each year.

(2) The application of all formulations of 2,4-D by any method is prohibited during the period beginning March 10 and ending October 1 of each year, in that portion of Wharton County lying west of the Colorado River.

(3) The use of high volatile herbicides is prohibited.

(4) In no case shall 2,4-D be used to treat any area that is nearer than two miles to any susceptible crop.

(pp) [(oo)] Wilbarger.

(1) No permit is required for the application of regulated herbicides during the period of September 16 to May 9 of the following calendar year.

(2) The application of the following regulated herbicides is prohibited during the regulated period beginning May 10 and ending September 15 of each year:

(A) Ester formulations of 2,4-Dichlorophenoxyacetic Acid (2,4-D);

(B) 2-Methyl-4-Chlorophenoxyacetic Acid (MCPA);

(3) The aerial application of polychlorinated benzoic acids and 2,4-D amine is prohibited during the regulated period except during the period of May 10 and ending May 20 of each year. Ground applications of polychlorinated benzoic acids and 2,4-D Amine may be made during the regulated period with the requirement of a permit.

(4) Research conducted by the Texas A&M University System under the auspices of brush and weed control, using all regulated herbicides, will be allowed during the regulated period. Aerial applications must provide a buffer zone of at least five statute miles from

any susceptible crops, and wind velocity must not exceed 10 mph during application. Research will be allowed during the period beginning May 15 and ending September 15 of each year. The department shall be notified before the commencement of such research projects.

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

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500547

Dolores Alvarado Hibbs

Deputy General Counsel

Texas Department of Agriculture

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 463-4075



TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 1. AGENCY ADMINISTRATION SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §1.15

The Texas Higher Education Coordinating Board proposes new §1.15 concerning the authority of the Commissioner of Higher Education to propose Board rules. Specifically, this new section authorizes the Commissioner of Higher Education to propose and submit proposed rules to the *Texas Register* for publication prior to consideration by the Board of the adoption of those rules. Historically, the Board has considered both the proposal and adoption of rules.

Ms. Jan Greenberg, General Counsel, has determined that for each year of the first five years the section is in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rules.

Ms. Greenberg has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be a more streamline process for the adoption of Board rules. 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 proposed new section may be submitted to Jan Greenberg, General Counsel, 1200 East Anderson Lane, Austin, Texas 78752, or by e-mail to: jan.greenberg@thehb.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, §61.027, which provide the Board with the authority to adopt and publish rules and regulations in accordance with and under the conditions applied to other agencies by Texas Government Code, Chapter 2001.

The new section affects Texas Education Code, §61.0027 .

§1.15. Authority of the Commissioner to Propose Board Rules.

The Board authorizes the Commissioner to approve proposed Board rules for publication in the *Texas Register*. The Commissioner may refer proposed rules for consideration by Coordinating Board committees established pursuant to §1.5 of this title (relating to Coordinating Board Committees) or for consideration by the Board.

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

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500479

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Proposed date of adoption: April 21, 2005

For further information, please call: (512) 427-6114



CHAPTER 4. RULES APPLYING TO ALL PUBLIC INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

SUBCHAPTER B. TRANSFER OF CREDIT, CORE CURRICULUM AND FIELD OF STUDY CURRICULA

19 TAC §4.25

The Texas Higher Education Coordinating Board proposes amendments to §4.25, concerning degree program requirements for undergraduate students transferring from a Texas public institution of higher education to another public institution of higher education. Sometimes a degree program's requirements change. Courses may be added or deleted, based on changes in the field, market needs, or other reasons. Students who are enrolled in the program when changes are enacted are generally given a choice of graduation under the requirements that were in effect when they first enrolled, or the revised requirements. Transfer students who follow published degree requirements should be afforded the same options for graduation as students native to the institution. Specifically, these amendments would require that institutions treat transfer students the same way they treat their own non-transfer students regarding graduation requirements under a particular catalog. Institutions would be required to include information about their policies regarding graduation under the degree requirements of a particular catalog in their official publications, including print and electronic catalogs. The proposed amendments would make §4.25 consistent with the definitions in §4.23.

Dr. Marshall A. Hill, Assistant Commissioner for Universities and Health-Related Institutions, has determined that for each year of the first five years the section is in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rules.

Dr. Hill has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be the improved consistency in institutional policies regarding graduation requirements

under a particular catalog for undergraduate students who transfer among Texas public institutions of higher education. Students will be able to feel more confident that the information they receive about degree requirements is reliable and will, in most cases, be the ones that will allow them to graduate. 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 proposed amendments may be submitted to Catherine Parsonneault, Ph.D., Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711-2788, or by e-mail to Catherine.Parsonneault@thehb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §61.027, which provides the Coordinating Board with general rule-making authority; §61.002, which establishes the Coordinating Board as an agency charged to provide leadership and coordination for the Texas higher education system; and §61.051, which provides the Coordinating Board with authority to develop and implement policies to provide for the free transferability of lower division course credit among institutions of higher education.

The amendments affect Texas Education Code, §61.002 and Texas Education Code, §61.051.

§4.25. *Requirements and Limitations.*

(a) (No change.)

(b) Each institution of higher education [university] must offer at least 45 semester credit hours of academic courses that are substantially equivalent to courses listed in the Lower Division Academic Course Guide Manual including those that fulfill the lower-division portion of the institution's Core Curriculum.

(c) All institutions of higher education [public colleges and universities] must accept transfer of credit for successfully completed courses identified in subsections (a) and (b) of this section as applicable to an associate or baccalaureate degree in the same manner as credit awarded to non-transfer students in that degree program.

(d) (No change.)

(e) All [senior] institutions of higher education in Texas shall provide support services appropriate to meet the needs of transfer students. These support services should be comparable to those provided to non-transfer students regularly enrolled at the institutions, including an orientation program similar to that provided for entering freshman enrollees.

(f) No institution of higher education [university] shall be required to accept in transfer, or apply toward a degree program, more than sixty-six (66) semester credit hours of lower-division academic credit. Institutions of higher education [Universities], however, may choose to accept additional credit hours.

(g) Each institution of higher education shall permit a student who transfers from another Texas public institution of higher education to choose a catalog for the purpose of specifying graduation requirements, based upon the dates of attendance at the receiving institution and at the transferring institution, in the same manner that a non-transfer student may choose a catalog. Each Texas public institution of higher education shall include information about graduation requirements under a particular catalog in its official publications, including print and electronic catalogs.

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

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500451

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Proposed date of adoption: April 21, 2005

For further information, please call: (512) 427-6114



SUBCHAPTER G. EARLY COLLEGE HIGH SCHOOLS AND MIDDLE COLLEGES

19 TAC §§4.151 - 4.160

The Texas Higher Education Coordinating Board proposes new §§4.151 - 4.160, concerning Early College High Schools and Middle Colleges. Specifically, these new sections will provide appropriate oversight by the Board of Early College High Schools (ECHS) by requiring notification of intent to develop an ECHS entity; assessment of students; appropriate faculty selection, supervision, and evaluation; oversight of curricula; transcribing of credit; program evaluation; and funding.

Dr. Glenda O. Barron, Assistant Commissioner, Community and Technical Colleges Division, 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 government as a result of enforcing or administering the new sections.

Dr. Barron has also determined that for each year of the first five years these sections are in effect, the public benefit anticipated as a result of administering these sections will be improved high school graduation and college going rates for those students attending ECHS. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Lynette Heckmann, Texas Higher Education Coordinating Board, P. O. Box 12788, Austin, TX, 78711, or Lynette.Heckmann@thehb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

These new sections are proposed under the Texas Education Code, §§61.027, 61.076, 130.001(b)(3) - (4), 130.008, and 130.090 which provide the Board with the authority to regulate courses and programs offered by public institutions of higher education in cooperation with secondary schools.

These new sections affect Texas Education Code, §§61.076, 130.001(b)(3) - (4), 130.008, and 130.090.

§4.151. Purpose.

This subchapter provides rules and regulations for public colleges or universities to engage in early college high schools or middle colleges.

§4.152. Authority.

Texas Education Code, §§61.027, 61.076, 130.001(b)(3) - (4), 130.008, and 130.090 provide the Board with the authority to regulate courses

and programs offered by public institutions of higher education in cooperation with secondary schools.

§4.153. Definitions.

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

(1) Assessment--The criterion-referenced assessment instruments adopted by the Board to assess a student's readiness to enroll in college-level coursework or curricula.

(2) Board--The Texas Higher Education Coordinating Board.

(3) Colleges or Universities, or C/U--Texas public two-year colleges or public universities.

(4) Commissioner--The Commissioner of Higher Education.

(5) Early College High School or Middle College, or ECHS/MC--The institution or entity that provides the outreach, curricula, and student learning and support programs for students who attain the Recommended High School Program (RHSP) diploma and up to two-years of college credit simultaneously.

§4.154. Notification of Institutional Intent to Develop an Early College High School/Middle College Entity.

Texas public colleges and universities (C/U) are eligible to enter into agreements with Texas public schools to create an ECHS/MC. Any Texas public college or university which participates in the creation of an ECHS/MC shall notify the Board in accordance with provisions and schedules determined by the Commissioner.

§4.155. Student Eligibility.

(a) An ECHS/MC shall assess each student for readiness to engage in any college-level curriculum offered for college credit prior to the student's enrollment in such curriculum.

(b) For this assessment, an ECHS/MC may use any instrument otherwise approved by the Board for Texas Success Initiative purposes in accordance with §4.54 of this title (relating to Exemptions/Exceptions) and §4.56 of this title (relating to Assessment Instrument) including, but not limited to, Texas Assessment of Knowledge and Skills (TAKS) scores, ACT scores, SAT scores, and Preliminary SAT scores.

(c) After assessment, the ECHS/MC, using guidelines established by the C/U, shall determine what forms of assistance and remediation, if any, are necessary prior to a student's enrollment in any college-level curriculum based on the results of the assessment and other indicators of student readiness.

§4.156. Faculty Selection, Supervision, and Evaluation.

(a) The college/university (C/U) shall select instructors of all college-level curricula offered for college credit in an ECHS/MC. These instructors must be regularly employed faculty members of the C/U or must meet the same standards, including but not limited to, minimal requirements of the Commission on Colleges of the Southern Association of Colleges and Schools.

(b) The C/U shall supervise and evaluate instructors of college-level curricula offered for college credit using the same or comparable procedures used for faculty at the C/U.

§4.157. Course Curriculum, Instruction, and Grading.

The C/U shall ensure that curricula offered for college credit and comparable courses offered by the C/U are equivalent with respect to the

curriculum, materials, instructional activity, and method/rigor of evaluation of student performance.

§4.158. *Transcripting of Credit.*

The C/U shall determine when the college credit for each ECHS/MC student should appear on the C/U transcript.

§4.159. *Evaluation and Accountability.*

Each ECHS/MC and sponsoring C/U shall be responsible for the development and implementation of an evaluation process to determine the effectiveness of the ECHS/MC. Measures of effectiveness shall include, but not limited to, student results on the K-12 accountability assessments (e.g., TAKS) and success of graduates at Texas public institutions of higher education (e.g., participation rates, grade point average, retention rates, and graduation rates).

§4.160. *Funding.*

(a) Each ECHS/MC shall receive funding in accordance with provisions and schedules determined by the Commissioner of Higher Education and Commissioner of Education.

(b) Beginning with the 2008 - 2009 biennium, funding may be based on the results of a cost study conducted by the Board and subject to subsection (a) of this section.

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

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500545

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Proposed date of adoption: April 21, 2005

For further information, please call: (512) 427-6114



CHAPTER 5. RULES APPLYING TO PUBLIC UNIVERSITIES AND/OR HEALTH-RELATED INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §5.6

The Texas Higher Education Coordinating Board proposes amendments to §5.6 concerning distribution of operating costs of the Common Admission Application. Specifically, the amendments would allow a different fee structure to be used in assessing the annual cost of using the Texas Common Application by Texas community colleges than the fee structure used by general academic teaching institutions.

Ms. Lois Hollis, Assistant Commissioner for Student Services, has determined that for each year of the first five years the section is in effect, there will be no fiscal implications to the state. There will be no fiscal implications to local government as a result of enforcing or administering the rules.

Ms. Hollis has also determined that for each year of the first five years the section is in effect, the public benefit anticipated

as a result of administering the section will be to help increase the number of students enrolling in higher education in Texas. There is no effect on small businesses. There is no anticipated economic cost 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 Lois Hollis, P.O. Box 12788, Austin, Texas 78711, 512-427-6465, Lois.Hollis@thehb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §51.762, which provides that the Coordinating Board, with the assistance of an advisory committee composed of representatives of general academic teaching institutions and in consultation with affected general academic teaching institutions, shall adopt by rule a common admission application form for use by a person seeking admission as a freshman student to a general academic teaching institution. The agency's statutory authority to contract with other entities, found in the Texas Education Code, §61.067, allows the Board to contract with community colleges for use of the Common Application.

The amendments affect Texas Education Code, §51.762.

§5.6. *Common Admission Application.*

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

(f) The Coordinating Board shall enter into a contract with a public institution of higher education to maintain the electronic common application system for use by the public in applying for admission to participating institutions and for distribution of the electronic application to the participating institutions designated by the applicant. Operating costs of the system will be paid for by all institutions required to use the common application plus those institutions that have contracted for use of the electronic application. Each participating institution will pay a portion of the cost based on the percentage of its enrollment compared to the total enrollment of all participating institutions based on the previous year's certified enrollment data. However, the Coordinating Board may, by contract, implement a reduced rate for participating community colleges. The Board shall monitor the cost of the system and notify the institution on an annual basis of their share of the cost. Billings for the services for the coming year will be calculated and sent to the institutions in March and payments must be received by September 15.

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

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500457

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Proposed date of adoption: April 21, 2005

For further information, please call: (512) 427-6114



SUBCHAPTER B. ROLE AND MISSION, TABLES OF PROGRAMS, COURSE INVENTORIES

19 TAC §5.23, §5.24

The Texas Higher Education Coordinating Board proposes amendments to §5.23 and §5.24 concerning planning authority for degree programs and the delegation of authority for approval of new degree programs at public universities and health-related institutions. Specifically, the amendments change the term planning authority to preliminary authority, require an institution requesting a new doctoral program to have prior preliminary authority for the program, and allow institutions to ask for a change in its table of programs for additional preliminary authority requests more often than every four years.

Dr. Marshall A. Hill, Assistant Commissioner for Universities and Health-Related Institutions, has determined that for each year of the first five years the section is in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rules.

Dr. Hill has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering these sections will be the clarification of the concept of preliminary authority, more control by the Board for approval of doctoral programs, and increased institutional flexibility in strategic planning. There is no effect on small businesses. There is 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 proposed rules may be submitted to Marshall A. Hill, Ph.D., Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711-2788, or by e-mail to Marshall.Hill@theccb.state.tx.us. Comments will be accepted for 30 days following publication of the proposed rules in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §61.027, which provides the Coordinating Board with general rule-making authority; §61.002, which establishes the Coordinating Board as an agency charged to provide leadership and coordination for the Texas higher education system; and §61.051, which provides the Coordinating Board with authority to coordinate institutions of public higher education in promoting quality education.

Texas Education Code, §61.002; and Texas Education Code, §61.051.

§5.23. Definitions.

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

(1) Preliminary [Authority or Planning] Authority--permission from the State of Texas to propose new [plan or offer] degree programs in a given disciplinary area at a given level of instruction. The Table of Programs, defined in paragraph (9) of this section, prescribes the academic areas and levels that are approved by the Board as being appropriate for an institution's existing role and mission.

(2) - (11) (No change.)

§5.24. Criteria and Approval of Mission Statements and Tables of Programs.

(a) Criteria. In reviewing an institution's request for additions to its Table of Programs for preliminary authority [the program authority of an institution], the Board shall consider:

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

(b) Review and Approval Process.

(1) As provided by Texas Education Code, §61.051 (e), at least every four years the Board shall review the role and mission statements, the table of programs and all degree and certificate programs offered by each public senior university or health related institution. Requests for preliminary authority for new degree programs shall be presented as part of this review. The review shall include the participation of the institution's board of regents.

(2) - (3) (No change.)

(4) Outside the normal review process described in paragraph 1 of this subsection, an institution may request of the Board an amendment to its authorized role and mission and/or preliminary authority for additional degree programs at any time the Commissioner determines that compelling circumstances warrant.

(5) [(4)] After approval or re-approval, requests for new programs and administrative changes shall be considered in the context of the approved role and mission for the institution.

[(5) An institution may request an amendment to its authorized role and mission at any time circumstances warrant.]

(6) The Commissioner may approve minor changes to the mission statement or table of programs of an institution during the period between the [four-year] reviews referenced in paragraph (1) of this subsection.

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

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500452
Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: April 21, 2005
For further information, please call: (512) 427-6114

◆ ◆ ◆
**SUBCHAPTER C. APPROVAL OF
NEW ACADEMIC PROGRAMS AND
ADMINISTRATIVE CHANGES AT PUBLIC
UNIVERSITIES AND/OR HEALTH-RELATED
INSTITUTIONS**

19 TAC §5.44, §5.50

The Texas Higher Education Coordinating Board proposes amendments to §5.44 and §5.50 concerning planning authority for degree programs and the delegation of authority for approval of new degree programs at public universities and health-related institutions. Specifically, the amendments change the term planning authority to preliminary authority, and permit the Commissioner to delegate to the Assistant Commissioner for Academic Affairs and Research approval of new degree programs at public universities and health-related institutions.

Dr. Marshall A. Hill, Assistant Commissioner for Universities and Health-Related Institutions, has determined that for each year of the first five years the section is in effect, there will not be

any fiscal implications to state or local government as a result of enforcing or administering the rules.

Dr. Hill has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering these sections will be the clarification of the concept of preliminary authority, more control by the Board for approval of doctoral programs, and increased institutional flexibility in strategic planning. There is no effect on small businesses. There is 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 proposed rules may be submitted to Marshall A. Hill, Ph.D., Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711-2788, or by e-mail to Marshall.Hill@thehb.state.tx.us. Comments will be accepted for 30 days following publication of the proposed rules in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §61.027, which provides the Coordinating Board with general rule-making authority; §61.002, which establishes the Coordinating Board as an agency charged to provide leadership and coordination for the Texas higher education system; and §61.051, which provides the Coordinating Board with authority to coordinate institutions of public higher education in promoting quality education.

Texas Education Code, §61.002; and Texas Education Code, §61.051.

§5.44. Presentation of Requests and Steps for Implementation.

(a) (No change.)

(b) Requests for new degree and certificate programs and for administrative changes require:

(1) Approval by the Board of preliminary [planning] authority, if needed prior to Board consideration; all requests for doctoral programs require preliminary authority prior to Board consideration.

(2) - (4) (No change.)

§5.50. Approvals by the Commissioner.

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

(f) If a proposal does not meet the criteria specified in this section, the Commissioner may deny approval or forward it to the Board for consideration at an appropriate quarterly meeting. Institutions may appeal the [Commissioner's] decision to deny approval to the Board.

(g) - (h) (No change.)

(i) The authority given to the Commissioner to approve proposals from public universities and health-related institutions for new degree programs (and other related duties given under this paragraph) may be delegated by the Commissioner to the Assistant Commissioner for Academic Affairs and Research.

(j) [(+) Each quarter, the Commissioner shall send a list of his approvals and disapprovals under this section to Board members. A list of the approvals and disapprovals shall also be attached to the minutes of the next quarterly Board meeting.

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

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500453

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Proposed date of adoption: April 21, 2005

For further information, please call: (512) 427-6114

◆ ◆ ◆
CHAPTER 7. PRIVATE AND OUT-OF-STATE
PUBLIC POSTSECONDARY EDUCATIONAL
INSTITUTIONS OPERATING IN TEXAS
SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §7.7, §7.9

The Texas Higher Education Coordinating Board proposes amendments to §7.7 and §7.9 concerning standards for certificates of authority and standards for off-campus operations at exempt institutions. Specifically, the standards of the Board in §7.7 of the Board's rules, which set out the standards for unaccredited institutions seeking certificates of authority to grant degrees, and in §7.9, which set out the standards for accredited out-of-state institutions seeking authority to operate off-campus locations in Texas, are being modified to make certain requirements of the Board more explicit and to change certain requirements to be more consistent with standard educational practice in the United States. Section 7.7(1) changes "proprietary" to "career" to be consistent with current terminology. Section 7.7(2) makes explicit the qualifications of the chief academic officer. Section 7.7(3) clarifies the mission of the governing board and adds the requirement of a compliance committee of the governing board. Section 7.7(6) creates explicit auditing requirements to accommodate for-profit institutions. Section 7.7(8) addresses the Texas Success Initiative and appropriate standards for assessing foreign credentials. Section 7.7(9) allows experience to be included in documenting the qualifications of faculty. Section 7.7(12) further defines what constitutes an adequate curriculum and sets out minimum and maximum lengths of programs. Section 7.7(13) sets out the minimum length of the general education requirement. Section 7.7(14) limits the credit for work outside a collegiate setting which may be applied to a degree. Section 7.7(15) clarifies the responsibilities of the librarian. Section 7.7(18) clarifies the items to be included in the academic catalog. Section 7.7(20) changes "student handbook" to "Student rights and responsibilities" to clarify the purpose of the standard. Section 7.9(a)(2) changes language to use a term that has been defined herein. Section 7.9(b)(5) addresses the Texas Success Initiative and appropriate standards for assessing foreign credentials. Section 7.9(b)(6) allows experience to be included in documenting the qualifications of faculty. Section 7.9(b)(9) further defines what constitutes an adequate curriculum and sets out minimum and maximum length of programs. Section 7.9(b)(10) sets out the minimum length of the general education requirement. Section 7.9(b)(11) limits the credit for work outside a collegiate setting which may be applied to a degree. Section 7.9(b)(12) clarifies the responsibilities of the librarian. Section 7.9(b)(15) clarifies the items to be included in the academic catalog. Section 7.9(b)(17) changes "student handbook" to "Student rights and responsibilities" to clarify purpose of the standard.

Dr. Marshall A. Hill, Assistant Commissioner for Universities and Health-Related Institutions, has determined that for each year of

the first five years the amendments are in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rules.

Dr. Hill has also determined that for each year of the first five years the amendment is in effect, the public benefit anticipated as a result of administering this amendment will be the improved organization and clarity of rules affecting private and out-of-state institutions offering baccalaureate, graduate or professional degrees in Texas. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no impact on local employment.

Comments on the proposed rules may be submitted to Marshall A. Hill, Ph.D., Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711-2788, or by e-mail to Marshall.Hill@thehb.state.tx.us. Comments will be accepted for 30 days following publication of the proposed rules in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §61.027, which provides the Board with general rule-making authority; Texas Education Code, §61.002, which establishes the Board as an agency charged to provide leadership and coordination for the Texas higher education system; Texas Education Code, §§61.301 - 61.319, concerning regulation of private postsecondary education institutions; §61.311, which provides the Board with the authority to promulgate rules governing certificates of authority; Texas Education Code, §§61.401 - 405, regarding regulation of public institutions of higher education established outside the boundaries of the State of Texas; and Texas Education Code, §61.403 which provides the Board with the authority to promulgate rules regarding out of state public institutions.

The amendments affect Texas Education Code, §§61.301 - 61.319, and Texas Education Code, §§61.401 - 61.405.

§7.7. *Standards for Certificates of Authority.*

The decision to grant a certificate of authority to an institution will be based on its demonstrated compliance with the following twenty-one standards. Particular attention will be paid to the institution's commitment to education, responsiveness to recommendations and suggestions for improvement, and, in the case of a renewal of a certificate of authority, record of improvement and progress following initial approval which would ensure accreditation within the time limits specified in §7.6(c)(3) of this title (relating to Certificate of Authority). The twenty-one standards represent generally accepted administrative and academic practices and principles of accredited institutions of higher education in Texas. Such practices and principles are generally set forth by regional and specialized accrediting bodies and the academic and professional societies which have established standards for their members' programs, such as the National Association of College and University Business Officers and the American Association of Collegiate Registrars and Admissions Officers.

(1) **Legal Compliance.** The institution shall be maintained and operated in compliance with all applicable ordinances and laws, including the rules and regulations adopted to administer those ordinances and laws. The institution shall demonstrate compliance with the Texas Education Code, Chapter 132 by supplying a copy of a certificate of approval to operate a career school or college [proprietary] school or a letter of exemption from the Texas Workforce Commission.

(2) **Qualifications of Institutional Officers.** The character, education, and experience in higher education of governing board

members, administrators, supervisors, counselors, agents, and other institutional officers shall be such as may reasonably ensure that the students will receive education consistent with the objectives of the course or program of study. In particular, the chief academic officer [administrator] shall be qualified by level and area of academic preparation, as well as through appropriate experience, to direct the academic affairs of the institution. In general, this requires at least five years of administrative experience at an institution of higher education accredited by a recognized accreditor or a master's degree with major in higher education administration awarded by an institution accredited by a recognized accreditor.

(3) **Governing Board.** The institution shall have a governing board [~~of the institution,~~] consisting of at least five members. [~~] The institution's governing board shall be an active policy-making body, focused on promoting the mission of the institution [independent from any person or organization], and shall exercise its authority to ensure that the mission of the institution is carried out. Members of the board shall represent the interests of the institution's constituencies of faculty, students, and supporters. The institution's governing board shall have a compliance committee consisting of not fewer than three board members. No member of the compliance committee shall have contractual, employment, personal or familial, or financial interest in the institution. The compliance committee as a whole shall be responsible for reviewing continuous compliance with this chapter and shall report in writing to the full governing board at least annually. The governing board shall ensure that the institution complies with this chapter. [The presiding officer of the board, along with a majority of the other voting members, shall have no contractual, employment, or personal or familial financial interest in the institution and derive no financial gain from the operations of the institution.]~~

(4) - (5) (No change.)

(6) **Financial Records.** Financial records and reports of the institution shall be kept and made separate and distinct from those of any affiliated or sponsoring person or entity. Financial records and reports at a not-for-profit institution shall be kept in accordance with the guidelines of the National Association of College and University Business Officers as set forth in College and University Business Administration, (Sixth Edition), or such later editions as may be published. Financial records and reports of a for-profit institution shall be kept in accordance with generally accepted accounting principles. A for-profit institution shall organize its reports and records under categories or cost centers comparable to accounting funds as set forth in College and University Business Administration, (Sixth Edition), or such later editions as may be published. An annual independent audit of all fiscal accounts of the educational institution shall be authorized by the governing board and shall be performed by a properly authorized certified public accountant.

(7) (No change.)

(8) **Student Admission and Remediation.**

(A) Upon the admission of a student to any undergraduate program, the institution shall document the student's level of preparation to undertake college level work by obtaining proof of the student's high school graduation or General Educational Development (GED) certification and by assessing the academic skills of each entering student with an instrument approved in §4.56 of this title (relating to Assessment Instruments), and otherwise complying with §§4.51 - 4.59 of this title (relating to the Texas Success Initiative) [appropriate diagnostic tests]. If a GED is presented, to be valid, the score must be at or above the passing level set by the Texas Education Agency. The institution shall provide an effective program of remediation for students diagnosed with deficiencies in their preparation for collegiate study.

(B) Upon the admission of a student to any graduate program, the institution shall document that the student is prepared to undertake graduate-level work by obtaining proof that the student holds a baccalaureate degree from an institution accredited by a recognized accrediting agency, or an institution holding a certificate of authority to offer baccalaureate degrees under the provisions of this chapter, or a degree from a foreign institution equivalent to a baccalaureate degree from an accredited institution. The procedures used by the institution for establishing the equivalency of a foreign degree shall be consistent with the guidelines of the National Council on the Evaluation of Foreign Education Credentials or its successor. [The institution shall follow standard practice in assessing the credentials of students who graduated from foreign institutions.]

(9) Faculty Qualifications. The character, education, and experience in higher education of the faculty shall be such as may reasonably ensure that the students will receive an education consistent with the objectives of the course or program of study.

(A) Each faculty member teaching in an academic associate or baccalaureate level degree program shall have at least a master's degree from an institution accredited by a recognized agency with at least 18 graduate semester credit hours in the discipline, or closely related discipline, being taught.

(B) At least 25 percent of the courses in an academic associate or baccalaureate level major shall be taught by faculty members holding doctorates, or other [terminal] degrees, generally recognized as the highest attainable in the discipline, or closely related discipline, being taught, from institutions accredited by a recognized agency.

(C) - (D) (No change.)

(E) Graduate-level degree programs shall be taught by faculty holding doctorates, or other degrees generally recognized as the highest attainable in the discipline, or closely related discipline, awarded by [being taught from] institutions accredited by an agency recognized by the Board [a recognized agency].

(F) With the approval of a majority of the institution's governing board, an individual with exceptional experience in the field of appointment, which may include direct and relevant work experience, professional licensure and certification, honors and awards, continuous documented excellence in teaching, or other demonstrated competencies and achievements, may serve as a faculty member without the degree credentials specified above. Such appointments shall be limited and the justification for appointment fully documented. The Coordinating Board shall evaluate the qualifications of the full complement of faculty providing instruction at the institution to determine that such appointments are justified and make up a small percentage of the faculty as a whole.

(10) - (11) (No change.)

(12) Curriculum.

(A) The quality, content, and sequence of each course, curriculum, or program of instruction, training, or study shall be appropriate to the purpose of the institution and shall be such that the institution may reasonably and adequately achieve the stated objectives of the course or program. Each program shall adequately cover the breadth of knowledge of the discipline taught and coursework must build on the knowledge of previous courses to increase the rigor of instruction and the learning of students in the discipline. Substantially all of the courses in the areas of specialization required for each degree program shall be offered in organized classes by the institution. An institution may offer no more than a very limited amount of for-credit coursework that does not directly relate to approved programs. [provided such courses are appropriate to the level of the institution.]

(B) An academic associate degree must consist of at least 60 semester credit hours or 90 quarter credit hours and not more than 66 semester credit hours or 99 quarter credit hours. A baccalaureate degree must consist of at least 120 semester credit hours or 180 quarter credit hours and not more than 139 semester credit hours or 208 quarter credit hours. A master's degree must consist of at least 30 semester credit hours or 45 quarter credit hours and not more than 36 semester credit hours or 54 quarter credit hours of graduate level work past the baccalaureate degree.

(C) Courses designed to correct deficiencies, remedial courses for associate and baccalaureate programs, and leveling courses for graduate programs, shall not count toward requirements for completion of the degree.

(D) The degree level, degree designation, and the designation of the major course of study shall be appropriate to the curriculum offered and shall be accurately listed on the student's diploma and transcript.

(13) General Education.

(A) Each academic associate degree program shall contain a general education component consisting of at least 30 semester credit hours or 45 quarter credit hours. Each baccalaureate degree program shall contain a general education component consisting of at least 25 percent of the total hours required for graduation from the program. [Each associate or baccalaureate degree program shall contain a general education component consisting of at least 25 percent of the total hours required for graduation from the program.]

(B) (No change.)

~~{(C) Courses designed to correct deficiencies, remedial courses for associate and baccalaureate programs, and leveling courses for graduate programs, may not count toward general education requirements for the degree.}~~

(C) ~~[(D)]~~ The applicant institution may arrange to have all or part of the general education component taught by another institution, provided that:

(i) the applicant institution's faculty shall design the general education requirement;

(ii) there shall be a written agreement between the institutions specifying the applicant institutions' general education requirements and the manner in which they will be met by the providing institution;

(iii) at least one-half of the courses shall be offered in organized classes; and

(iv) the providing institution shall be accredited by a recognized accrediting agency.

(14) Credit for Work Completed Outside a Collegiate Setting.

(A) (No change.)

(B) No more than one quarter of the credit applied toward [15 semester credit hours or 23 quarter credit hours in] a student's associate or baccalaureate degree program may be based on work completed outside a collegiate setting. Those credits must be [and] validated in the manner set forth in subparagraph (A) of this paragraph. No more than 15 semester credit hours or 23 quarter credit hours of that credit may be awarded by means other than recognized evaluative examinations. No graduate credit for work completed outside a collegiate setting may be awarded. In no instance may credit be awarded for life experience per se or merely for years of service in a position or job.

(15) Library.

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

(C) The librarian shall hold a graduate degree in library science from an institution accredited by a recognized accrediting agency. The librarian shall have authority to select and acquire resources with funds in the library budget, have interaction with faculty sufficient to ensure a library collection that supports the courses and programs offered, and have adequate interaction with students to support the library and research needs of the students.

(D) (No change.)

(16) - (17) (No change.)

(18) Accurate and Fair Representation in Publications, Advertising, and Promotion.

(A) (No change.)

(B) The institution shall provide students, prospective students prior to enrollment, and other interested persons with a catalog containing, at minimum, the following information:

(i) the institution's mission;

(ii) a statement of admissions policies;

(iii) information describing the purpose, length, and objectives of the program or programs offered by the institution;

(iv) the schedule of tuition, fees, and all other charges and expenses necessary for completion of the course of study;

(v) cancellation and refund policies;

(vi) a definition of the unit of credit as it applies at the institution;

(vii) an explanation of satisfactory progress as it applies at the institution, including an explanation of the grading or marking system;

(viii) the institution's calendar, including the beginning and ending dates for each instructional term, holidays, and registration dates;

(ix) a complete listing of each regularly employed faculty member showing name, area of assignment, rank, and each earned degree held, including degree level, degree designation, and institution that awarded the degree;

(x) a complete listing of each administrator showing name, title, area of assignment, and each earned degree held, including degree level, degree designation, and institution that awarded the degree;

(xi) a statement of legal control with the names of the trustees, directors, and officers of the corporation;

(xii) a complete listing of all scholarships offered, if any;

(xiii) a statement describing the nature and extent of available student services;

(xiv) complete and clearly stated information about the transferability of credit to other postsecondary institutions including two-year and four-year colleges and universities;

(xv) a statement of Texas Success Initiative requirements;

(xvi) any such other material facts concerning the institution and the program or course of instruction as are reasonably likely to affect the decision of the student to enroll therein; and

(xvii) any disclosures specified by the Board or defined in Board rules. [The institution shall provide students, prospective students prior to enrollment, and other interested persons with a catalog containing information describing the purpose, length, and objectives of the programs offered by the institution; its schedule of tuition, fees, and all other charges and expenses necessary for completion of the course of study; its cancellation and refund policy; a list of administrative personnel and faculty members, including the degrees held by each person and the institutions awarding those degrees; and such other material facts concerning the institution and the program or course of instruction as are reasonably likely to affect the decision of the student to enroll therein. Any disclosures specified by the Board or defined in the rules shall be included. The cancellation and refund policy of the institution shall be fair and shall be applied equitably.]

(C) The cancellation and refund policy of the institution shall be fair and shall be applied equitably.

(D) The institution shall provide to each prospective student, newly-enrolled student, and returning student, complete and clearly presented information indicating the institution's current graduation rate by program and, if required by the Board, job placement rate by program.

(E) Any special requirements, or limitations of program offerings, for the students at the Texas branch must be made explicit in writing. This may be accomplished by either a separate section in the catalog or a brochure separate from the catalog. However, if a brochure is produced, the student must also be given the regular catalog.

(F) [(C)] Upon satisfactory completion of the program of study, the student shall be given appropriate educational credentials indicating the degree level, degree designation, and the designation of the major course of study, and a transcript accurately listing the information typically found on such a document, subject to institutions' obligation, if any, to cooperate with the rules and regulations governing state, and federally guaranteed student loans.

(19) (No change.)

(20) Student Rights and Responsibilities [Handbook]. The institution shall establish and adhere to a clear and fair policy regarding due process in disciplinary matters, and publish this policy in a handbook, which shall include other rights and responsibilities of the students. This handbook shall be supplied to each student upon enrollment in the institution.

(21) (No change.)

§7.9. Operation of Branch Campuses, Extension Centers, or Other Off-Campus Units by Exempt Institutions.

(a) Off-Campus Operations.

(1) (No change.)

(2) An exempt private postsecondary institution must be approved by the Board to operate a branch campus, extension center, or other off-campus unit in Texas, except as noted in §7.4(a)(2) of this title (relating to Exemptions, Revocation of Exemptions and Certificates of Authorization).

(3) - (9) (No change.)

(b) Standards for Off-Campus Operations at Exempt Institutions.

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

(5) Student Admission and Remediation.

(A) Upon the admission of a student to any undergraduate program, the institution shall document the student's level of preparation to undertake college level work by obtaining proof of the student's high school graduation or General Educational Development (GED) certification and by assessing the academic skills of each entering student with an instrument approved in §4.56 of this title (relating to Assessment Instruments), and otherwise complying with §§4.51 - 4.59 of this title (relating to the Texas Success Initiative) [appropriate diagnostic tests]. If a GED is presented, to be valid, the score must be at or above the passing level set by the Texas Education Agency. The institution shall provide an effective program of remediation for students diagnosed with deficiencies in their preparation for collegiate study.

(B) Upon the admission of a student to any graduate program, the institution shall document that the student is prepared to undertake graduate-level work by obtaining proof that the student holds a baccalaureate degree from an institution accredited by a recognized accrediting agency, or an institution holding a certificate of authority to offer baccalaureate degrees under the provisions of this chapter, or a degree from a foreign institution equivalent to a baccalaureate degree from an accredited institution. The procedures used by the institution for establishing the equivalency of a foreign degree shall be consistent with the guidelines of the National Council on the Evaluation of Foreign Education Credentials or its successor. [The institution shall follow standard practice in assessing the credentials of students who graduated from foreign institutions.]

(6) Faculty Qualifications. The character, education, and experience in higher education of the faculty shall be such as may reasonably ensure that the students will receive an education consistent with the objectives of the course or program of study.

(A) Each faculty member teaching in an academic associate or baccalaureate level degree program shall have at least a master's degree from an institution accredited by a recognized agency with at least 18 graduate semester credit hours in the discipline, or closely related discipline, being taught.

(B) At least 25 percent of the courses in an academic associate or baccalaureate level major shall be taught by faculty members holding doctorates, or other degrees generally recognized as the highest attainable in the discipline, or closely related discipline, being taught, from institutions accredited by a recognized agency.

(C) - (D) (No change.)

(E) Graduate-level degree programs shall be taught by faculty holding doctorates, or other [terminal] degrees, generally recognized as the highest attainable in the discipline, or closely related discipline, being taught from institutions accredited by a recognized agency.

(F) With the approval of a majority of the institution's governing board, an individual with exceptional experience in the field of appointment, which may include direct and relevant work experience, professional licensure and certification, honors and awards, continuous documented excellence in teaching, or other demonstrated competencies and achievements, may serve as a faculty member without the degree credentials specified above. Such appointments shall be limited and the justification for appointment fully documented. The Coordinating Board shall evaluate the qualifications of the full complement of faculty providing instruction at the institution to determine that such appointments are justified and make up a small percentage of the faculty as a whole. [The institution may be justified in allowing a limited number of faculty members to teach classes

on the basis of their expertise in the field; but the expertise, and not mere competence, should be well documented. Difficulty in finding qualified faculty does not constitute a basis for an exception.]

(7) - (8) (No change.)

(9) Curriculum.

(A) The quality, content, and sequence of each course, curriculum, or program of instruction, training, or study shall be appropriate to the purpose of the institution and shall be such that the institution may reasonably and adequately achieve the stated objectives of the course or program. Each program shall adequately cover the breadth of knowledge of the discipline taught and coursework must build on the knowledge of previous courses to increase the rigor of instruction and the learning of students in the discipline. Substantially all of the courses in the areas of specialization required for each degree program shall be offered in organized classes by the institution. An institution may offer no more than a very limited amount of for-credit coursework that does not directly relate to approved programs. [; provided such courses are appropriate to the level of the institution. The degree level, degree designation, and the designation of the major course of study shall be appropriate to the curriculum offered and shall be accurately listed on the student's diploma and transcript.]

(B) An academic associate degree must consist of at least 60 semester credit hours or 90 quarter credit hours and not more than 66 semester credit hours or 99 quarter credit hours. A baccalaureate degree must consist of at least 120 semester credit hours or 180 quarter credit hours and not more than 139 semester credit hours or 208 quarter credit hours. A master's degree must consist of at least 30 semester credit hours or 45 quarter credit hours and not more than 36 semester credit hours or 54 quarter credit hours of graduate level work past the baccalaureate degree.

(C) Courses designed to correct deficiencies, remedial courses for associate and baccalaureate programs, and leveling courses for graduate programs, shall not count toward requirements for completion of the degree.

(D) The degree level, degree designation, and the designation of the major course of study shall be appropriate to the curriculum offered and shall be accurately listed on the student's diploma and transcript.

(10) General Education.

(A) Each academic associate degree program shall contain a general education component consisting of at least 30 semester credit hours or 45 quarter credit hours. Each baccalaureate degree program shall contain a general education component consisting of at least 25 percent of the total hours required for graduation from the program. [Each associate or baccalaureate degree program shall contain a general education component consisting of at least 25 percent of the total hours required for graduation from the program.]

(B) (No change.)

~~{(C) Courses designed to correct deficiencies, remedial courses for associate and baccalaureate programs, and leveling courses for graduate programs, may not count toward general education requirements for the degree.}~~

(C) ~~{(D)}~~ The applicant institution may arrange to have all or part of the general education component taught by another institution, provided that:

(i) the applicant institution's faculty shall design the general education requirement;

(ii) there shall be a written agreement between the institutions specifying the applicant institutions' general education requirements and the manner in which they will be met by the providing institution;

(iii) at least one-half of the courses shall be offered in organized classes; and

(iv) the providing institution shall be accredited by a recognized accrediting agency.

(11) Credit for Work Completed Outside a Collegiate Setting.

(A) (No change.)

(B) No more than one quarter of the credit applied toward ~~30 semester credit hours or 46 quarter credit hours in~~ a student's associate or baccalaureate degree program may be based on work completed outside a collegiate setting. Those credits must be ~~and~~ validated in the manner set forth in subparagraph (A) of this paragraph. No more than 15 semester credit hours or 23 quarter credit hours of that credit may be awarded by means other than recognized evaluative examinations. No graduate credit for work completed outside a collegiate setting may be awarded. In no instance may credit be awarded for life experience per se or merely for years of service in a position or job.

(12) Library.

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

(C) The librarian shall hold a graduate degree in library science from an institution accredited by a recognized accrediting agency. The librarian shall have authority to select and acquire resources with funds in the library budget, have interaction with faculty sufficient to ensure a library collection that supports the courses and programs offered, and have adequate interaction with students to support the library and research needs of the students.

(D) (No change.)

(13) - (14) (No change.)

(15) Accurate and Fair Representation in Publications, Advertising, and Promotion.

(A) (No change.)

(B) The institution shall provide students, prospective students prior to enrollment, and other interested persons with a catalog containing, at minimum, the following information:

(i) the institution's mission;

(ii) a statement of admissions policies;

(iii) information describing the purpose, length, and objectives of the program or programs offered by the institution;

(iv) the schedule of tuition, fees, and all other charges and expenses necessary for completion of the course of study;

(v) cancellation and refund policies;

(vi) a definition of the unit of credit as it applies at the institution;

(vii) an explanation of satisfactory progress as it applies at the institution, including an explanation of the grading or marking system;

(viii) the institution's calendar, including the beginning and ending dates for each instructional term, holidays, and registration dates;

(ix) a complete listing of each regularly employed faculty member showing name, area of assignment, rank, and each earned degree held, including degree level, degree designation, and institution that awarded the degree;

(x) a complete listing of each administrator showing name, title, area of assignment, and each earned degree held, including degree level, degree designation, and institution that awarded the degree;

(xi) a statement of legal control with the names of the trustees, directors, and officers of the corporation;

(xii) a complete listing of all scholarships offered, if any;

(xiii) a statement describing the nature and extent of available student services;

(xiv) complete and clearly stated information about the transferability of credit to other postsecondary institutions including two-year and four-year colleges and universities;

(xv) a statement of Texas Success Initiative requirements;

(xvi) any such other material facts concerning the institution and the program or course of instruction as are reasonably likely to affect the decision of the student to enroll therein; and

(xvii) any disclosures specified by the Board or defined in Board rules. [The institution shall provide students, prospective students prior to enrollment, and other interested persons with a catalog containing information describing the purpose, length, and objectives of the programs offered by the institution; its schedule of tuition, fees, and all other charges and expenses necessary for completion of the course of study; its cancellation and refund policy; a list of administrative personnel and faculty members, including the degrees held by each person and the institutions awarding those degrees; and such other material facts concerning the institution and the program or course of instruction as are reasonably likely to affect the decision of the student to enroll therein. Any disclosures specified by the Board or defined in the rules shall be included. The cancellation and refund policy of the institution shall be fair and shall be applied equitably to the Texas Residents.]

(C) The cancellation and refund policy of the institution shall be fair and shall be applied equitably.

(D) The institution shall provide to each prospective student, newly-enrolled student, and returning student, complete and clearly presented information indicating the institution's current graduation rate by program and job placement rate by program.

(E) ~~(C)~~ Any special requirements, or limitations of program offerings, for the students at the Texas branch must be made explicit in writing. This may be accomplished by either a separate section in the catalog or a brochure separate from the catalog. However, if a brochure is produced, the student must also be given the regular catalog.

(F) ~~(D)~~ Upon satisfactory completion of the program of study, the student shall be given appropriate educational credentials indicating the degree level, degree designation, and the designation of the major course of study, and a transcript accurately listing the information typically found on such a document, subject to institutions' obligation, if any, to cooperate with the rules and regulations governing state, and federally guaranteed student loans.

(16) (No change.)

(17) Student Rights and Responsibilities [~~Handbook~~]. The institution shall establish and adhere to a clear and fair policy regarding due process in disciplinary matters, and publish this policy in a handbook, which shall include other rights and responsibilities of the students. This handbook shall be supplied to each student upon enrollment in the institution.

(18) (No change.)

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

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500454

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Proposed date of adoption: April 21, 2005

For further information, please call: (512) 427-6114



CHAPTER 9. PROGRAM DEVELOPMENT IN PUBLIC TWO-YEAR COLLEGES SUBCHAPTER E. CERTIFICATE AND ASSOCIATE DEGREE PROGRAMS

19 TAC §9.93, §9.96

The Texas Higher Education Coordinating Board proposes amendments to §9.93 and §9.96, concerning approval of certificate programs and applied associate degree programs. Specifically, the amendments permit the Commissioner to delegate to the Assistant Commissioner for Academic Affairs and Research the approval of all certificate programs and applied associate degree programs that comply with Board policies as outlined in the Guidelines for Instructional Programs in Workforce Education.

Dr. Glenda O. Barron, Assistant Commissioner for Community and Technical Colleges, has determined that for each year of the first five years the sections are in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the sections.

Dr. Barron 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 administering these sections will be to allow the Commissioner more flexibility in delegating authority to an Assistant Commissioner in approving requests for new certificate programs, applied associate degree programs, and administrative changes. There is no effect on small businesses. There is no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Glenda O. Barron, Ph.D., Texas Higher Education Coordinating Board, P. O. Box 12788, Austin, Texas 78711-2788, or by e-mail to Glenda.Barron@thehb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §61.027, which provides the Coordinating Board with general rule-making authority; §61.002, which establishes the Coordinating Board as an agency charged to provide leadership and coordination for the Texas higher education system; and §61.051, which provides the Coordinating Board with authority to coordinate institutions of public higher education in promoting quality education.

Texas Education Code, §61.002; and Texas Education Code §61.051.

§9.93. Application, Approval, and Revision Procedures for Instructional Programs in Workforce Education

(a) In accordance with the Guidelines for Instructional Programs in Workforce Education as approved by the Board, each institution wishing to offer a new certificate or applied associate degree program must have completed the following procedures:

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

~~[(4) The Assistant Commissioner for the Community and Technical Colleges Division shall recommend certificate and applied associate degree programs to the Commissioner for approval or disapproval or referral to the Board.]~~

[(5)] New Program Approval. The Board delegates to the Commissioner final approval authority for all certificate programs, and for applied associate degree programs that meet Board policies for approval as outlined in the Guidelines for Instructional Programs in Workforce Education. The Commissioner may delegate this final authority to the Assistant Commissioner for Academic Affairs and Research.

[(5)] ~~[(6)]~~ Each quarter, the Commissioner shall send a list of the [his] approvals and disapprovals under this section to Board members. A list of the approvals and disapprovals shall also be attached to the minutes of the next appropriate quarterly meeting.

[(6)] ~~[(7)]~~ The Commissioner must forward a program to the Board for consideration at an appropriate quarterly meeting if either of the following conditions is met:

(A) The proposed program is the subject of an unresolved grievance or dispute between institutions.

(B) The Commissioner has disapproved of the proposed program and the institution has requested a Board review.

(b) - (e) (No change.)

§9.96. Disapproval of Programs; Noncompliance

No funds appropriated to any public two-year college or other institution providing certificate or associate degree programs shall be expended for any program which has not been approved by the Commissioner or the Assistant Commissioner for Academic Affairs and Research or, when applicable, by the Board.

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

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500546

Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: April 21, 2005
For further information, please call: (512) 427-6114

◆ ◆ ◆

CHAPTER 12. CAREER SCHOOLS AND COLLEGES

SUBCHAPTER B. GENERAL PROVISIONS

19 TAC §12.21

The Texas Higher Education Coordinating Board proposes amendments to §12.21 concerning the procedures for career schools and colleges to seek authority to offer academic degrees. Specifically, §§12.1 - 12.46 of Board rules set forth provisions allowing institutions holding from the Texas Workforce Commission a certificate of approval to operate a career school or college to gain permission from the Coordinating Board to offer applied associate degrees. The proposed amendment to §12.21 would make more explicit the point that institutions have the option to obtain approval to offer academic degrees in Texas under the existing provisions in §§7.1 - 7.17 of the Board's rules. This change would add a reference to the procedures for seeking degree granting authority into the section heading to draw attention to the procedures and to clarify that career schools and colleges are specifically included in the group of institutions eligible to apply for authority to offer academic degrees under the procedures in §§7.1 - 7.17. Since 1976, institutions of all types, including career schools and colleges, have been eligible to apply for authority from the Board to offer academic degrees. Board rules in §§7.1 - 7.17 (implementing the Texas Education Code, Chapter 61, Subchapter G) require an institution to meet the standards of the Board and then seek accreditation from an accrediting agency recognized by the Board. The institution must gain accreditation within eight years of receiving its first certificate of authority. The institution becomes exempt from Board oversight when it becomes accredited by a recognized accrediting agency.

Dr. Marshall A. Hill, Assistant Commissioner for Universities and Health-Related Institutions, has determined that for each year of the first five years the section is in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rules.

Dr. Hill has also determined that for each year of the first five years the amendments are in effect, the public benefit anticipated as a result of administering these sections will be the improved clarity of rules affecting institutions of higher education. 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 proposed rules may be submitted to Marshall A. Hill, Ph.D., Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711-2788, or by e-mail to Marshall.Hill@thehb.state.tx.us. Comments will be accepted for 30 days following publication of the proposed rules in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §§61.301-61.319. §61.311 provides the Coordinating Board with general rule-making authority regarding the use of

protected academic terms, offering of degrees and of courses said to be applicable to degrees, and institutional standards for issuance of a Certificate of Authority to grant degrees and to offer courses to be applicable toward a degree.

The amendments affect Texas Education Code, §§61.301 - 61.319.

§12.21. Degree Titles Authorized Under This Chapter.

(a) Associate of Applied Science (AAS), Associate of Applied Arts (AAA), and Associate of Occupational Studies (AOS) degrees shall be the only associate degrees authorized under this chapter.

(b) A career school or college [~~private postsecondary institution~~] seeking authority to offer an academic associate, a baccalaureate, or higher degree shall seek approval from the Board for a certificate of authority under [~~and is subject to~~] the provisions outlined in Chapter 7 of this title (relating to Private and Out-of-State Public Postsecondary Educational Institutions Operating in Texas).

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

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500455
Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: April 21, 2005
For further information, please call: (512) 427-6114

◆ ◆ ◆

CHAPTER 13. FINANCIAL PLANNING

SUBCHAPTER G. RESEARCH DEVELOPMENT FUND

19 TAC §§13.120 - 13.130

The Texas Higher Education Coordinating Board proposes new §§13.120 - 13.130, concerning reporting restricted research expenditures for equitable distribution of the Research Development Fund. Specifically, §§13.120 - 13.122 are proposed concerning purpose, scope, authority, and definitions. Section 13.123 is proposed concerning the restricted research advisory committee. Sections 13.124 - 13.130 are proposed concerning the standards and accounting methods, report on restricted research projects and activities, the restricted research review panel, the report of restricted research expenditures, report to the comptroller, reviews and appeals, and audits.

Dr. Linda Domelsmith, Director, Research, 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 government as a result of enforcing or administering the rules.

Dr. Domelsmith 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 administering the section will be the development of increasing research capacity and excellence at participating universities. There is no effect on small businesses. There is no anticipated economic costs to persons who are required to comply with the proposed sections. There is no impact on local employment.

Comments on the proposal may be submitted to Linda Domelsmith, P.O. Box 12788, Austin, Texas 78711 or by email to Linda.domelsmith@the.cb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The new sections are proposed under Texas Education Code, §62.096 which provides the Coordinating Board with the authority to verify restricted research expenditures reports to the Texas Comptroller of Public Accounts for equitable distribution of the Research Development Fund.

The new sections affect Texas Education Code, Chapter 62, Subchapter E, §§62.091 - 62.098.

§13.120. Purpose and Scope.

The purpose of this subchapter is to establish standards and accounting methods for determining restricted research expenditures, the process for reporting of verified restricted research expenditures to the Comptroller of Public Accounts, and the process for audit of the reported restricted research expenditures and for appeal of decisions relating to restricted research expenditures.

§13.121. Authority.

Texas Education Code, §62.091, establishes the Research Development Fund to promote increased research capacity at eligible general academic teaching institutions. Texas Education Code, §62.096, authorizes the Board, with the assistance of an advisory committee, to prescribe methods for the verification of allocation factors for the Research Development Fund.

§13.122. Definitions.

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

(1) Advanced Research Program/Advanced Technology Program (ARP/ATP)--research programs administered by the Board under Texas Education Code, Chapters 142 and 143.

(2) Advisory committee--The Board's Restricted Research Advisory Committee.

(3) Board or Coordinating Board--the Texas Higher Education Coordinating Board.

(4) Clinical Trial Agreement--an externally sponsored agreement for the administration of a specifically mandated patient protocol (sometimes in multiple clinical sites involving other institutions), in which some costs typically are paid from patient charges or other sources.

(5) Commissioner--Commissioner of Higher Education.

(6) Comptroller--the Texas Comptroller of Public Accounts.

(7) Demonstration Projects--projects in which the primary purpose is to apply previous Research and Development findings in new settings and to demonstrate their utility.

(8) Departmental Research--research, development, and scholarly activities that are not organized research and, consequently, are not separately budgeted by an institution.

(9) Development--the systematic use of knowledge and understanding gained from research directed toward the production of useful materials, devices, systems, or methods, including design and development of prototypes and processes.

(10) Eligible institution or institution--a general academic teaching institution, as defined by Texas Education Code, §61.003,

other than The University of Texas at Austin, Texas A&M University, and Prairie View A&M University.

(11) Higher Education Assistance Fund (HEAF)--a fund established in Article 7, §17, of the Texas Constitution to fund capital improvements and capital equipment for institutions not included in the Permanent University Fund.

(12) Indirect Costs--costs incurred for certain overhead related to administering a particular sponsored project, an instructional activity, or any other institutional activity. Indirect costs are synonymous with "facilities and administrative (F&A) costs."

(13) Industrial Collaboration Agreements--agreements with universities, colleges, centers, or institutes under which funds are provided for collaborative R&D activities. The activity must be sponsored by private philanthropic organizations and foundations, for-profit businesses, or individuals.

(14) Instruction--the teaching and training activities of an institution. This term includes all teaching and training activities, whether they are offered for credit toward a degree or certificate or on a non-credit basis, and whether they are offered through regular academic departments or separate divisions, such as a summer school division or an extension division.

(15) Multiple Function Awards--awards that have multiple goals, such as research, instruction, and public service.

(16) Organized research--research and development activities of an institution that are separately budgeted by an institution.

(17) Other Sponsored Activities--programs and projects financed by Federal and non-Federal agencies and organizations that involve the performance of work other than instruction and organized research. Examples of such programs and projects are health service projects and community service programs. Other Sponsored Activities may include travel grants, unless for research activities; support for conferences or seminars; support for university public events; provision of non-instructional and economic services beneficial to individuals and groups external to the university such as testing or diagnostic services, surveys, urban planning and mapping, etc.; publications by the university press; support for student participation in community service projects; support for projects pertaining to library collections, acquisitions, bibliographies or cataloging, unless primarily for documented research purposes, or programs to enhance institutional resources, including computer enhancements, unless primarily for documented research purposes.

(18) Permanent University Fund (PUF)--A fund established in Article 7, §11, of the Texas Constitution to fund capital improvements and capital equipment at certain institutions of higher education.

(19) Pass-Throughs to Subrecipients--external award funds passed from one entity ("pass-through" entity) to another entity (sub-recipient). The subrecipient administers the program, expending the award funds on behalf of or in connection with the pass-through entity.

(20) Research--a systematic study directed toward fuller scientific knowledge or understanding of the subject studied and the training of individuals in research techniques where such activities utilize the same facilities as other research and development activities.

(21) Research and Development (R&D)--all research activities, both basic and applied, and all development activities that are supported at universities, colleges, and other non-profit institutions. R&D also includes activities involving the training of individuals in research techniques where such activities utilize the same facilities as other research and development activities and where such activities

are not included in the instruction function. Curriculum development projects may be considered as R&D when the primary purpose of the project is to develop and test an instructional or educational model through appropriate research methodologies, such as data collection, evaluation, dissemination, and publication.

(22) Research Development Fund--a fund established outside the state treasury to promote increased research capacity at eligible general academic teaching institutions under Texas Education Code, §§62.091 - 62.098.

(23) Restricted funds (restricted awards)--funds for which some external agency or organization has placed limitations on the uses for which the funds may be spent.

(24) Sponsored Instruction and Training--specific instructional or training activity established by grant, contract, or cooperative agreement with federal, state, or local governmental agencies; private philanthropic organizations and foundations; for-profit businesses; or individuals. Sponsored Instruction includes:

(A) any project for which the primary purpose is to instruct any student at any location; recipients of this instruction may be university students or staff, teachers or students in elementary or secondary schools, or the general public;

(B) curriculum development projects at any level either to improve significantly or to add to an institution's general instructional offerings, and do not include R&D;

(C) projects that involve university students in community service activities for which they are receiving academic credit;

(D) activities funded by awards to departments or schools for the support of students, except for those activities defined in paragraph (25), part E of this Section as Sponsored R&D;

(E) dissertation work funded by grants, including grants for travel in relation to a dissertation, unless associated with a R&D activity as defined in paragraph (21) of this Section;

(F) outreach programs that bring local students on campus for classes; or

(G) general support for the writing of textbooks or reference books, video, or software to be used as instructional materials.

(25) Sponsored Research and Development (Sponsored R&D)--activity funded (sponsored) by grants, gifts, and/or contracts, including sponsored research contracts, that are designated by the sponsor as primarily for R&D purposes. The activity must be sponsored by federal, state, or local governmental agencies; private philanthropic organizations and foundations; for-profit businesses; or individuals. Sponsored R&D includes:

(A) awards to university faculty to support R&D activities;

(B) external faculty "career awards" to support the R&D efforts of the faculty;

(C) external funding to maintain facilities or equipment and/or operation of a center or facility that will be used for R&D;

(D) external support for the writing of books, when the purpose of the writing is to publish R&D results;

(E) activities involving the training of individuals in R&D techniques (commonly called R&D training) where such activities utilize the same facilities as other R&D activities and where such activities are not included in the Instruction function;

(F) the research portion of expenditures in the federal work-study program, in accordance with instructions for preparing the annual financial report that is submitted by an institution to the Comptroller after each fiscal year ends; or

(G) clinical trial agreements in which data collection and analysis are the primary components of the institution's role in the trial, excluding costs that are covered by patient charges or similar sources.

(26) University Research and Development (University R&D)--activity that is supported by unrestricted university funds that the university has designated for use in R&D, such as unrestricted gifts, distributions from unrestricted endowments, interest income, technology licensing income, fees received from external entities for non-research services, proceeds from cost recovery enterprises, state appropriations not identified specifically by the legislature for R&D purposes, non-capitalized allocations from the PUF or HEAF for R&D purposes other than construction and remodeling, state appropriations made directly to the university for R&D through formula or special item funding including ARP/ATP, or cost-sharing expenditures by the university.

§13.123. *Restricted Research Advisory Committee.*

The Commissioner shall appoint an advisory committee to review and recommend changes to standards and accounting methods for determining restricted research expenditures.

(1) The advisory committee shall consist of 11 to 15 representatives from eligible higher education institutions.

(2) The Commissioner shall select institutions that represent both system institutions and institutions that are not in systems, including institutions that provide diversity in size, mission, and geographic distribution for membership on the advisory committee.

(3) At least 30 days prior to the first meeting each calendar year, the Commissioner shall inform the president(s) of a selected institution(s) that he or she may each recommend an institutional representative to fill a vacant position on the advisory committee.

(4) Advisory committee members shall serve staggered, three-year terms.

(5) At its first meeting during each calendar year, the advisory committee shall elect a member to serve as its chair.

(6) The Commissioner may remove an advisory committee member who is absent for three consecutive meetings of the advisory committee.

§13.124. *Standards and Accounting Methods for Determining Restricted Research Expenditures.*

(a) Only those expenditures from restricted awards made from the following types of projects and activities and sponsored by federal, state, or local governmental agencies; private philanthropic organizations and foundations; for-profit businesses; or individuals shall be classified as restricted research expenditures:

(1) Sponsored R&D, as defined in §13.122 of this title (relating to Definitions).

(2) Industrial Collaboration Agreements for R&D activities, as defined in §13.122 of this title (relating to Definitions) with universities, colleges, centers, or institutions.

(3) Demonstration Projects, as defined in §13.122 of this title (relating to Definitions), which have a significant new R&D component.

(4) Sponsored instruction and training, as defined in §13.122 of this title (relating to Definitions), for curriculum development projects when the primary purpose of the project is developing and testing an instructional or educational model through appropriate research methodologies that include data collection, evaluation, dissemination, and publication.

(5) Multiple Function Awards, as defined in §13.122 of this title (relating to Definitions), if the scope or activity of the restricted award includes R&D subject to the following limitation: if the purpose of a restricted award is primarily (more than 50 percent) research, then all expenditures made from that award qualify as restricted research expenditures. If the purpose of the restricted award is not primarily research (less than 50 percent), then none of the expenditures may be counted as restricted research.

(b) Institutions shall document the process for determining restricted research awards and shall maintain documentation justifying the rationale used to classify the awards as restricted research.

§13.125. Report on Restricted Research Projects and Activities.

(a) Not later than June 30, each eligible institution shall provide to the Commissioner a verified report of restricted research projects and activities for the current state fiscal year with awards greater than \$250,000 in annual funding.

(b) Classified military projects or any sponsored program deemed confidential or proprietary by funding entities shall not be included in the award lists.

(c) The report shall be in a format and with the specific content prescribed by the Commissioner.

(d) Only those projects or activities described in §13.124(a) of this title (relating to Standards and Accounting Methods for Determining Restricted Research Expenditures) shall be included in the report.

(e) All projects and activities reported by institutions shall be classified in accordance with these rules and, if the project or activity is pursuant to an award from the federal government, shall be classified by the federal government as R&D

(f) The report shall indicate the person or persons who determined that the projects or activities were restricted research projects or activities.

(g) The Commissioner shall provide the reports made under this section to each eligible institution.

(h) Institutions that fail to provide a report of restricted research projects and activities shall not be eligible for an allocation from the Research Development Fund and shall not be included in the Board's report to the Comptroller.

§13.126. Restricted Research Review Panel.

Not later than July 31 of each year, the Commissioner shall convene a panel of representatives of all eligible institutions. The president of each eligible institution shall recommend the institution's representative on the review panel.

(1) The Commissioner shall provide each review panel member with a copy of each eligible institution's report on restricted research awards.

(2) The review panel shall examine the institutions' reports on restricted research awards and provide a report to the Commissioner, recommending to the Commissioner those awards from which expenditures may be classified as restricted research expenditures.

(3) The Commissioner shall review the report of the review panel and any appeals made under §13.129 of the title (relating to Reviews and Appeals) and determine those awards from which expenditures may be classified as restricted research expenditures.

(4) Not later than August 15, the Commissioner shall provide each institution with a copy of the recommendations of the review panel and notify each institution of its awards from which expenditures may be classified as restricted research expenditures.

§13.127. Report of Restricted Research Expenditures.

(a) Not later than October 15, each eligible institution shall provide a verified, preliminary report of its restricted research expenditures to the Commissioner.

(b) The preliminary report shall contain only those restricted research expenditures from awards approved by the Commissioner under §13.126 of this title (relating to Restricted Research Review Panel).

(c) Expenditures for indirect costs of any restricted research award shall not be included in the report.

(d) Expenditures for pass-throughs to subrecipients shall not be included in the report.

(e) The institution shall maintain separate budgets and accounts for restricted research awards.

(f) Reported restricted research expenditures shall be separately identified for awards equal to or greater than \$2,000,000 in annual funding.

(g) If an eligible institution fails to report its restricted research expenditures, the Commissioner shall use data reported in previous years to estimate that institution's allocation from the Research Development Fund.

§13.128. Report to the Comptroller.

(a) Not later than November 1 of each fiscal year for which there is an appropriation for the Research Development Fund, the Commissioner shall provide a preliminary restricted research expenditure report to the Comptroller and recommend funding allocations from the Research Development Fund to eligible institutions.

(b) The Commissioner shall not recommend a funding allocation for an institution that has failed to report its restricted research expenditures until the institution has completed the required report. The Commissioner may recommend that a percentage of the institution's funding allocation, not to exceed 15 percent, be withheld permanently and redistributed among the other eligible institutions as a penalty for restricted research expenditure reports that are more than 60 days late.

(c) If there are remaining funds in the Research Development Fund after the initial allocation, the Commissioner shall provide updated reports to the Comptroller for distribution of those funds.

§13.129. Reviews and Appeals.

(a) If an institution wishes to appeal the recommendation of the Restricted Research Review Panel, the President of the institution shall notify the Commissioner, in writing, not later than September 1.

(b) After completion of the institutions' annual financial reports, scheduled audits of restricted research expenditures, and incorporation of corrections from audits, each eligible institution shall provide the Commissioner with a final report of restricted research expenditures.

(c) Each institution shall provide to the Commissioner a copy of the institution's fiscal year report to the Legislative Budget Board

that describes the expenditures of the allocation from the Research Development Fund within 30 days of submission to the Legislative Budget Board.

(d) The Commissioner may reduce an institution's allocation from the Research Development Fund as a penalty for failure to comply with recommendations made by the review panel, the auditors, or the Commissioner. In determining such a penalty, the Commissioner shall consider any excess distribution(s) received by the institution as a result of not complying with the recommendations.

§13.130. Audits.

(a) Institutions that receive an allocation from the Research Development Fund are subject to periodic audits to ensure that the projects and activities reported under §13.125 of this title (relating to Report on Restricted Research Projects and Activities) were properly classified as restricted research projects and activities.

(b) Institutions that receive an allocation from the Research Development Fund are subject to periodic audits to ensure that the restricted research expenditure reports required in §13.127 of this title (relating to Report of Restricted Research Expenditures) were properly classified as restricted research expenditures.

(c) The Commissioner shall coordinate the selection of a team of independent auditors.

(d) The advisory committee shall determine the frequency and scope of audits and shall select institutions to be audited.

(e) Under an interagency cooperation agreement, all eligible institutions shall agree to payment of the costs of the audits in proportion to the institution's allocation from the Research Development Fund.

(f) Copies of the final audit reports shall be provided to the Commissioner and each audited institution.

(g) Institutions that do not comply with the provisions of this paragraph shall be ineligible for an allocation from the Research Development Fund and shall not be included in the Commissioner's report to the Comptroller.

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

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500456

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Proposed date of adoption: April 21, 2005

For further information, please call: (512) 427-6114



TITLE 22. EXAMINING BOARDS

PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 107. DENTAL BOARD PROCEDURES

SUBCHAPTER B. PROCEDURES FOR INVESTIGATING COMPLAINTS

22 TAC §107.103

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

The Texas State Board of Dental Examiners (Board) proposes the repeal of 22 TAC Chapter 107, §107.103, concerning compliance with board orders. The repeal is proposed to allow for a new §107.103, regarding dismissal. The Board is concurrently proposing a new §107.110 to contain the language currently residing in §107.103. This restructuring will provide for better structure and flow in the chapter.

Mr. Bobby D. Schmidt, Executive Director, Texas State Board of Dental Examiners has determined that for each year of the first five-year period following the repeal, there will be no fiscal implications for local or state government as a result.

There is no public benefit anticipated as a result of the repeal.

There will be no impact on large, small or micro-businesses.

There is no anticipated economic cost to persons as a result of the repeal.

Comments on the proposal may be submitted to Bobby D. Schmidt, M.Ed. Executive Director, Texas State Board of Dental Examiners, 333 Guadalupe, Tower 3, Suite 800, Austin, Texas 78701, (512) 475-1660. To be considered, all written comments must be received by the Texas State Board of Dental Examiners no later than 30 days from the date that this section is published in the *Texas Register*.

The repeal is proposed under Texas Government Code §§2001.021 et seq., Texas Civil Statutes; the Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The proposed repeal affects Title 3, Subtitle D of the Occupations Code and Title 22, Texas Administrative Code, Chapter 101 - 125.

§107.103. Compliance.

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

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500509

Bobby D. Schmidt, M.Ed.

Executive Director

State Board of Dental Examiners

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 475-0972



22 TAC §107.103

The Texas State Board of Dental Examiners (Board) proposes new 22 TAC Chapter 107, §107.103, concerning dismissal of complaints. The new section is proposed to relocate language regarding dismissal that is currently contained in §107.102, as

well as to enact certain requirements imposed by Senate Bill 263, §12, 78th Legislature, that amended Texas Occupations Code §255.006.

Occupations Code §255.006(d)(7) requires that the Board establish procedures for the expunction of dismissed complaints. Section 107.103(d) as proposed describes such a procedure.

The Board is concurrently proposing amendments to §107.102, the repeal of the current §107.103, and a new §107.110 to contain the language currently residing in §107.103.

Mr. Bobby D. Schmidt, Executive Director, Texas State Board of Dental Examiners has determined that for each year of the first five-year period the section is in effect, there will be no fiscal implications for local or state government as a result of enforcing or administering the section.

There is no public benefit anticipated as a result of enforcing or administering the section.

There will be no impact on large, small or micro-businesses.

There is no anticipated economic cost to persons as a result of enforcing or administering the section.

Comments on the proposal may be submitted to Bobby D. Schmidt, M.Ed. Executive Director, Texas State Board of Dental Examiners, 333 Guadalupe, Tower 3, Suite 800, Austin, Texas 78701, (512) 475-1660. To be considered, all written comments must be received by the Texas State Board of Dental Examiners no later than 30 days from the date that this section is published in the *Texas Register*.

The new section is proposed under Texas Government Code §§2001.021 et seq., Texas Civil Statutes; the Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The proposed new section affects Title 3, Subtitle D of the Occupations Code and Title 22, Texas Administrative Code, Chapter 101 - 125.

§107.103. Dismissal of Cases.

(a) Dismissal.

(1) The director of enforcement may recommend dismissal of a complaint if an investigation fails to reveal a violation.

(2) If the director of enforcement recommends dismissal of a complaint, he or she shall state, with specificity, the reason or reasons for the recommended dismissal.

(3) A complaint recommended for dismissal by the director of enforcement shall be reviewed by a member of the enforcement committee. For complaints involving patient morbidity, professional conduct, or minimum standard of care, the reviewer must be a dentist member of the committee.

(4) If the committee member does not recommend dismissal, the complaint shall be forwarded to an informal settlement conference. If the committee member agrees that the complaint should be dismissed, then the dismissal shall be final.

(5) All jurisdictional complaints shall be investigated. No complaint shall be dismissed without appropriate consideration.

(6) If a complaint is dismissed, the SBDE shall notify the complainant within ten days of the date of the dismissal. The notice of dismissal must be in writing, include the reason(s) for the dismissal and inform the complainant of the right to appeal the dismissal. An appeal

under this section shall be considered a request for reconsideration of the dismissed complaint.

(7) All complaints dismissed under this section must be reported to the full board in a public meeting of the board.

(b) Appeal.

(1) The SBDE may hear an appeal in a dismissed complaint only if new information or evidence is presented, the acceptance of such, if taken as true, supports the original complaint.

(2) The complainant must request reconsideration of a dismissed complaint in writing, postmarked no later than twenty days from the date of receipt of the SBDE's dismissal letter. The complainant is presumed and deemed to be in receipt of the dismissal letter on the third day after the date on which the dismissal letter is mailed.

(3) A request for reconsideration of a dismissed complaint shall not be considered by the SBDE unless it is timely submitted.

(4) A request for reconsideration must contain the requirements specified in this subsection.

(5) Requests meeting the requirements of this subsection shall be heard by the professional evaluation committee no later than sixty days after the date the SBDE receives the request from the complainant requesting reconsideration. This time frame may be extended upon good cause shown by the SBDE. If the professional evaluation committee meets to reconsider the complaint after this sixty-day period, the SBDE shall notify the complainant in writing.

(6) This subsection does not apply to complaints dismissed by the full board pursuant to a recommendation from an informal settlement conference panel.

(7) All complaints dismissed by the full board may be appealed in accordance with the Government Code.

(c) Professional evaluation committee.

(1) The professional evaluation committee shall consist of three board members appointed by the presiding officer of the board, one of whom must be a public member.

(2) Complaints referred to the professional evaluation committee by the board secretary or the board secretary's designee may be dismissed, referred to an informal settlement conference or returned to the director of enforcement for further investigation. The professional evaluation committee may also propose an agreed board order imposing sanctions. All board orders proposed by the professional evaluation committee shall include a statement that the respondent should not agree to the order if he or she wants to explain any part of his or her conduct in connection with the complaint.

(A) Meetings of the professional evaluation committee are open meetings as defined by the Open Meetings Act;

(B) Only professional evaluation committee members and SBDE staff may participate in discussions concerning any complaint. The members may review and consider all information in the investigative file.

(C) All determinations reached by the professional evaluation committee involving reconsideration of an earlier dismissal by the SBDE are final.

(d) Expunging dismissed complaints.

(1) The director of enforcement may, at his or her discretion, recommend that a complaint be expunged from SBDE records on written request from the respondent if:

(A) The complaint has been dismissed under this section;

(B) There has been no successful appeal;

(C) There is no pending appeal;

(D) At least 30 days has passed since the dismissal notice letter was sent to the complainant; and,

(E) The executive director has determined that the complaint was clearly groundless and completely without merit.

(2) A recommendation that a complaint be expunged shall be reviewed by a member of the enforcement committee. For complaints involving patient morbidity, professional conduct, or minimum standard of care, the reviewer must be a dentist member of the committee. The determination of this reviewer shall be final.

(3) The expunging of any complaint under this subsection must be reported to the full board at a public meeting of the board.

(4) This subsection does not apply to complaints dismissed by the full board pursuant to a recommendation from an informal settlement conference panel.

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

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500508

Bobby D. Schmidt, M.Ed.

Executive Director

State Board of Dental Examiners

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 475-0972



22 TAC §107.110

The Texas State Board of Dental Examiners (Board) proposes new 22 TAC Chapter 107, §107.110, concerning compliance with board orders. The new section relocates the language currently residing in §107.103, the repeal of which the Board is concurrently proposing. This restructuring will provide for better structure and flow in the chapter.

The proposed language differs from the current language in that it removes language that has proven extraneous and over-specific in its description of the computer database system to be employed for compliance purposes. The proposed language also eliminates the need for the director of enforcement to coordinate with the executive director and board secretary before initiating a complaint against a licensee for non-compliance with a board order.

All other changes to the relocated language are solely for clarity and grammatical purposes.

Mr. Bobby D. Schmidt, Executive Director, Texas State Board of Dental Examiners has determined that for each year of the first five-year period the section is in effect, there will be no fiscal implications for local or state government as a result of enforcing or administering the section.

There is no public benefit anticipated as a result of enforcing or administering the section.

There will be no impact on large, small or micro-businesses.

There is no anticipated economic cost to persons as a result of enforcing or administering the section.

Comments on the proposal may be submitted to Bobby D. Schmidt, M.Ed. Executive Director, Texas State Board of Dental Examiners, 333 Guadalupe, Tower 3, Suite 800, Austin, Texas 78701, (512) 475-1660. To be considered, all written comments must be received by the Texas State Board of Dental Examiners no later than 30 days from the date that this section is published in the *Texas Register*.

The new section is proposed under Texas Government Code §§2001.021 et seq., Texas Civil Statutes; the Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The proposed new section affects Title 3, Subtitle D of the Occupations Code and Title 22, Texas Administrative Code, Chapter 101 - 125.

§107.110. Compliance.

(a) The director of enforcement shall ensure that a compliance monitoring program is established and maintained for those licensees who have received a board order. The monitoring program shall be maintained by an SBDE employee assigned to act as the compliance officer.

(b) Upon determination that a licensee has not complied with the requirements specified in his or her board order, the compliance officer shall report the details of the non-compliance to the director of enforcement.

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

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500510

Bobby D. Schmidt, M.Ed.

Executive Director

State Board of Dental Examiners

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 475-0972



CHAPTER 116. DENTAL LABORATORIES

22 TAC §116.10

The Texas State Board of Dental Examiners (Board) proposes new §116.10, concerning prosthetic identification. The new section reinstates the language of previous §116.11, which was repealed effective May 10, 2004. The language was to be simultaneously moved to a new §116.10, but due to an oversight, the new section was not proposed.

The language proposed contains no substantive changes from the language of the previous §116.11, except that the requirement of a full name in a suitable prosthetic marking has been changed to last name and first initial. The language also contains revisions to clarify and standardize language, and to improve organization.

Bobby D. Schmidt, Executive Director, Texas State Board of Dental Examiners has determined that for each year of the first five-

year period the section is in effect, there will be no fiscal implications for local or state government as a result of enforcing or administering the section.

The public benefit anticipated as a result of enforcing or administering the section will be to help ensure that dental prosthetic appliances are delivered to the correct patients.

There is no impact on large, small or micro-businesses.

There is no anticipated economic cost to persons as a result of enforcing or administering the section.

Comments on the proposal may be submitted to Bobby D. Schmidt, M.Ed. Executive Director, Texas State Board of Dental Examiners, 333 Guadalupe, Tower 3, Suite 800, Austin, Texas 78701, (512) 475-1660. To be considered, all written comments must be received by the Texas State Board of Dental Examiners no later than 30 days from the date that this proposal is published in the *Texas Register*.

The section is proposed under Texas Government Code §§2001.021 et seq., Texas Civil Statutes; the Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The proposed section affects Title 3, Subtitle D of the Occupations Code and Title 22, Texas Administrative Code, Chapters 101 - 125.

§116.10. Prosthetic Identification.

(a) It shall be the duty of the licensed dentist to insure that all removable prosthetic devices or removable orthodontic appliances delivered to a patient under his or her care bear a permanent identification marking suitable to determine that the prosthetic device or removable orthodontic appliance belongs to that patient.

(b) A suitable marking shall be defined as one that includes the patient's last name and first initial, and/or social security number. This marking shall be placed in the denture base of the removable prosthetic device or acrylic portion of the removable orthodontic appliance in such a manner as not to compromise the aesthetics of the restoration.

(c) The licensed dentist shall install this identification marking or shall request on the prescription to a registered dental laboratory that the laboratory place the identification marking in the removable prosthetic device or removable orthodontic appliance.

(d) Nothing in this rule shall preclude a dental laboratory from charging a fee for this service.

(e) This rule shall not apply to any removable prosthetic device or removable orthodontic appliance that contains no acrylic, vinyl or plastic denture base, or if said appliance is too small to reasonably accomplish this procedure.

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

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500503
Bobby D. Schmidt, M.Ed.
Executive Director
State Board of Dental Examiners

Earliest possible date of adoption: March 20, 2005
For further information, please call: (512) 475-0972

◆ ◆ ◆
PART 6. TEXAS BOARD OF PROFESSIONAL ENGINEERS

CHAPTER 133. LICENSING
SUBCHAPTER D. EDUCATION

22 TAC §133.31

The Texas Board of Professional Engineers proposes amendments to §133.31, relating to Educational Requirements for Applicants. The proposed amendments add language to allow accredited Computer Science programs to be accepted as equivalent to accredited engineering programs, and to consider the academic qualifications of licensed Canadian engineers to be equivalent to an accredited engineering program.

The Board is proposing to consider Computer Science programs accredited by CAC/ABET to be eligible for licensure under §1001.302(a)(1)(A). As a result of the NAFTA agreement, the Board is also proposing to consider all applicants who are currently licensed in Canada to have academic qualifications that are substantially equivalent to an accredited engineering program.

Lance Kinney, P.E., Director of Licensing for the board, has determined that for the first five-year period the proposed amendment is in effect there are no fiscal implications for state or local government as a result of enforcing or administering the section as amended. Mr. Kinney has determined that there is no additional cost to the agency or to licensees. There is no effect to individuals required to comply with the rule as proposed. There is no effect to small or micro businesses.

Mr. Kinney also has determined that for the first five years the proposed amendment is in effect, the public benefit anticipated as a result of enforcing the proposed amendment will be clarification of the license and registration process.

Comments may be submitted no later than 30 days after the publication of this notice to Lance Kinney, P.E., Director of Licensing, Texas Board of Professional Engineers, 1917 IH-35 South, Austin, Texas 78741 or faxed to his attention at (512) 440-0417.

The amendment is proposed pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

No other statutes, articles or codes are affected by the proposed amendment.

§133.31. Educational Requirement for Applicants.

(a) Applicants for a license shall have graduated from at least one of the following degree programs or degree program combinations listed in this section:

(1) Approved engineering curriculums under §1001.302(a)(1)(A) of the Act. The following degrees are acceptable to the board for meeting the educational requirements of §1001.302(a)(1)(A) of the Act:

(A) a degree from an engineering program accredited or otherwise approved by the:

(i) Engineering Accreditation Commission of the Accreditation Board for Engineering and Technology, United States (EAC/ABET) as published in the 2002 ABET Accreditation Yearbook and the 2002 ABET International Yearbook or as published in the yearbook applicable to a previous year in which the applicant graduated; or

(ii) Consejo de Acreditacion de la Ensenanza de la Ingenieria, Mexico (Council of Accreditation for Engineering Education, C.A.).

(B) a degree from a computer science program provided that:

(i) the program has been accredited or otherwise approved by the Computing Accreditation Commission of the Accreditation Board for Engineering and Technology, United States (CAC/ABET) as published in the 2002 ABET Accreditation Yearbook and the 2002 ABET International Yearbook or as published in the yearbook applicable to a previous year in which the applicant graduated; and

(ii) the applicant has completed at least six (6) hours of physics or chemistry classroom and laboratory coursework that would be acceptable for an accredited engineering program.

(C) [~~(B)~~] A bachelor's degree in engineering or one of the mathematical, physical, or engineering sciences, plus a graduate degree in engineering or computer science, provided that:

(i) the graduate degree is obtained from a college having an engineering program approved by one of the organizations listed in subparagraph (A) or (B) of this paragraph where either the graduate or undergraduate degree in the same discipline is accredited; and

(ii) the combination of the degrees is acceptable to the Board as equivalent in EAC/ABET or CAC/ABET approved curricula content, and the combination of degrees contain sufficient design curricula to provide minimal competency in the use of engineering algorithms and procedures.

(D) [~~(C)~~] a completed degree that has not been accredited or approved by either of the organizations identified in subparagraph (A) of this section but has been evaluated in accordance with §133.33 of this chapter, (relating to Proof of Educational Qualifications-Non-Accredited/Non-Approved Programs), and determined to meet the ABET general and program criteria requirements for an EAC/ABET-accredited or -approved program.

(2) Other programs under §1001.302(a)(1)(B) of the Act. The following degrees are acceptable to the board for meeting the educational requirements of §1001.302(a)(1)(B) of the Act:

(A) a bachelor degree from an engineering technology program that is accredited by the Technology Accreditation Commission of the Accreditation Board for Engineering and Technology (TAC/ABET) as published in the 2002 ABET Accreditation Yearbook or as published in the yearbook applicable to a previous year in which the applicant graduated;

(B) A bachelors or graduate degree in engineering, mathematical, physical, or related science that has not been accredited or approved by any of the organizations identified in paragraphs (1)(A) or (2)(A) of this subsection but has been obtained from a recognized institution of higher education as defined in Chapter 131 of this title. Such degree programs must include, as a minimum, the courses listed in clauses (i) and (ii) of this subparagraph or these courses must be taken in addition to the bachelor or graduate degree program:

(i) eight semester hours (12 quarter hours) of mathematics beyond trigonometry, including differential and integral calculus; and

(ii) 20 semester hours (30 quarter hours) of related engineering sciences including subjects such as mechanics, thermodynamics, electrical and electronic circuits, and others selected from material sciences, transport phenomena, computer science and comparable subjects depending on the discipline or branch of engineering. Course work should incorporate hands-on laboratory work as described in the EAC/ABET criteria, and shall contain a sufficient design program to provide minimal competency in the use of engineering algorithms and procedures.

(3) Other degree programs submitted to the board by the conferring institutions and determined by the board as meeting or exceeding the criteria of either of the accrediting organizations referred to in this section.

(A) The programs at the University of Texas at Tyler have been reviewed by the board and determined to be eligible for licensure under §1001.302(a)(1)(A) of the Act, effective for those who graduated in 1999.

(B) The following programs have been reviewed by the board and determined to be eligible for licensure under §1001.302(a)(1)(B) of the Act and eligible for taking the examination on the fundamentals of engineering, effective the date listed:

(i) Tarleton State University, Accepted Programs: Hydrology(1992) and Engineering Physics(2001),

(ii) West Texas State A&M, Accepted Program: Mechanical Engineering (2003)

(b) Degree programs that have not been accredited or approved by any of the organizations identified in subsection (a)(1)(A) or (2)(A) of this section are not acceptable for fulfilling the educational requirements of the Act if they do not meet the definition of a recognized institution of higher learning as defined in Chapter 131 of this title and:

(1) give credit for life experience; or

(2) consist primarily of engineering, mathematical, physical, or engineering sciences courses that are correspondence courses that are self-taught outside a formal classroom setting.

(c) Applicants who have graduated from a degree program that is accredited by the jurisdictional authority in the Canadian or European community that have been evaluated pursuant to §133.33 of this chapter (relating to Proof of Educational Qualifications/Non-Accredited/Non-Approved Programs) and contain sufficient course hours to meet the requirements of §133.31(a)(2)(B) of this chapter but not found to have sufficient course hours to be deemed equivalent or comparable to a Bachelor of Science degree as would be issued by a recognize institution of higher education in the United States may apply for licensure solely through the examination process.

(d) An applicant holding a verified Canadian P.Eng. or ing. License shall be considered to have academic qualifications substantially equivalent to an accredited engineering program.

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

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500559

Dale Beebe Farrow, P.E.
Executive Director
Texas Board of Professional Engineers
Earliest possible date of adoption: March 20, 2005
For further information, please call: (512) 440-7723



SUBCHAPTER F. REFERENCE DOCUMENTATION

22 TAC §133.53

The Texas Board of Professional Engineers proposes an amendment to §133.53, relating to Reference Statements. The proposed amendment adds language to allow the Board to consider evidence of retaliation by an applicant against a reference provider during the application process.

The proposed rule change permits evidence of retaliation by an applicant against a reference provider to be considered by the Board during the application review process.

Lance Kinney, P.E., Director of Licensing for the board, has determined that for the first five-year period the proposed amendment is in effect there are no fiscal implications for the state or local government as a result of enforcing or administering the section as amended. Mr. Kinney has determined that there is no additional cost to the agency or to licensees. There is no effect to individuals required to comply with the rule as proposed. There is no effect to small or micro businesses.

Mr. Kinney also has determined that for the first five years the proposed amendment is in effect, the public benefit anticipated as a result of enforcing the proposed amendment will be clarification of the license and registration process.

Comments may be submitted no later than 30 days after the publication of this notice to Lance Kinney, P.E., Director of Licensing, Texas Board of Professional Engineers, 1917 IH-35 South, Austin, Texas 78741 or faxed to his attention at (512) 440-0417.

The amendment is proposed pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

No other statutes, articles or codes are affected by the proposed amendment.

§133.53. *Reference Statements.*

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

(f) Evidence of retaliation by an applicant against a person who provides reference material for an application may be considered in the application process as described in §133.81(d) of this chapter (relating to Receipt and Process).

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

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500560

Dale Beebe Farrow, P.E.
Executive Director
Texas Board of Professional Engineers
Earliest possible date of adoption: March 20, 2005
For further information, please call: (512) 440-7723



SUBCHAPTER G. EXAMINATIONS

22 TAC §133.65

The Texas Board of Professional Engineers proposes amendments to §133.65, relating to the Examination on the Fundamentals of Engineering. The proposed amendments add language to allow examinees with a CAC/ABET accredited degree or enrolled in a CAC/ABET program to take the Fundamentals of Engineering examination and to require that examinees be enrolled in a degree program in Texas or be current residents of Texas.

The proposed rule change permits examinees who are currently enrolled in a CAC/ABET accredited program or who have graduated from a CAC/ABET accredited program to sit for the Fundamentals of Engineering exam. The proposed rule also requires examinees to either be currently enrolled in a degree program in Texas or to be residents of Texas.

Lance Kinney, P.E., Director of Licensing for the board, has determined that for the first five-year period the proposed amendment is in effect there are no fiscal implications for the state or local government as a result of enforcing or administering the section as amended. Mr. Kinney has determined that there is no additional cost to the agency or to licensees. There is no effect to individuals required to comply with the rule as proposed. There is no effect to small or micro businesses.

Mr. Kinney also has determined that for the first five years the proposed amendment is in effect, the public benefit anticipated as a result of enforcing the proposed amendment will be clarification of the license and registration process.

Comments may be submitted no later than 30 days after the publication of this notice to Lance Kinney, P.E., Director of Licensing, Texas Board of Professional Engineers, 1917 IH-35 South, Austin, Texas 78741 or faxed to his attention at (512) 440-0417.

The amendment is proposed pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

No other statutes, articles or codes are affected by the proposed amendment.

§133.65. *Examination on the Fundamentals of Engineering.*

(a) An undergraduate student who is within two full-time regular semesters (not including summer sessions) of graduating may take the examination on the fundamentals of engineering at a location prescribed by the board provided that the student is in enrolled in a degree program in Texas and the program is:

(1) [and who is enrolled in] an engineering program accredited or approved by the EAC/ABET; []

(2) a four year baccalaureate computer science program accredited or approved by the CAC/ABET;

(3) a four year baccalaureate technical program accredited or approved by the TAC/ABET; [;] or

(4) an engineering-related science program of four years or more that has been approved by the board. [~~; may take the examination on the fundamentals of engineering at the student's school provided the school administers the examination as prescribed by the board.~~]

(b) A graduate student may take the examination on the fundamentals of engineering at a location [~~the student's school provided that the school administers the examination as~~] prescribed by the board provided that [~~and~~] the student is enrolled in an EAC/ABET-accredited graduate degree program or in a graduate program at an institution which has an EAC/ABET or CAC/ABET-accredited undergraduate degree program in that discipline, and the student has:

(1) a baccalaureate degree that is EAC/ABET or CAC/ABET-accredited;

(2) an engineering or engineering-related science program degree that has been approved by the board; or

(3) a non-engineering related curriculum or other degree in which the student has provided evidence acceptable to the executive director as meeting the minimum requirements of §1001.302(a)(1)(A) or (B) of the Act.

~~[(c) Engineering students may schedule the examination on the fundamentals of engineering at their participating school through the engineering dean, department head, or other program administrator.]~~

(c) [~~(d)~~] Persons who demonstrate that they meet the educational requirements for a license and who have not passed the examination on the fundamentals of engineering while in college and who are residents of Texas may apply to the board to take the examination in accordance with the applicable examination schedule adopted by the board.

(d) [~~(e)~~] Persons who do not meet the criteria of subsection (a) of this section, but who need only to complete the examination on the fundamentals of engineering to fulfill the graduation requirements of a degree program that would meet the educational requirements for a license, may apply to the board to take the examinations in accordance with the applicable examination schedule adopted by the board.

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

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500561

Dale Beebe Farrow, P.E.

Executive Director

Texas Board of Professional Engineers

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 440-7723



SUBCHAPTER H. REVIEW PROCESS OF APPLICATIONS AND LICENSE ISSUANCE

22 TAC §133.81

The Texas Board of Professional Engineers proposes amendments to §133.81, relating to the Receipt and Process of applications. The proposed amendments add language to allow applicants to voluntarily withdraw applications for licensure and to prevent applicants from filing having more than one pending application on file.

The proposed rule change permits applicants who are not currently approved for the examination process and who are not currently in the board review process to voluntarily withdraw their application. The proposed rule change also allows applicants to have only one pending application at a time.

Lance Kinney, P.E., Director of Licensing for the board, has determined that for the first five-year period the proposed amendment is in effect there are no fiscal implications for the state or local government as a result of enforcing or administering the section as amended. Mr. Kinney has determined that there is no additional cost to the agency or to licensees. There is no effect to individuals required to comply with the rule as proposed. There is no effect to small or micro businesses.

Mr. Kinney also has determined that for the first five years the proposed amendment is in effect, the public benefit anticipated as a result of enforcing the proposed amendment will be clarification of the license and registration process.

Comments may be submitted no later than 30 days after the publication of this notice to Lance Kinney, P.E., Director of Licensing, Texas Board of Professional Engineers, 1917 IH-35 South, Austin, Texas 78741 or faxed to his attention at (512) 440-0417.

The amendment is proposed pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

No other statutes, articles or codes are affected by the proposed amendment.

§133.81. *Receipt and Process.*

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

(e) An applicant may request an application to be withdrawn from consideration provided that the application has not been approved for licensure subject to passage of an examination and the application has not begun circulation under the Board Review Process under §133.85 of this chapter (relating to Board Review of and Action on Applications). All requests for withdrawal must be submitted to the Board in writing.

(f) An applicant may only have one pending application on file with the Board at any time.

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

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500562

Dale Beebe Farrow, P.E.

Executive Director

Texas Board of Professional Engineers

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 440-7723

◆ ◆ ◆

CHAPTER 137. COMPLIANCE AND PROFESSIONALISM
SUBCHAPTER A. INDIVIDUAL AND ENGINEER COMPLIANCE

22 TAC §137.13

The Texas Board of Professional Engineers proposes an amendment to §137.13, relating to Inactive Status. The proposed amendment adds language to clarify which activities a professional engineer on Inactive Status may perform.

The proposed rule change clarifies that a professional engineer on Inactive Status may not offer or perform engineering services to the public.

Lance Kinney, P.E., Director of Licensing for the board, has determined that for the first five-year period the proposed amendment is in effect there are no fiscal implications for the state or local government as a result of enforcing or administering the section as amended. Mr. Kinney has determined that there is no additional cost to the agency or to licensees. There is no effect to individuals required to comply with the rule as proposed. There is no effect to small or micro businesses.

Mr. Kinney also has determined that for the first five years the proposed amendment is in effect, the public benefit anticipated as a result of enforcing the proposed amendment will be clarification of the license and registration process.

Comments may be submitted no later than 30 days after the publication of this notice to Lance Kinney, P.E., Director of Licensing, Texas Board of Professional Engineers, 1917 IH-35 South, Austin, Texas 78741 or faxed to his attention at (512) 440-0417.

The amendment is proposed pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

No other statutes, articles or codes are affected by the proposed amendment.

§137.13. Inactive Status.

(a) - (g) (No change.)

(h) Offering or performing engineering services to the public while the license is inactive is a violation of the inactive status and is subject to disciplinary action by the board.

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

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500563
Dale Beebe Farrow, P.E.
Executive Director
Texas Board of Professional Engineers
Earliest possible date of adoption: March 20, 2005
For further information, please call: (512) 440-7723

◆ ◆ ◆

PART 29. TEXAS BOARD OF PROFESSIONAL LAND SURVEYING

CHAPTER 661. GENERAL RULES OF PROCEDURES AND PRACTICES
SUBCHAPTER E. CONTESTED CASES

22 TAC §661.100

The Texas Board of Professional Land Surveying (TBPLS) proposes a new rule §661.100, concerning Probation Guidelines. This section establishes the requirements and procedures for placing an affected registrant or licensee on probationary status.

The new rule outlines the guidelines to be followed in response to a complaint or violation of the Act and Board Rules in addition to or in lieu of an action to revoke, suspend, reprimand, refuse to renew or assess a penalty.

Sandy Smith, Executive Director, has determined that for the first five year period the rule is in effect there will be no fiscal impact to state or local government as a result of enforcing or administering this new rule.

Ms. Smith has also determined that for each year of the first five years the rule is in effect the public will benefit from the rule because it will clarify the methodology used when probating a disciplinary action.

There will be no effect on small or micro businesses that are in compliance with the Board's Act and Rules.

Comments on the new rule may be submitted in writing to Sandy Smith, Executive Director, Texas Board of Professional Land Surveying, 7701 North Lamar, Suite 400, Austin, TX 78752. Comments may also be faxed to Ms. Smith at the Board at (512) 452-7711 or may be sent electronically to sandy.smith@mail.cap-net.state.tx.us. All requests for a public hearing on the proposed section submitted under the Administrative Procedure Act must be received by the Executive Director not more than 15 calendar days after notice of a proposed change in the section has been published in the *Texas Register*.

The new rule is proposed pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

The new rule implements the Texas Administrative Code, Title 22, Part 29, General Rules of Procedures and Practices.

§661.100. Probation Guidelines.

(a) In addition to or in lieu of an action to revoke, suspend, reprimand, refuse to renew or assess a penalty the Board may initiate an action which will result in the affected registrant or licensee being placed on probationary status. The following factors may be considered in making a decision regarding probation:

- (1) type and severity of violation;
- (2) economic harm;
- (3) history of violations;
- (4) efforts to correct the violation;
- (5) action premeditated or intentional;

- (6) motive;
- (7) attempted concealment of violation;
- (8) the likelihood of future misconduct as shown by:
 - (A) degree of remorse;
 - (B) remedial procedures to prevent future violations;
 - (C) rehabilitative motivation or potential.
- (9) any other relevant circumstances or facts.

and

(b) If the Board determines that probation is appropriate to deter future violations of the Act and Board Rules by the Respondent, probation shall be administered consistently under the following guidelines:

(1) for violations with greater potential to jeopardize public health, safety, welfare, or property, the term of the probation may not be less than one year or more than five years; and

(2) for violations with less potential to jeopardize public health, safety, welfare, or property, the term of the probation may not be less than six months or more than one year.

(c) The Board may prescribe conditions of probation on a case-by-case basis depending on the severity of the violation that will include reporting requirements, restrictions on practice, site inspections, and/or continuing education requirements as applicable as described in this subsection. The Board reserves the right to reconsider the terms of probation based upon any extenuating circumstances.

(d) The Board will determine the reporting requirements for each probation and will include a list of Board probation requirements and schedule for completion of those requirements in which the Board may require the license holder to submit documentation including, but not limited to, survey plats, client lists, job assignments, proof of continuing education participation, restricted practice reports, and other documents concerning the probation to demonstrate compliance with the conditions of probation. As a condition of probation, the license holder shall accept that schedule deadlines are final.

(e) The Board will receive and date stamp documentation on the day received and track compliance with probation requirements for each probated suspension. The Board shall honor postmarks for date of submittal; however, if not received by the required deadline, the license holder shall have the burden of proof to demonstrate documentation was submitted by the schedule deadline.

(f) As a condition of probation, the Board may require the license holder to obtain additional continuing education in addition to the minimum requirements of §664.3 of this title (relating to Numerical Requirements for Continuing Education) and may prescribe formal classroom study, workshops, seminars, and other specific forms of continuing education.

(g) Failure to comply with probation requirements shall result in revocation of probation and reinstatement of the original sanction.

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

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500491

Sandy Smith
 Executive Director
 Texas Board of Professional Land Surveying
 Earliest possible date of adoption: March 20, 2005
 For further information, please call: (512) 452-9427



22 TAC §661.102

The Texas Board of Professional Land Surveying (TBPLS) proposes a new rule §661.102, concerning Alternative Dispute Resolution for Personnel and Contracting Matters. This section encourages the resolution and early settlement of all disputed matters, internal and external, through voluntary settlement procedures.

The new rule outlines the guidelines to be followed to resolve disputes involving personnel and contracting matters.

Sandy Smith, Executive Director, has determined that for the first five year period the rule is in effect there will be no fiscal impact to state or local government as a result of enforcing or administering this new rule.

Ms. Smith has also determined that for each year of the first five years the rule is in effect the public will benefit from the rule because the Board will encourage the resolution and early settlement of all disputed matters through voluntary settlement procedures.

There will be no effect on small or micro businesses that are in compliance with the Board's Act and Rules.

Comments on the new rule may be submitted in writing to Sandy Smith, Executive Director, Texas Board of Professional Land Surveying, 7701 North Lamar, Suite 400, Austin, TX 78752. Comments may also be faxed to Ms. Smith at the Board at (512) 452-7711 or may be sent electronically to sandy.smith@mail.capnet.state.tx.us. All requests for a public hearing on the proposed section submitted under the Administrative Procedure Act must be received by the Executive Director not more than 15 calendar days after notice of a proposed change in the section has been published in the *Texas Register*.

The new rule is proposed pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

The new rule implements the Texas Administrative Code, Title 22, Part 29, General Rules of Procedures and Practices.

§661.102. Alternative Dispute Resolution for Personnel and Contracting Matters

(a) It is the Board's policy to encourage the resolution and early settlement of all disputed matters, internal and external, through voluntary settlement procedures.

(b) The executive director shall designate at least one employee of the Board to serve as the Board's alternative dispute resolution coordinator to:

(1) coordinate the implementation of the Board's alternative dispute resolution policies;

(2) serve as a resource for any training needed to implement the procedures for alternative dispute resolution; and

(3) collect data concerning the effectiveness of these procedures, as implemented by the Board.

(c) The Board, a respondent, the executive director, or any other party involved in an internal or external disputed matter may request that the matter be resolved through any manner of alternative dispute resolution specified in Chapter 154, Civil Practice and Remedies Code, including mediation, arbitration, and moderated settlement conferences, or through the appointment of an ombudsman.

(d) The allocation of the costs of alternative dispute resolution is subject to negotiation and agreement between the parties. The party who requests alternative dispute resolution may be liable for the cost of any third-party mediator, moderator, arbitrator, or ombudsman and shall otherwise bear her or his own cost arising from alternative dispute resolution.

(e) Any resolution reached as a result of an alternative dispute resolution procedure is intended to be through the voluntary agreement of the parties. Any resolution that purports to bind the Board must be approved by the Board at a meeting subject to the Texas Open Meetings Act, Chapter 551, Government Code.

(f) The Board is subject to the Texas Public Information Act, Chapter 552, Government Code. Any written record, communication, or other material is confidential only to the extent provided by law and subject to the exemptions provided in that Act.

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

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500492
Sandy Smith
Executive Director
Texas Board of Professional Land Surveying
Earliest possible date of adoption: March 20, 2005
For further information, please call: (512) 452-9427



22 TAC §661.104

The Texas Board of Professional Land Surveying (TBPLS) proposes a new rule §661.104, concerning Negotiated Rulemaking. This section addresses guidelines to be used during negotiated rulemaking processes.

The new rule outlines the Board's policy to encourage public input and employ negotiated rule making procedures in the Board's rule making process when appropriate.

Sandy Smith, Executive Director, has determined that for the first five year period the rule is in effect there will be no fiscal impact to state or local government as a result of enforcing or administering this new rule.

Ms. Smith has also determined that for each year of the first five years the rule is in effect the public will benefit from the rule because of the new procedures which will encourage public input in the Board's rule making process.

There will be no effect on small or micro businesses that are in compliance with the Board's Act and Rules.

Comments on the new rule may be submitted in writing to Sandy Smith, Executive Director, Texas Board of Professional Land Surveying, 7701 North Lamar, Suite 400, Austin, TX 78752. Comments may also be faxed to Ms. Smith at the Board at (512) 452-

7711 or may be sent electronically to sandy.smith@mail.cap-net.state.tx.us. All requests for a public hearing on the proposed section submitted under the Administrative Procedure Act must be received by the Executive Director not more than 15 calendar days after notice of a proposed change in the section has been published in the *Texas Register*.

The new rule is proposed pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

The new rule implements the Texas Administrative Code, Title 22, Part 29, General Rules of Procedures and Practices.

§661.104. Negotiated Rulemaking.

(a) It is the Board's policy to encourage public input and employ negotiated rule making procedures in the Board's rule making process when appropriate. When the Board is of the opinion that proposed rules are likely to be complex, or controversial, or to affect disparate groups, negotiated rulemaking will be considered.

(b) When negotiated rulemaking is to be considered, the Board may elect to develop a draft rule either through an informal process or through the formal process described in Chapter 2008, Government Code.

(c) If the Board elects to use an informal process, the Executive Director shall identify persons likely to be affected and invite them to participate in a public process for development of a draft rule.

(d) If the Board elects to use a formal process, the Board will appoint a convener to assist it in determining whether it is advisable to proceed. The convener shall have the duties described in Chapter 2008, Government Code, and shall make a recommendation to the Executive Director to proceed or to defer negotiated rulemaking. The recommendation shall be made after the convener, at a minimum, has considered all of the items enumerated in Government Code, §2008.052(c).

(e) Upon the convener's recommendation to proceed, the department shall initiate negotiated rulemaking according to the provisions of Chapter 2008, Government Code.

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

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500493
Sandy Smith
Executive Director
Texas Board of Professional Land Surveying
Earliest possible date of adoption: March 20, 2005
For further information, please call: (512) 452-9427



TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 65. WILDLIFE

SUBCHAPTER H. PUBLIC LANDS PROCLAMATION

31 TAC §§65.190, 65.191, 65.193, 65.198, 65.199, 65.201

The Texas Parks and Wildlife Department proposes amendments to §§65.190, 65.191, 65.193, 65.198, 65.199, and 65.201, concerning the Public Lands Proclamation.

The proposed amendment to §65.190, concerning Application, alters nomenclature by replacing the term 'non-consumptive use' with the term 'recreational use.' The term 'non-consumptive' is meant to be an umbrella term encompassing all activities other than hunting and fishing; however, it gives the impression that public usage other than hunting and fishing results in little or no impact to public resources on wildlife management areas and public hunting lands. The change is necessary because all uses of wildlife management areas and public hunting lands involve, to varying degrees, some type of resource impact. This change is made throughout the subchapter where necessary. The proposed amendment also updates references and citations where necessary, removes reference to Caddo Lake State Park (which is no longer a unit of public hunting lands), and removes references to the Bryan Beach Unit of the Peach Point Wildlife Management Area, which is no longer owned by the department.

The proposed amendment to §65.191, concerning Definitions, consists of several actions. The proposed amendment alters the definition of 'all terrain vehicle.' The current definition is too broad, in that any motor vehicle that cannot be operated on a public roadway qualifies as an all terrain vehicle. Therefore the definition as currently written would allow inappropriate motor vehicles, such as farm machinery, treaded or tracked vehicles, and construction equipment to be considered as ATVs. The department's intent in allowing the use of ATVs (where they are allowed) is to permit public users, particularly disabled users, greater ease of access, but only within biologically acceptable parameters. Obviously, heavy equipment is incompatible with sound biological management, as fragile soils and vegetative communities are easily disturbed, resulting in impacts to the fish and wildlife resources that depend upon them for habitat. Therefore, the department proposes to replace the current definition with the definition of all terrain vehicles used in the Transportation Code. In concert with the change, the department also proposes to add another definition from the Transportation Code, the definition for 'motor vehicle,' in order to be completely consistent, and a definition for 'off-road vehicle,' to create an inclusive term to encompass all vehicles that could be used for off-road purposes.

The amendment also would add a new definition for 'camping.' That term is currently not defined, and a definition is needed in order to clarify exactly what is meant by that term as it applies to public use of wildlife management areas and public hunting lands.

The amendment would also alter the definition of 'disabled person.' The current definition requires a person, in order to take advantage of provisions for disabled persons, to possess a physician's statement attesting to the person's permanent ambulatory disability as defined in the Transportation Code. In order to avoid confusion and difficulties associated with verification of physician's statements, the proposed definition would require all persons seeking status as disabled to possess a state-issued disabled placard or license plate.

The amendment would also alter the definition of the Limited Public Use (LPU) permit by removing language that prohibits the use of an LPU permit to take wildlife resources and clarifying that the LPU can be used to access wildlife management areas as well as public hunting lands. The change is necessary because the proposed amendment to §65.193 would allow the LPU permit to be used for fishing on wildlife management areas and public hunting lands.

The amendment also would remove the definition for 'non-consumptive activities' and replace it with the term 'recreational use,' which is defined as 'any use other than hunting or fishing.' The new definition is necessary because all users of wildlife management areas and public hunting lands, even those who do not hunt or fish, participate in some sort of impact on those areas. The proposed definition simply aggregates the variety of public uses other than hunting and fishing under a single term of reference.

The amendment to §65.193, concerning Access Permit Required and Fees, would alter subsection (b)(2) to allow persons entering wildlife management areas and public hunting lands to fish under a Limited Public Use permit (LPU). The proposed amendment also alters subsection (k) to remove a reference to hunting and fishing activities with respect to the waiver of fees for a person participating in a regular hunt under an Annual Public Hunting (APH) permit. The change is necessary to allow persons to access wildlife management areas and public hunting lands, when feasible, for fishing activities under an LPU on days when regular permit hunts are being conducted. The proposed amendment also removes references to the Bryan Beach Unit of the Peach Point Wildlife Management Area, which is no longer owned by the department.

The proposed amendment to 65.198, concerning Entry, Registration, and Checkout, replaces the term 'non-consumptive use' with the term 'recreational use' for the reasons noted previously in the discussion of amendments to §65.190.

The proposed amendment to §65.199, concerning General Rules of Conduct, removes a reference to the Texas Conservation Passport, which has been discontinued by the department.

The proposed amendment also would prohibit camping on any given unit of public hunting lands for more than 14 consecutive days or more than 21 days in any 30-day period. The amendment is necessary in order to ensure that recreational opportunity is equitably distributed.

The proposed amendment also changes an outmoded reference to WMA antlerless permits. The department issues such permits on units of public hunting lands shared by the department and the U.S. Forest Service. The permits are now referred to as USFS antlerless permits.

The proposed amendment also would restrict the parking or leaving of motor vehicles to designated parking areas. The amendment is necessary to prevent the creation of impromptu parking areas, which result in degradation of habitat and storm water runoff erosion.

The proposed amendment also would require persons seeking to operate a motor vehicle, ATV, or off-road vehicle under special provisions for disabled persons to possess a state-issued disabled placard or license plate, or other state-issued evidence that the person is entitled to disabled status. Under current rules, people seeking to use vehicles under provisions for disabled persons are required to possess a physician's statement stating that the person meets the requirements in the Transportation Code

to be eligible for a disabled placard or license plate. Since the requirement of the current rule and the requirement under Transportation Code for issuance of a placard or plate are the same, by requiring a placard or plate the department seeks to avoid confusion and difficulties associated with verification of physician's statements.

The proposed amendment also would prohibit any activity not specifically authorized by order of the executive director or regulation of the commission. The amendment is necessary to address unanticipated situations or instances in which an aspect of public use is clearly antithetical to the department's mission or injurious or potentially injurious to resources or habitat, but is not specifically addressed within this subchapter.

The proposed amendment to §65.201, concerning Motor Vehicles, alters subsection (d) to include off-road vehicles. The amendment is necessary to make the provisions of the section consistent with changes that alter the meaning of the term 'motor vehicle' and introduce the term 'off-road vehicle' in §65.191, concerning Definitions. Under current rules, an ATV is any motor vehicle that cannot be legally operated on a public roadway. The proposed amendment to §65.191 creates scenarios in which off-road vehicles can be used in the same way as ATVs, making it necessary to include them in provisions of §65.201.

Robert Macdonald, regulations coordinator, has determined that for each of the first five years the rules as proposed are in effect, there will be no fiscal implications to state and local governments as a result of enforcing or administering the rules.

Mr. Macdonald also has determined that for each of the first five years the rules as proposed are in effect, the public benefit anticipated as a result of enforcing or administering the rules as proposed will be clearer and more user-friendly regulations, as well as the enhanced ability of the department to discharge its statutory obligation to manage fish and wildlife resources on wildlife management areas and public hunting lands.

There will be no adverse economic effect on small businesses, microbusinesses, or persons required to comply with the rules as proposed.

The department has not drafted a local employment impact statement under the Administrative Procedures Act, §2001.022, as the agency has determined that the rules as proposed will not impact local economies.

The department has determined that there will not be a taking of private real property, as defined by Government Code, Chapter 2007, as a result of the proposed rules.

Comments on the proposed rules may be submitted to Dennis Gissell, Texas Parks and Wildlife Department 4200 Smith School Road, Austin, Texas, 78744; (512) 389-4407 (e-mail: dennis.gissell@tpwd.state.tx.us).

The amendments are proposed under Parks and Wildlife Code, Chapter 81, Subchapter E, which provides the Parks and Wildlife Commission with authority to establish an open season on wildlife management areas and public hunting lands and authorizes the executive director to regulate numbers, means, methods, and conditions for taking wildlife resources on wildlife management areas and public hunting lands; Chapter 12, Subchapter A, which provides that a tract of land purchased primarily for a purpose authorized by the code may be used for any authorized function of the department if the commission determines that multiple use is the best utilization of the land's

resources; and §42.0177, which authorizes the commission to modify or eliminate the tagging requirements of Chapter 42.

The amendments affect Parks and Wildlife Code, Chapter 12, Subchapter A; Chapter 42; and Chapter 81, Subchapter E.

§65.190. Application.

(a) This subchapter applies to all activities subject to department regulation on lands designated by the department as public hunting lands, regardless of the presence or absence of boundary markers. Public hunting lands are acquired by lease or license, management agreements, trade, gift, and purchase. Records of such acquisition are on file at the Department's central repository.

(b) On U.S. Forest Service Lands designated as public hunting lands (Alabama Creek, Bannister, Caddo, Lake McClellan Recreation Area, Moore Plantation, and Sam Houston National Forest WMAs) or any portion of Units 902 and 903, persons other than hunters are exempt from the provisions of this subchapter, except for the provisions of §65.199(15) [~~§65.199(14)~~] of this title (relating to General Rules of Conduct).

(c) On U.S. Army Corps of Engineer Lands designated as public hunting lands (Aquilla, Cooper, Dam B, Granger, Pat Mayse, Ray Roberts, Somerville, and White Oak Creek WMAs), persons other than hunters and equestrian users are exempt from requirements for an access permit.

(d) On state park lands designated as public hunting lands, access for fishing and recreational [~~non-consumptive~~] use is governed by state park regulations.

(e) Public hunting lands include, but are not limited to, the following:

- (1) Alabama Creek WMA (Unit 904);
- (2) Alazan Bayou WMA (Unit 747);
- (3) Aquilla WMA (Unit 748);
- (4) Atkinson Island WMA;
- (5) Bannister WMA (Unit 903);
- (6) Big Lake Bottom WMA (Unit 733);
- (7) Black Gap WMA (Unit 701);
- (8) Caddo Lake [~~State Park and~~] WMA (Unit 730);
- (9) Caddo National Grasslands WMA (Unit 901);
- (10) Candy Abshier WMA;
- (11) Cedar Creek Islands WMA (includes Big Island, Bird Island, and Telfair Island Units);
- (12) Chaparral WMA (Unit 700);
- (13) Cooper WMA (Unit 731);
- (14) D.R. Wintermann WMA;
- (15) Dam B WMA--includes Angelina-Neches Scientific Area (Unit 707);
- (16) Designated Units of the Las Palomas WMA;
- (17) Designated Units of Public Hunting Lands Under Short-Term Lease;
- (18) Designated Units of the Playa Lakes WMA;
- (19) Designated Units of the State Park System;
- (20) Elephant Mountain WMA (Unit 725);

- (21) Gene Howe WMA (Unit 755)--includes Pat Murphy Unit (Unit 706);
- (22) Granger WMA (Unit 709);
- (23) Guadalupe Delta WMA (Unit 729)--includes Mission Lake Unit (720), Guadalupe River Unit (723), Hynes Bay Unit (724), and San Antonio River Unit (760);
- (24) Gus Engeling WMA (Unit 754);
- (25) James Daughtrey WMA (Unit 713);
- (26) J.D. Murphree WMA (Unit 783);
- (27) Keechi Creek WMA (Unit 726);
- (28) Kerr WMA (Unit 756);
- (29) Lake McClellan Recreation Area (Unit 906);
- (30) Lower Neches WMA (Unit 728)--includes Old River Unit and Nelda Stark Unit;
- (31) Mad Island WMA (Unit 729);
- (32) Mason Mountain WMA (Unit 749);
- (33) Matador WMA (Unit 702);
- (34) Matagorda Island State Park and WMA (Unit 1134);
- (35) M.O. Neasloney WMA;
- (36) Moore Plantation WMA (Unit 902);
- (37) Nannie Stringfellow WMA (Unit 716);
- (38) North Toledo Bend WMA (Unit 615);
- (39) Old Sabine Bottom WMA (Unit 732);
- (40) Old Tunnel WMA;
- (41) Pat Mayse WMA (Unit 705);
- (42) Peach Point WMA (Unit 721)[--includes Bryan Beach Unit (Unit 1075)];
- (43) Ray Roberts WMA (Unit 501);
- (44) Redhead Pond WMA;
- (45) Richland Creek WMA (Unit 703);
- (46) Sam Houston National Forest WMA (Unit 905);
- (47) Sierra Diablo WMA (Unit 767);
- (48) Somerville WMA (Unit 711);
- (49) Tawakoni WMA (Unit 708);
- (50) Walter Buck WMA (Unit 757);
- (51) Welder Flats WMA;
- (52) White Oak Creek WMA (Unit 727); and
- (53) Other numbered units of public hunting lands.

§65.191. *Definitions.*

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise. All other words and terms shall have the meanings assigned in §65.3 of this title (relating to Statewide Hunting and Fishing Proclamation).

- (1) Adult--A person 17 years of age or older.

(2) All terrain vehicle (ATV)--Any vehicle meeting the definition of an ATV under Transportation Code, §663.001 [A motor vehicle which does not meet traffic code requirements for operation on a public roadway with respect to licensing, inspection and insurance requirements].

(3) Annual Public Hunting (APH) Permit--A permit, valid from issuance date through the following August 31, which allows entry to designated public hunting lands at designated times and the taking of wildlife resources as designated.

(4) Application fee--A non-refundable fee that [which] may be required to accompany and validate an individual's application for a special permit.

(5) Authorized supervising adult--A parent, legal guardian, or individual at least 18 years of age who assumes liability responsibility for a youth.

(6) Blind--Any structure assembled of man-made or natural materials for the purpose or having the effect of promoting concealment or increasing the field of vision of a person.

(7) Buckshot--Lead pellets ranging in size from .24-inch to .36-inch in diameter normally loaded in a shotgun (includes, but is not limited to 0 and 00 buckshot).

(8) Camping--the use of public hunting lands for overnight accommodation, which includes sleeping, the storage of unattended personal possessions, or the use of a motor vehicle as a lodging.

(9) [~~8~~] Competitive hunting dog event (field trial)--A department-sanctioned contest in which the skills of hunting dogs are tested.

(10) [~~9~~] Concurrent hunt--A hunt that maintains the same permit requirements, hunt dates, means and methods, or shooting hours or combinations thereof for more than one species of animal, as designated and subject to any special provisions.

(11) [~~10~~] Consumptive user--A person who takes or attempts to take wildlife resources.

(12) [~~11~~] Designated campsite--A designated area where camping and camping activities are authorized.

(13) [~~12~~] Designated days--Specific days within an established season or period of time as designated by the executive director.

(14) [~~13~~] Designated road--A constructed roadway indicated as being open to the public by either signs posted to that effect or by current maps and leaflets distributed at the area. Roads closed to the public may additionally be identified by on-site signing, barricades at entrances, or informational literature made available to the public. Designated roads do not include county or state roads or highways.

(15) [~~14~~] Designated target practice area--An area designated by on-site signing or by order of the executive director within which the discharge of firearms for target practice is authorized.

(16) [~~15~~] Designated units of the state park system--Specific units of the state park system approved by the commission for application of provisions of this subchapter.

(17) [~~16~~] Disabled person--A [~~paraplegic or a~~] person who possesses a placard, license plate, or other documentation issued to that person by the State of Texas under the provisions of [has a physician's statement in their immediate possession certifying that they qualify for handicapped parking privileges (criteria for permanent ambulatory disability as defined in] Transportation Code, Chapter 681[)].

(18) [(17)] General Season--A specified time period, or designated days within a specified time period, during which more than one means or methods (as designated) may be used to take designated species.

(19) [(18)] Headwear--Garment or item of apparel worn on or about the head.

(20) [(19)] Immediate supervision--Control of a youth by an authorized supervising adult issuing verbal instructions in a normal voice level.

(21) [(20)] Lands within a desert bighorn sheep cooperative--An aggregation of lands for which the concerned landowners and the Texas Parks and Wildlife Department have agreed to coordinate efforts to restore, manage, and harvest desert bighorn sheep.

(22) [(21)] Limited Public Use (LPU) Permit--A permit, valid from issuance date through the following August 31, which allows access to designated wildlife management areas and public hunting lands at the same times that access is provided by an APH permit. [A LPU permit does not authorize the taking of wildlife resources.]

(23) [(22)] Limited use zone--An area designated by order of the executive director and/or by boundary signs on the area, within which public use is prohibited or restricted to specified activities.

(24) [(23)] Loaded firearm--A firearm containing a live round of ammunition within the chamber and/or the magazine, or if muzzleloading, one which has a cap on the nipple or a priming charge in the pan.

(25) Motor vehicle--As defined by Transportation Code, Chapter 541.

[(24) ~~Non-consumptive activities--Activities which do not involve the take or attempted take of wildlife resources.~~]

(26) Off-road vehicle--An ATV, a utility vehicle, a vehicle that may not lawfully be operated on a public roadway, or any vehicle that is manufactured or adapted for off-road use.

(27) [(25)] On-site registration--The requirement for public users to register at designated places upon entry to and exit from specified public hunting lands, but does not constitute a permit.

(28) [(26)] Permit--Documentation authorizing specified access and public use privileges on public hunting lands.

(29) [(27)] Predatory animals--Coyotes and bobcats.

(30) [(28)] Preference point system--A method of special permit distribution in which the probability of selection is progressively enhanced by prior unsuccessful applications within a given hunt category by individuals or groups.

(31) [(29)] Public hunting area--A portion of public hunting lands designated as being open to the activity of hunting, and may include all or only a portion of a certain unit of public hunting land.

(32) [(30)] Public hunting compartment--A defined portion of a public hunting area to which hunters are assigned and authorized to perform public hunting activity.

(33) [(31)] Public hunting lands--Lands identified in §65.190 of this title (relating to Application) or by order of the executive director on which provisions of this subchapter apply.

(34) Recreational use--any use or activity other than hunting or fishing.

(35) [(32)] Regular Permit--A permit issued on a first-come-first-served basis, on-site, at the time of the hunt that allows the taking of designated species of wildlife on the issuing area.

(36) [(33)] Restricted area--All or portions of public hunting lands identified by boundary signs as being closed to public entry or use.

(37) [(34)] Sanctuary--All or a portion of public hunting lands identified by boundary signs as being closed to the hunting of specified wildlife resources.

(38) [(35)] Slug--A metallic object designed for being fired as a single projectile by discharge of a shotgun.

(39) [(36)] Special Permit--A permit, issued pursuant to a selection procedure, which allows the taking of designated species of wildlife.

(40) [(37)] Special package hunt--A public hunt conducted for promotional or fund raising purposes and offering the selected applicant(s) a high quality experience with enhanced provisions for food, lodging, transportation, and guide services.

(41) [(38)] Tagging fee--A fee which may be assessed in addition to the special permit fee for the harvest of alligators for commercial sale or prior to the attempted harvest of desert bighorn sheep or designated exotic mammals.

(42) [(39)] Wildlife management area (WMA)--A unit of public hunting lands which is intensively managed for the conservation, enhancement, and public use of wildlife resources and supporting habitats.

(43) [(40)] Wildlife resources--Game animals, game birds, furbearing animals, alligators, marine mammals, frogs, fish, crayfish, other aquatic life, exotic animals, predatory animals, rabbits and hares, and other wild fauna.

(44) [(41)] Wounded exotic mammal--An exotic mammal leaving a blood trail.

(45) [(42)] Youth--A person less than 17 years of age.

§65.193. *Access Permit Required and Fees.*

(a) It is an offense for a person without a valid access permit to enter public hunting lands, except:

- (1) on areas or for activities where no permit is required;
- (2) persons who are authorized by, and acting in an official capacity for the department or the landowners of public hunting lands;
- (3) persons participating in educational programs, management demonstrations, or other scheduled activities sponsored or sanctioned by the department with written approval;
- (4) persons owning or leasing land within the boundaries of public hunting lands, while traveling directly to or from their property;
- (5) for a non-hunting or non-fishing adult who is assisting a permitted disabled person; or
- (6) for youth under the supervision of an authorized supervising adult possessing an APH permit or a LPU permit.

(b) Annual Public Hunting (APH) Permit and Limited Public Use (LPU) Permit.

(1) It is an offense for a person 17 years of age or older to enter public hunting lands or take or attempt to take wildlife resources on public hunting lands at times when an APH permit is required without possessing an APH permit or to fail to display the APH permit,

upon request, to a department employee or other official authorized to enforce regulations on public hunting lands.

(2) A person possessing a LPU permit may enter public hunting lands at times that access is allowed under the APH permit, and is authorized to fish but may not hunt ~~[but is not authorized to hunt or fish]~~.

(3) Persons possessing an APH permit or an LPU permit may use public hunting lands to access adjacent public waters, and may fish in adjacent public waters from riverbanks on public hunting lands.

(4) The permits required under paragraphs (1) - (3) of this subsection are not required for:

(A) persons who enter on United States Forest Service lands designated as a public hunting area or any portion of Units 902 and 903 for any purpose other than hunting;

(B) persons who enter on U.S. Army Corps of Engineers lands (Aquilla, Cooper, Dam B, Granger, Pat Mayse, Ray Roberts, Somerville, and White Oak Creek WMAs) designated as public hunting lands for purposes other than hunting or equestrian use;

(C) persons who enter Caddo Lake ~~[State Park and]~~ Wildlife Management Area and do not hunt or enter upon the land;

(D) persons who enter and hunt waterfowl within the Bayside Marsh Unit of Matagorda Island State Park and Wildlife Management Area; or

~~[(E) persons who enter the Bryan Beach Unit of Peach Point Wildlife Management Area and do not hunt; or]~~

(E) ~~[(F)]~~ persons who enter Zone C of the Guadalupe River Unit of the Guadalupe Delta Wildlife Management Area and do not hunt or fish.

(5) The permit required by paragraphs (1) - (3) of this subsection is not valid unless the signature of the holder appears on the permit.

(6) A person, by signature of the permit and by payment of a permit fee waives all liability towards the landowner (licensor) and Texas Parks and Wildlife Department (licensee).

(c) Regular Permit--A regular permit is issued on a first come-first served basis at the hunt area on the day of the scheduled hunt with the department reserving the right to limit the number of regular permits to be issued.

(d) Special Permit--A special permit is issued to an applicant selected in a drawing.

(e) Permits for hunting wildlife resources on public hunting lands shall be issued by the department to applicants by means of a fair method of distribution subject to limitations on the maximum number of permits to be issued.

(f) The department may implement a system of issuing special permits that gives preference to those applicants who have applied previously but were not selected to receive a permit.

(g) Application fees.

(1) The department may charge a non-refundable fee, which may be required to accompany and validate an individual's application in a drawing for a special hunting permit.

(2) The application fee for a special hunting permit is waived for a person under 17 years of age; however, the youth must apply in conjunction with an authorized supervising adult to whom an

application fee is assessed, except as provided in paragraphs (3) and (4) of this subsection.

(3) The application fee for a special permit is waived for an adult who is making application to serve as a non-hunting authorized supervising adult for a youth in a youth-only drawn hunt category.

(4) Persons under 17 years of age may be disqualified from applying for special package hunts or may be assessed the application fee.

(5) The application fee for a special permit is waived for on-site applications made under standby procedures at the time of a hunt.

(6) Incomplete or incorrectly completed applications will be disqualified.

(h) Legal animals to be taken by special or regular permit shall be stipulated on the permit.

(i) Only one special or regular permit fee will be assessed in the event of concurrent hunts for multiple species, and the fee for the legal species having the most expensive permit will prevail.

(j) Any applicable special or regular permit fees will be waived for youth under the supervision of a duly permitted authorized supervising adult.

(k) Any applicable regular permit fees ~~[for hunting or fishing activities]~~ will be waived for persons possessing an APH permit.

(l) Certain hunts may be conducted totally or in part by regular permit. It is an offense to fail to comply with established permit requirements specifying whether a regular permit is required of all participants or required only of adult participants who do not possess an APH permit.

(m) Any applicable regular permit fees for authorized activities other than hunting or fishing will be waived for persons possessing an APH permit or an LPU permit.

(n) An access permit applies only to the individual to whom the permit is issued, and neither the permit nor the rights granted thereunder are transferable to another person.

(o) A person who fails to obey the conditions of a permit issued under this subchapter commits an offense.

§65.198. Entry, Registration, and Checkout.

(a) It is an offense if a person:

(1) who does not possess a valid permit enters public hunting lands at a time when access is restricted only to persons possessing a valid permit;

(2) enters an area identified by boundary signs as a limited use zone, sanctuary, or restricted area and fails to obey the restrictions on public use posted at the area or as set forth in this subchapter; or

(3) on areas where on-site registration is required, fails to check in at a registration station and properly complete registration procedures before initiation of hunting, fishing, or recreational ~~[non-consumptive]~~ use activities or fails to properly check out at the registration station before departing the area.

(b) Unless otherwise authorized in writing by the department or as provided in subsection (c) of this section, it is an offense if a person participating in a hunt conducted by special permit or totally or in part by regular permit fails to:

(1) check in at a designated check station prior to initiation of hunting activities; and

(2) check out at a designated check station or otherwise fails to allow inspection of the bag before leaving the area.

(c) The requirements of subsection (b) of this section may be waived for specific hunts as designated by order of the executive director or by direction of the hunt supervisor. Participation in regular permit hunts for which the check station requirement has been waived will be solely by APH permit.

(d) Access for recreational ~~[non-consumptive]~~ use and fishing may be temporarily restricted while hunts are being conducted by special or regular permit or at times when ongoing research or management activities may be impacted.

§65.199. *General Rules of Conduct.*

This section applies to all public hunting lands unless an exception for a specific area and time period is designated by the executive director or by written permission of the department. It is unlawful for any person to:

(1) fail to obey regulations posted at the area or policies established by order of the executive director, fail to comply with instructions on permits or area leaflets, or refuse to follow directives given by departmental personnel in the discharge of official duties;

(2) possess a firearm, archery equipment, or any other device for taking wildlife resources on public hunting lands, except for persons authorized by the department to hunt or conduct research on the area, commissioned law enforcement officers, and department employees in performance of their duties;

(3) camp or construct an open fire anywhere other than in a designated campsite. On the Alabama Creek, Bannister, Caddo, Moore Plantation, and Sam Houston National Forest WMAs, this restriction applies only during the period from the day prior to the opening of the archery deer season through the day following the close of the general deer season;

(4) camp for than more than 14 consecutive days on the same unit of public hunting lands, or for more than 21 days in any 30-day period;

(5) ~~[(4)]~~ cause, create, or contribute to excessive or disturbing sounds beyond the person's immediate campsite between the hours of 10 p.m. and 6 a.m.;

(6) ~~[(5)]~~ establish a camp and leave it unattended for a period of longer than 24 hours;

(7) ~~[(6)]~~ disturb or remove plants, wood, rocks, gravel, sand, soil, shell, artifacts, or other objects from public hunting lands, except as authorized by the department;

(8) ~~[(7)]~~ write on, scratch, or otherwise deface natural features, signs, buildings, or other structures;

(9) ~~[(8)]~~ fail to deposit refuse in designated containers or fail to remove it from the area;

(10) ~~[(9)]~~ consume or be under the influence of alcohol while engaged in hunting activities, or to publicly consume or display an alcoholic beverage while on public hunting lands;

(11) ~~[(10)]~~ possess dogs in camp that are not confined or leashed;

(12) ~~[(11)]~~ use or possess any type of riding stock or pack animal on public hunting lands at any time, except:

(A) as may be provided by order of the executive director; or

(B) by written authorization of the department; ~~[(or)]~~

~~[(C) when authorized for specific areas and time periods scheduled under the Texas Conservation Passport Program;]~~

(13) ~~[(12)]~~ use an airboat within the boundaries of public hunting lands, except as designated for specific areas and time periods by order of the executive director or by written permission of the department;

(14) ~~[(13)]~~ take an antlerless deer during the general open season on wildlife management areas jointly managed by TPW and the U.S. Forest Service (Alabama Creek, Bannister, Caddo, Moore Plantation, or Sam Houston National Forest) unless that person possesses on their person a U.S.F.S. antlerless permit~~[TPW-issued WMA Antlerless Permit]; [or]~~

(15) ~~[(14)]~~ enter a unit of public hunting lands with an equine or equines, or cause the entry of an equine or equines to a unit of public hunting lands, unless that person has in their immediate possession, for each equine in the person's custody or equine that the person allowed to enter the unit of public hunting lands, a completed VS Form 10-11 (Texas Animal Health Commission) showing that the equine has tested negative to an official Equine Infectious Anemia test within the previous 12 months. The documentation required by this paragraph shall be made available for inspection upon the request of any department employee acting within the scope of official duties;~~[-]~~

(16) park or leave a motor vehicle unattended anywhere other than in designated parking areas, if parking areas have been designated;

(17) use a motor vehicle, off-road vehicle, or ATV on a road, in an area, or at a time when such use is restricted to disabled persons, unless the person is in possession of a state-issued disabled parking placard or disabled license plate or assisting such a person;

(18) engage in any activity not specifically authorized by order of the executive director or regulation of the commission.

§65.201. *Motor Vehicles.*

(a) It is an offense to not confine motor vehicle use to designated roads, except parking is permitted on the shoulder of or immediately adjacent to designated roads, and as provided for a disabled person or for a person directly assisting a disabled person.

(b) It is unlawful to hunt any wildlife resource from a motor vehicle, motor-driven land conveyance, or possess a loaded firearm in or on the vehicle, except as provided for a disabled person.

(c) A disabled person may possess a loaded firearm in or on a motor vehicle and may hunt from a motor vehicle except only paraplegics and single or double amputees of legs may hunt migratory birds from a motor vehicle, provided the motor vehicle is not in motion, the engine is not running, and the motor vehicle is not located on a designated road, designated vehicle parking area, or designated campground.

(d) Except as authorized for specific areas and time periods by order of the executive director, or by written permission of the hunt supervisor or area manager, it is an offense for an individual other than a disabled person or a person directly assisting a disabled person to operate an off-road vehicle ~~[all terrain vehicle (ATV)]~~ on public hunting lands.

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

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500564
Gene McCarty
Chief of Staff
Texas Parks and Wildlife Department
Earliest possible date of adoption: March 20, 2005
For further information, please call: (512) 389-4775



PART 17. TEXAS STATE SOIL AND WATER CONSERVATION BOARD

CHAPTER 523. AGRICULTURAL AND SILVICULTURAL WATER QUALITY MANAGEMENT

31 TAC §523.6

The Texas State Soil and Water Conservation Board (State Board) proposes an amendment to 31 TAC §523.6(e)(2) concerning when the State Board may grant a waiver for an eligible person to receive cost share more than once on certified water quality management plan. The proposed amendment would allow the State Board, on a case-by-case basis, to grant a waiver to an eligible person to receive another cost share where the life expectancy of the previously cost shared best management practice(s) has expired.

Kenny Zajicek, Fiscal Officer, Texas State Soil and Water Conservation Board, has determined that for the first five year period there will be no fiscal implications for state or local government as a result of administering this rule amendment.

Mr. Zajicek has also determined that for the first five-year period this rule amendment is in effect, the public benefit anticipated/cost will be the continued implementation of best management practices to address nonpoint source water pollution in areas of the state with potential and/or identified problems. Individual farmers and ranchers voluntarily participate in the program to receive cost share to implement best management practices to address water quality concerns. There is no anticipated cost to small businesses or individuals resulting from this rule amendment.

Comments on the proposed new rule may be submitted in writing to Rex Isom, Executive Director, Texas State Soil and Water Conservation Board, P.O. Box 658, Temple, Texas 76503, (254) 773-2250, ext. 231.

The amendment is proposed under the Agriculture Code Title 7, Chapter 201. §201.020 of that code authorizes the State Board to adopt rules that are necessary for the performance of its functions under this chapter and §201.026 provides authorization for the State Board to administer a water quality management plan program.

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

§523.6. *Cost-Share Assistance for Soil and Water Conservation Land Improvement Measures.*

- (a) - (d) (No change.)
- (e) Eligibility for Cost-Share Assistance.
 - (1) (No change.)

(2) In accordance with the terms of the maintenance agreement an eligible person may receive cost share only once for a conservation management unit. The State Board on a case by case, project or watershed basis in consultation with the soil and water conservation district may grant a waiver to this requirement in situations where:

(A) Research and/or advanced technology indicates a plan modification to include additional measures to meet water quality standards is needed;

(B) The operating unit is significantly increased in size by the addition of new land areas that require conservation land treatment measures in order to meet water quality standards;

(C) More stringent measures become necessary to meet water quality standards.

(D) A landowner has assumed the responsibilities of a maintenance agreement in cases where the landowner was not the applicant.

(E) The life expectancy of the previously cost-shared best management practice(s) has expired.

(3) - (8) (No change.)

(f) - (i) (No change.)

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

Filed with the Office of the Secretary of State on February 3, 2005.

TRD-200500496
Mel Davis
Special Projects Coordinator
Texas State Soil and Water Conservation Board
Earliest possible date of adoption: March 20, 2005
For further information, please call: (254) 773-2250



TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 3. TEXAS YOUTH COMMISSION

CHAPTER 91. PROGRAM SERVICES

SUBCHAPTER D. HEALTH CARE SERVICES

37 TAC §91.99

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

The Texas Youth Commission (the commission) proposes the repeal of §91.99, Medical Admissions for Al Price State Juvenile Correctional Facility. The repeal of the section will allow for a significantly revised rule to be published in its place. The revised rule can be found in this issue of the *Texas Register*.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the repeal is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the repeal.

Neil Nichols, General Counsel, has determined that for each year of the first five years the repeal is in effect the public benefit anticipated as a result of repealing the section will be the publication of an updated rule to replace this section. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the repeal as proposed. No private real property rights are affected by adoption of this repeal.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or e-mail to deanna.lloyd@tyc.state.tx.us.

The repeal is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its function.

The proposed repeal implements the Human Resources Code, §61.034.

§91.99. Medical Admissions for Al Price State Juvenile Correctional Facility.

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

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500460

Dwight Harris

Executive Director

Texas Youth Commission

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 424-6301



37 TAC §91.99

The Texas Youth Commission (the commission) proposes new §91.99, Medical Admissions for Al Price State Juvenile Correctional Facility. The new section will provide a greater consistency and clarity as to the medical admission of youth at Al Price State Juvenile Correctional Facility (APSJCF) Medical Recovery Dorm (MRD). The MRD is a male only dorm for youth who have chronic illnesses requiring frequent monitoring by medical staff or youth with acute conditions that require frequent care. Youth may be referred to the MRD from the commission's operated institutions or high restriction contract care programs. The new section also provides criteria and procedures as to when a youth is placed in the MRD for medical reasons.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Neil Nichols, General Counsel, has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will allow for accurate and clear procedures for medical admission to the MRD program at Al Price State Juvenile Correctional Facility. There will be no effect on small 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 rule.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or e-mail to deanna.lloyd@tyc.state.tx.us.

The new section is proposed under the Human Resources Code, §61.076, which provides the commission with the authority to provide any medical treatment that is necessary for Texas Youth Commission youth.

The proposed section implements the Human Resources Code, §61.034.

§91.99. Medical Admissions for Al Price State Juvenile Correctional Facility.

(a) Purpose. The purpose of this rule is to establish criteria and procedures for medical admission of youth to the Al Price State Juvenile Correctional Facility (APSJCF) Medical Recovery Dorm (MRD). The MRD is a male only dorm for Texas Youth Commission (TYC) youth who have chronic illnesses requiring frequent monitoring by medical staff or youth with acute conditions that require frequent care. Youth may be referred to the MRD from TYC-operated institutions or high restriction contract care programs.

(b) Applicability. When a youth is placed in the MRD for medical reasons, this policy must be read in conjunction with:

(1) §91.81 of this title (relating to Medical Consent).

(2) §91.83 of this title (relating to Criteria for Health Care).

(3) §91.85 of this title (relating to Medical Care).

(4) §91.92 of this title (relating to Psychotropic Medication-Related Emergencies).

(5) §87.1 of this title (relating to Case Planning).

(c) Explanation of Terms Used.

(1) Admission Review Team--is a team that reviews referrals for medical admission to the MRD. At a minimum, the admission review team consists of a program administrator (PA), facility nurse manager or designee, primary service worker (PSW), juvenile corrections officer VI (JCO) and a psychologist.

(2) Phase Assessment Team (PAT)--is responsible for monitoring and assessing a youth's progress through the Resocialization program. At a minimum, the PAT consists of the PA or designee, PSW, JCO, facility nurse manager or designee and designated education staff.

(d) Admission Criteria. Youth from a residential setting or Marlin Orientation and Assessment Unit (MOAU) may be eligible for placement to the MRD for medical reasons according to the following criteria:

(1) youth with a chronic condition who need more frequent health counseling to manage their disease upon release, youth whose chronic condition is uncontrolled, or youth whose condition requires frequent medical monitoring. Examples of conditions include, but are not limited to, uncontrolled diabetes, hepatitis B or C, sickle cell disease or multiple sclerosis; or

(2) youth with acute conditions that require more frequent care. Examples of conditions include, but are not limited to, severe fractures or post-operative care. These youth would be considered to be in need of transitional care; or

(3) youth requiring frequent trips to University of Texas Medical Branch (UTMB) for any reason. Examples include, but not limited to, extensive diagnostic testing or chemotherapy.

(e) Admission Process.

(1) Youth may be referred from the MOAU or from another facility or high restriction contract care program to the MRD. If referred from another facility or high restriction contract care program, the action is considered an administrative transfer under §85.45 of this title (relating to Movement Without Program Completion). Youth may contest such a transfer by filing a complaint under §93.31 of this title (relating to Complaints Resolution System).

(A) A referral packet is completed and forwarded with the appropriate signature from the sending superintendent or the quality assurance administrator to the MRD admissions review team at APSJCF.

(B) The admission review team will review the referral packet to determine if the MRD placement is appropriate for the youth.

(2) Emergency Referrals. If an emergency exists, the sending superintendent or the quality assurance administrator may request of the APSJCF superintendent immediate placement in the MRD.

(f) General MRD Requirements.

(1) The MRD focus will be on the coordination and provision of health care services.

(2) Health care services will be provided in the MRD, and the APSJCF infirmary, whichever is most appropriate.

(3) Parents or guardians of youth under the age of 18 will be notified of all movements to or from the MRD, any significant change in medical condition or if their child is on psychotropic medication. Youth 18 or older must give consent to disclose any of the information listed above to parents or guardians.

(g) MRD Requirements.

(1) Individual Case Plan (ICP) reflecting treatment goals shall be developed for and with each youth. Refer to §87.1 of this title.

(2) The facility nurse manager or designee will provide updates at the monthly PAT meeting regarding medical treatment goals and objectives. The PSW will incorporate the medical treatment goals and objectives into the youth's ICP.

(3) The PAT shall conduct a review of the youth's progress at least every 30 days in conjunction with the ICP review until the youth's placement in the MRD has ended. The review must:

(A) find that the admission criteria continue to be met;

(B) find that the treatment needs are appropriate;

(C) update the ICP to include reasons for continued stay in the MRD.

(4) Upon a determination by the PAT that the youth has met program completion criteria, the youth will be released or transferred under the appropriate rule:

(A) §85.55 of this title (relating to Program Completion for Other Than Sentenced Offenders).

(B) §85.59 of this title (relating to Program Completion for Sentenced Offenders Under Age 19).

(C) §85.61 of this title (relating to Program Completion for Sentenced Offenders Age 19 or Older).

(D) §85.69 of this title (relating to Program Completion for Sentenced Offenders Adjudicated for Capital Murder).

(E) §85.41 of this title (relating to Maximum Length of Stay for Other Than Type A Violent and Sentenced Offenders).

(h) Release from the MRD.

(1) Upon a determination by the youth's physician, that the youth's medical condition is stable enough to be released, transitioned, or transferred from the MRD, the PAT recommends to the APSJCF superintendent the release, transition or administrative/TDCJ transfer of a youth from the MRD. The facility's physician will be consulted when questions arise regarding the release, transition or transfer. The TYC medical director may be consulted before making final decisions regarding the release, transition or transfer of youth from the MRD.

(2) The admission review team may recommend the youth to remain at the APSJCF.

(3) The APSJCF superintendent must approve the release, transition, or transfer of youth from the MRD.

(4) If the youth has not completed the program completion criteria, the youth will be returned to his/her originally assigned facility. This is considered an administrative transfer as described in §85.45 of this title, unless the original assignment was APSJCF. This movement is considered a dorm change.

(5) When a youth is released, transitioned, or administrative transferred or transferred to TDCJ, the PSW will ensure that a summary of pertinent medical information and required follow-up care is included in the transition ICP in the special needs section.

(i) Transportation.

(1) The referring facility will make the transportation arrangements to APSJCF for initial admission referrals.

(2) When a youth is medically released and needs to be transported, APSJCF will request transportation through statewide transportation. See §117.7 of this title (relating to Terminations/Discharges (Article VII, NAJCA)).

(3) When required by a youth's condition, the APSJCF medical van will be used to transport the youth to and from APSJCF.

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

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500461

Dwight Harris

Executive Director

Texas Youth Commission

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 424-6301



CHAPTER 99. GENERAL PROVISIONS

SUBCHAPTER C. MISCELLANEOUS

37 TAC §99.90

The Texas Youth Commission (the commission) proposes an amendment to §99.90, Vehicle Fleet Management. The amendment to the section will provide clarity for using "pooled" vehicles

and personal vehicles and include who is responsible for compiling and reporting the annual Fleet Operations Indirect Costs report to Texas Building Procurement Commission. Minor grammatical changes also occurred.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the amendment is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the amended section.

Neil Nichols, General Counsel, has determined that for each year of the first five years the amendment is in effect the public benefit anticipated as a result of enforcing the amended section will reflect the statutory requirements mandated by the Texas Building Procurement Commission, Office of Vehicle Fleet Management's *State Vehicle Fleet Management Plan*. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the amendment as proposed. No private real property rights are affected by adoption of this amendment.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or e-mail to deanna.lloyd@tyc.state.tx.us.

The amendment is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The proposed amendment implements the Human Resources Code, §61.034.

§99.90. *Vehicle Fleet Management.*

- (a) (No change.)
- (b) Explanation of Terms Used.

(1) Fleet Manager--a TYC employee in the Central Office Support Services Department [~~central office business services department~~] who is responsible for day-to-day agency-wide fleet management. Responsibilities include guidance to Central Office [~~central office~~] and field fleet motor pool operations and maintenance, data collection and reporting, and acting as the central point of contact with the TBPC OVFM.

- (2) - (3) (No change.)

(4) Vehicle Utilization Board (VUB)--a special TYC Board [~~board~~] appointed by the deputy executive director and chaired by the assistant deputy executive director for financial support with members from the TYC Finance and Juvenile Corrections Departments [~~finance and juvenile corrections departments~~] that oversee development and implementation of TYC fleet management policy, and make recommendations to the Executive Committee [~~executive committee~~] relative to agency vehicle fleet matters such as vehicle authorization levels, purchasing and replacement.

- (5) - (9) (No change.)

- (c) Applicability. This rule applies to all TYC staff[; ~~state-employed contract nurses;~~] and volunteers under certain circumstances.
- (d) Fleet Management Structure.

(1) The TYC Executive Committee [~~executive committee~~] will provide executive level oversight and support and be the final approval authority for major vehicle fleet decisions relative to policy, authorization levels, and appropriations requests based on the recommendations of the TYC VUB and agency fleet manager.

- (2) (No change.)

(3) The fleet manager will make purchasing, replacement, repair, assignment and use, disposal decisions and recommendations to the VUB and Executive Committee [~~executive committee~~] as appropriate. The fleet manager coordinates the rotation of authorized vehicles between agency locations based on mission and utilization requirements.

(4) The VCO will be the fleet manager in Central Office [~~central office~~], business manager at the institutions, superintendent at the halfway houses, and quality assurance administrator/parole supervisor at the service areas. VCO's are responsible for maintenance and repair of vehicles, scheduling use of motor pool vehicles, collecting and reporting fleet data, securing and issuing keys and fuel cards and documenting return of same. The VCO is required to sign the Agreement for Vehicle Control Officer form, BSD-807 and submit the form to the fleet manager in Central Office [~~central office~~].

- (e) (No change.)
- (f) Explanation of Motor Pool.

(1) TYC will form statewide motor pools based on the primary function or utilization of each vehicle. Each agency vehicle will be assigned within an agency motor pool at a specific location and made available for checkout for official duty purposes where applicable. Each agency location will be authorized a specific number of vehicles within each designated utilization pool based on relative size or unique mission requirements. Vehicles will be rotated among locations and pools as necessary to meet utilization and efficiency criteria. Sub-pools may be formed at a location for more efficient management or utilization purposes. The following statewide pools will be formed.

- (A) (No change.)
- (B) Administrative Support Vehicles.

(i) Pool vehicles will be made available for employee check-out as needed with local responsibility for prioritizing their use in the event of conflicting requirements. Administrative vehicle utilization can be augmented with leased or rental vehicles within mission and budget requirements.

(ii) When needs exceed availability, the chief local administrator (CLA) will ensure the "best value" between using pool vehicles, rental vehicles, and/or personal reimbursement and make assignments accordingly. Employees cannot be required to use their personal vehicles for state business.

- (C) - (D) (No change.)

(E) Special Requirements Vehicles. The heavy equipment or special purpose vehicles, such as dump trucks, fire trucks, and staked flatbed trucks ~~are~~ specifically authorized at some TYC locations because of unique circumstances or need.

(2) Individual Vehicle Assignments. The executive director may assign state owned vehicles to an individual or executive employee on a regular basis only with written documentation that the assignment is critical to the mission of the agency. The following information must be reported to the OVFM as individual assignments occur. For specific policy and procedures regarding state vehicle assignment(s) refer to TYC's Personnel Policy and Procedure Manual (PRS) [§]43.15 [~~of this title~~] (relating to State Vehicle Assignments).

(A) (No change.)

(B) name and position of the individual to whom it is assigned unless a determination is made by the Executive Committee [~~executive committee~~] that there is a law enforcement or security determination and the vehicle has been issued alias license plates; and

(C) (No change.)

(3) TYC will establish and maintain the general minimum mileage criteria for its pooled vehicles based on the guidelines provided by OVFM. The [agency] fleet manager will track utilization and initiate actions to rotate vehicles between locations or pools to meet minimum utilization criteria. The [agency] fleet manager will assist the VCOs as necessary in identifying [identify] unique requirements and justification for specific other minimum use criteria for OVFM consideration and waiver. The fleet manager will provide responses and justification to OVFM within 30 days of receipt of the semi-annual [quarterly] vehicle utilization reports.

(4) - (5) (No change.)

(6) TYC will out-source maintenance and repair of fleet assets unless it is demonstrated to be more economical to perform those functions in-house. TYC will seek [develop] interagency agreements to obtain maintenance, repairs and fuel where feasible.

(7) - (8) (No change.)

(9) The fleet manager will collect, compile and report the data for the annual Fleet Operations Indirect Costs report to TBPC based on data provided by the VCOs.

(g) Driving Requirements.

(1) Authorized Drivers. Individuals [Persons] authorized to drive a state owned vehicle, privately owned vehicle, or a leased vehicle on TYC business shall do so in a responsible manner obeying all state laws and in compliance with the following rules. [~~This policy applies to vehicles that are driven on public roads, highways and on the grounds of TYC facilities.~~] For specific procedures regarding authorized drivers refer to (PRS) [§]43.13 [to this title] (relating to Driving Requirements).

(2) General Driver Rules.

(A) State vehicles shall be used only for official business. Official business may include travel directly to an employee's home the night before official travel begins or travel directly from an employee's home to his/her work site the morning after official travel

ends when such is authorized by the employee's supervisor and will expedite the employee's travel or otherwise make the most efficient use of the employee's time. See (PRS) [§]43.13 [to this title] (relating to Driving Requirements).

~~[(B) State owned vehicles will be available to TYC staff, volunteers, and contract nurses to transport youth at TYC staffed facilities in emergencies.]~~

(B) [~~(C)~~] Drivers and passengers are not permitted to smoke or use tobacco while operating or traveling in a state owned vehicle.

(C) [~~(D)~~] Drivers and passengers are not permitted to consume or transport alcohol while operating or traveling in a state owned vehicle.

(3) Vehicle Accident. If an authorized [the] driver is involved in an accident, he/she should notify his/her supervisor and the VCO immediately. If the accident occurs on a public thoroughfare, the proper authorities must be notified. See (PRS) [§]43.13 [to this title] (relating to Driving Requirements).

(4) Use of Fuel Cards. TYC assigned [gasoline] fuel credit cards [~~assigned by TYC~~] are to be used only for purchase of fuel [gasoline], standard preventive maintenance items (oil and filter changes, etc.), car washes, and minor repairs [~~and ear washes~~]. TYC issued fuel cards may be used only in state owned vehicles and vehicle(s) leased for state proposes. See (PRS) [§]43.13 [to this title] (relating to Driving Requirements).

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

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500490

Dwight Harris

Executive Director

Texas Youth Commission

Earliest possible date of adoption: March 20, 2005

For further information, please call: (512) 424-6301

◆ ◆ ◆

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 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 109. BUDGETING, ACCOUNTING, AND AUDITING

SUBCHAPTER AA. COMMISSIONER'S RULES CONCERNING FINANCIAL ACCOUNTABILITY RATING SYSTEM

19 TAC §109.1002

The Texas Education Agency (TEA) withdraws an amendment to §109.1002, concerning the financial accountability rating system that was published as proposed in the August 6, 2004, issue of the *Texas Register* (29 TexReg 7626). The section addresses financial accountability ratings assigned to school districts by the TEA and provides the financial accountability rating form entitled "School FIRST--Rating Worksheet." The proposed amendment would have updated the rating system by adding a critical indicator and enhancing other indicators. A new proposal adding more indicators, establishing a different scoring process for many measures, and creating new disclosure requirements will be brought forward at a future date.

Senate Bill (SB) 875, 76th Texas Legislature, 1999, added TEC, §39.201, requiring the commissioner of education in consultation with the comptroller of public accounts to develop proposals for a school district financial accountability rating system that was to be presented to the legislature no later than December 15, 2000. TEC, §39.201, expired September 1, 2001. Subsequently, SB 218, 77th Texas Legislature, 2001, added TEC, §§39.201 - 39.204, requiring the commissioner to adopt rules for the implementation and administration of the financial accountability rating system prescribed by TEC, Chapter 39, Subchapter I.

19 TAC Chapter 109, Budgeting, Accounting, and Auditing, Subchapter AA, Commissioner's Rules Concerning Financial Accountability Rating System, adopted to be effective October 20, 2002, establishes provisions that detail the purpose, ratings, types of ratings, criteria, reporting, and sanctions for the financial accountability rating system, in accordance with

SB 218, 77th Texas Legislature, 2001. The adopted rules include the financial accountability rating form entitled "School FIRST--Rating Worksheet" that explains the indicators that the Texas Education Agency will analyze to assign school district financial accountability ratings. This form specifies the minimum financial accountability rating information that a district is to report to parents and taxpayers in the district.

The rating worksheet, along with accompanying calculation instructions, was adopted in 19 TAC §109.1002 to be effective October 20, 2002, and later amended to be effective May 7, 2003. The 2003 amendment to 19 TAC §109.1002 included minor technical edits that crosswalked exhibit numbers referenced in the "School FIRST--Rating Worksheet," according to the new standard for the Annual Financial and Compliance Report filed by school districts for fiscal year 2002 - 2003. This rating worksheet, dated May 2003, establishes the indicators applicable to school district financial accountability ratings issued in fiscal years 2002 - 2003, 2003 - 2004, and to be issued in 2004 - 2005. These ratings are assigned based on data from fiscal years 2001 - 2002, 2002 - 2003, and 2003 - 2004, respectively.

The withdrawn amendment to 19 TAC §109.1002 would have updated the rating system by adding a new critical indicator and enhancing other existing indicators. The revised rating system would have been applicable to school district financial accountability ratings issued beginning in fiscal year 2005 - 2006. A new proposal adding more indicators, establishing a different scoring process for many measures, and creating new disclosure requirements will be brought forward at a future date.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500512

Cristina De La Fuente-Valadez
Director, Policy Coordination

Texas Education Agency

Effective date: February 4, 2005

For further information, please call: (512) 475-1497



ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text as published in 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 4. OFFICE OF THE SECRETARY OF STATE

CHAPTER 81. ELECTIONS

SUBCHAPTER I. IMPLEMENTATION OF THE HELP AMERICA VOTE ACT OF 2002

1 TAC §81.176

The Office of the Secretary of State, Elections Division, adopts new §81.176 concerning provisional voting for direct record electronic voting systems. The rule is adopted without change to the text as proposed in the September 17, 2004, issue of the *Texas Register* (29 TexReg 8978).

The new section will authorize voting systems to utilize electronic voting where the results of provisional votes are properly segregated from the totals until the votes are accepted by the early voting ballot board.

No comments were received concerning the proposed rule.

The rule is adopted under the Texas Election Code (Code), Chapter 31, Subchapter A, §31.003, which provides the Secretary of State with authority to promulgate rules to obtain uniformity in the interpretation and application of the Code, and under the Code, Chapter 122, §122.001(c), which authorizes the Secretary of State to prescribe additional standards for voting systems.

The Code, Chapter 122, is affected by this adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500494

Ann McGeehan

Director of Elections

Office of the Secretary of State

Effective date: February 22, 2005

Proposal publication date: September 17, 2004

For further information, please call: (512) 475-2821



PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8063

The Health and Human Service Commission (HHSC or the Commission) adopts amended §355.8063, Reimbursement Methodology for Inpatient Hospital Services, with changes to the proposed text as published in the October 22, 2004, issue of the *Texas Register* (29 TexReg 9754). The text of the rule will be republished.

The amended §355.8063 allows for subsection (u) to replace the standard dollar amount (SDA) high-volume add-on factor with a proportionate payment methodology that allocated payments based on uncompensated care losses of designated Medicaid high-volume hospitals. The amended rule also adds language to target increases in high-volume payments to hospitals with Medicaid inpatient utilization in excess of 160% of the statewide average and distribute the payments based on Medicaid inpatient days. The amended rule will allow HHSC to achieve greater Medicaid program budget certainty while simplifying and streamlining the overall administrative process regarding high-volume Medicaid payments. The amendment to §355.8063(t)(1) will also add Potter and Randall counties to the list of urban counties with a publicly-owned hospital or hospital affiliated with a hospital district that is eligible to receive supplemental Medicaid payments for inpatient hospital services provided to Medicaid patients.

HHSC received comments regarding the proposed rule during the comment period, which included a public hearing on October 22, 2004, expressing support for the rule to implement high-volume payments to non-public, non-state hospitals. Written and public hearing comments were received from the following associations: Health Care Association, Tenet, Universal Health Services, Association of Volunteer Hospitals, Christus Santa Rosa Health Care, Texas Hospital Association, Christus St. Joseph Hospital, Scott & White Memorial Hospital, Christus Health Gulf Coast, Trinity Mother Frances Health System and from a Texas State Representative.

Comment: Comments concerning §355.8063 were received from Health Care Association, Tenet, Universal Health Services, Association of Volunteer Hospitals, Christus Santa Rosa Health Care, Texas Hospital Association, Christus St. Joseph Hospital, Scott & White Memorial Hospital, Christus Health Gulf Coast, Trinity Mother Frances Health System and from a Texas State Representative requesting that disproportionate share hospital status be required to qualify for the high-volume payments.

Response: The Commission acknowledges the comments received. High-volume payments are intended to provide additional reimbursement for higher medical assistance costs and indigent care cost of both DSH and non-DSH hospitals that treat higher levels of low-income and indigent patients. The supplemental payments allow both DSH and non-DSH hospitals to better cover the cost of serving Medicaid patients, thus assuring continued provider participation in the Medicaid program and high quality healthcare for Medicaid clients. No change was made to the rule in response to these comments.

Comment: HHSC received a comment from an HHSC staff member who recommended some grammatical changes to the rule.

Response: HHSC agrees with the commenter. The rule was revised to include the grammatical changes suggested by the HHSC staff member.

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

§355.8063. *Reimbursement Methodology for Inpatient Hospital Services.*

(a) Introduction. Except as otherwise specified in subsection (q) of this section, the Texas Medical Assistance Program (Medicaid) reimburses hospitals, except in-state children's hospitals, for covered inpatient hospital services using a prospective payment system. In-state children's hospitals are reimbursed for covered inpatient hospital services using the methodology described in subsection (o) of this section. For hospitals other than in-state children's hospitals, the department or its designee groups hospitals into payment divisions using the average base year payment per case in each hospital after adjusting each hospital's base year payment per case by a case mix index, a cost-of-living index, and a budgetary reduction factor of 10%. The budgetary reduction factor for admissions occurring in state fiscal year 1990 (September 1, 1989, through August 31, 1990) is 7.0% and the budgetary reduction factor for admissions occurring in state fiscal year 1991 (September 1, 1990, through August 31, 1991) is 5.5%. For admissions occurring in state fiscal year 1992 (September 1, 1991, through August 31, 1992) and subsequent state fiscal years, a budgetary reduction factor is not applied. The payment divisions are separated into \$100 increments. If a payment division has less than ten observations for Medicaid data, the department or its designee considers that payment division to be statistically invalid. Hospitals within that payment division are placed into the nearest valid payment division.

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

(1) Diagnosis-related group (DRG)--The taxonomy of diagnoses as defined in the Medicare DRG system or as otherwise specified by the department or its designee.

(2) Case mix index--The hospital-specific average relative weight.

(3) Relative weight--The arithmetic mean of the dollars for a specific DRG divided by the arithmetic mean of the dollars for all cases.

(4) Standard dollar amount--The weighted mean base year payment for all hospitals in a payment division after adjusting each hospital's base year payment per case by a case mix index, a cost-of-living index, and a budgetary reduction factor of 10%. The budgetary reduction factor for admissions occurring in state fiscal year 1990 (September 1, 1989, through August 31, 1990) is 7.0% and the budgetary reduction factor for admissions occurring in state fiscal year 1991 (September 1, 1990, through August 31, 1991) is 5.5%. For admissions occurring in state fiscal year 1992 (September 1, 1991, through August 31, 1992) and subsequent state fiscal years, a budgetary reduction factor is not applied. The department or its designee establishes a minimum standard dollar amount of \$1,600 and applies it to those hospitals whose standard dollar amount is less than the minimum. The department or its designee applies cost-of-living indexes to the standard dollar amounts established for the base year to calculate standard dollar amounts for prospective years. A cost-of-living index is not applied to the minimum standard dollar amount.

(5) Base year--A 12-consecutive-month period of claims data selected by the department or its designee as the basis for establishing the payment divisions, standard dollar amounts, and relative weights. The department or its designee selects a new base year at least every three years.

(6) Base year payment per case--The payment that would have been made to a hospital if the department or its designee reimbursed the hospital under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248. In calculating the base year payment per case, the department or its designee uses the interim rate established at tentative or final settlement, if applicable, of the most recent cost reporting period up to and including the cost reporting period associated with the base year.

(7) Interim rate--Total reimbursable Title XIX inpatient costs, as specified in paragraph (6) of this subsection, divided by total covered Title XIX inpatient charges per tentative or final cost reporting period. Beginning with 1985 hospital fiscal year cost reporting periods, the interim rate established at tentative settlement includes incentive/penalty payments to the extent that they continue to be permitted by federal law and regulation and continue to be included on Title XVIII cost reports.

(8) New hospital--A facility that has been in operation under present and previous ownership for less than three years and that initially enrolls as a Title XIX provider after the current base year. A new hospital must have been substantially constructed within the five previous years from the effective date of the prospective rate period.

(9) 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.

(10) Out-of-state children's hospital--A hospital outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(c) Calculating relative weights and standard dollar amounts. The department or its designee uses recent Texas claims data to calculate both the relative weights and standard dollar amounts. A relative weight is calculated for each DRG and applied to all payment divisions. A separate standard dollar amount is calculated for each payment division. Except for border hospitals with a Texas Medicaid provider number beginning with an H and out-of-state children's hospitals, the department or its designee uses the overall arithmetic mean base year payment per case, including the cost of living update as specified in subsection (n) of this section, as the standard dollar amount to reimburse out-of-state hospitals. The overall arithmetic mean base year

payment per case, including the cost of living update as specified in subsection (n) of this section, is also used as the standard dollar amount to reimburse military hospitals providing inpatient emergency services for admissions on or after October 1, 1993. The calculation of the standard dollar amount for out-of-state children's hospitals is described in subsection (r) of this section. Except for new hospitals, the overall arithmetic mean base year payment per case, including the cost of living update as specified in subsection (n) of this section, is also used as the standard dollar amount to reimburse hospitals that initially enroll as a Title XIX provider after the current base year. The standard dollar amount for new hospitals is the lesser of the overall arithmetic mean base year payment per case plus three percentile points, including the cost of living update as specified in subsection (n) of this section, or the hospital's average Medicaid cost per Medicaid discharge based on the tentative or final settlement, if applicable, of the hospital's first 12-month cost reporting period occurring after the hospital's enrollment as a Title XIX provider. In the event that the new hospital is a replacement facility for a hospital that is currently enrolled as a Title XIX provider, the hospital is reimbursed by using either the standard dollar amount of the existing provider or the standard dollar amount for new hospitals, whichever is greater. The use of the hospital's average Medicaid cost per Medicaid discharge, after adjusting for case-mix intensity, as its standard dollar amount is applied prospectively to the beginning of the next prospective year and is applicable only if the tentative or final settlement is completed and available at least 60 days before the beginning of the prospective year. The hospital's Medicaid costs are determined using similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248. When two or more Title XIX participating providers merge, the department or its designee combines the Medicaid inpatient costs, as described in this subsection, of each of the individual providers to calculate a standard dollar amount, effective at the start of the next prospective period, to be used to reimburse the merged entity. Acquisitions and buyouts do not result in a recalculation of the standard dollar amount of the acquired provider unless acquisitions or buyouts result in the purchased or acquired hospital becoming part of another Medicaid participating provider. When the department or its designee determines that the department or its designee has made an error that, if corrected, would result in the standard dollar amount of the provider for which the error was made changing to a new payment division, either higher or lower, the department or its designee moves the provider into the correct payment division, and the department or its designee reprocesses claims paid using the initial, incorrect standard dollar amount that was in effect for the current state fiscal year by using the existing standard dollar amount of the payment division in which the provider was moved. In the determination of the corrected payment division, the department or its designee uses the relative weights that are currently in effect for the state fiscal year. The correction of this error condition only applies to the current state fiscal year payments. No corrections are made to payment rates for services provided in previous state fiscal years. If a specific DRG has less than ten observations for Medicaid data, the department or its designee uses the corresponding Medicare relative weight, except for DRGs relating to organ transplants. Relative weights for organ transplant DRGs with less than ten observations may be developed using Medicaid-specific data. The relative weights include organ procurement costs for both solid and nonsolid organs. The department or its designee makes no distinction between urban and rural hospitals and there is no federal-national portion within the payment.

(d) Add-on payments. There are no separate add-on payments. The department or its designee:

(1) includes capital costs in the standard dollar amount for each payment division;

(2) includes the cost of indirect medical education in the standard dollar amount for each payment division;

(3) includes the cost of malpractice insurance in the standard dollar amount for each payment division; and

(4) includes return on equity in the standard dollar amount for each payment division.

(e) Calculating the payment amount. The department or its designee reimburses each hospital for covered inpatient hospital services by multiplying the standard dollar amount established for the hospital's payment division by the appropriate relative weight. The patient's DRG classification is primarily based on the patient's principal diagnosis. The resulting amount is the payment amount to the hospital.

(f) Patient transfers. If a patient is transferred, the department or its designee establishes payment amounts as specified in paragraphs (1) - (4) of this subsection. If appropriate, the department or its designee manually reviews transfers for medical necessity and appropriate payment.

(1) If the patient is transferred to a skilled nursing facility or intermediate care facility, the department or its designee pays the transferring hospital the total payment amount of the patient's DRG.

(2) If the patient is transferred to another hospital, the department or its designee pays the receiving hospital the total payment amount of the patient's DRG. The department or its designee pays the transferring hospital a DRG per diem. The DRG per diem is based on the following formula: (DRG relative weight x standard dollar amount)/DRG mean length of stay (LOS) x LOS. The LOS is the lesser of the DRG mean LOS, the claim LOS, or 30 days. The 30-day factor is not used in establishing a DRG per diem amount for a medically necessary stay of a recipient less than age one in a Title XIX participating hospital or a recipient less than age six in a disproportionate share hospital as defined by the department.

(3) If the department or its designee determines that the transferring hospital provided a greater amount of care than the receiving hospital, the department or its designee reverses the payment amounts. The transferring hospital is paid the total payment amount of the patient's DRG and the receiving hospital is paid the DRG per diem.

(4) The department or its designee makes multiple transfer payments by applying the per diem formula to the transferring hospitals and the total DRG payment amount to the discharging hospital.

(g) Split billing. The department or its designee does not allow interim billings by providers. The hospital may bill the department or its designee when the patient exceeds his 30-day inpatient hospital limit or is discharged. The department or its designee bases payment on the diagnosis codes known at billing. The payment is final.

(h) Rebased the standard dollar amounts. The HHSC or its designee rebases the standard dollar amount for each payment division at least every three years. HHSC will not rebase or recalculate the standard dollar amounts for each payment division for admissions during the period September 1, 2003 through August 31, 2005. The relative weights are recalibrated whenever the standard dollar amounts are recalculated. The standard dollar amounts are not rebased on an interim basis unless the HHSC or its designee determines that special circumstances warrant rebasing.

(i) Recalibrating the relative weights. The department or its designee recalibrates the relative weights whenever the standard dollar amounts are rebased.

(j) Revising the diagnosis related groups. The department or its designee parallels the taxonomy of diagnoses as defined in the Medicare DRG prospective payment system unless a revision is required based on Texas claims data or other factors as determined by the department or its designee.

(k) Appeals.

(1) A hospital may appeal individual claims as specified in other department rules. As specified in subparagraphs (A) - (C) of this paragraph, a hospital may also appeal mechanical, mathematical, and data entry errors in base year claims data and incorrectly computed subsequent adjustments to the hospital's base year claims data because of the base year's tentative or final settlement.

(A) If a hospital believes that the department or its designee made a mechanical, mathematical, or data entry error in computing the hospital's base year claims data, the hospital may request a review of the disputed calculation by the department or, at the department's direction, its designee. A hospital may not request a review if the disputed calculation is the result of the hospital's submittal of incorrect data or the result of the department's or its designee's application of an interim rate to the base year claims data derived from a cost reporting period occurring before the base year. Upon the provider hospital's request, the department or its designee provides the applicable available data used in calculating the hospital's base year claims data to the provider hospital. The hospital must submit a specific written request for review and appropriate specific documentation supporting its contention that there has been a mechanical, mathematical, or data entry error to the department or its designee. Except as specified in subparagraph (C) of this paragraph, the request must be submitted within 60 days after the hospital receives initial notification of its payment division and standard dollar amount. The department or its designee conducts the review as quickly as possible and notifies the hospital of the results. If the hospital is dissatisfied with the results of the review, the hospital may request a formal hearing under the procedures, including the expedited processing provisions, contained in Chapter 1 of this title (relating to the Texas Board of Health), except that, in the event of any conflict, the procedures contained in this section apply. Except as specified in subparagraph (C) of this paragraph, if the review or appeal is completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied to that next prospective year. If the review or appeal is not completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied only to the subsequent prospective year. The base year claims data used by the department or its designee pending the review or appeal is the base year claims data established by the department or its designee.

(B) If a hospital believes that the department or its designee incorrectly computed subsequent adjustments to the hospital's base year claims data because of the base year's tentative or final settlement, the hospital may request a review of the disputed calculation related to the tentative or final settlement by the department or, at the department's direction, its designee. The hospital's request may also include a request to review the tentative or final settlement. The hospital must submit a specific written request for review and appropriate specific documentation supporting its contention that the tentative or final settlement is incorrect to the department or its designee. Except as specified in subparagraph (C) of this paragraph, the request must be submitted within 60 days after the hospital receives notification of a tentative or final settlement of the base year data. The department or its designee conducts the review as quickly as possible and notifies the hospital of the results. If the hospital is dissatisfied with the results of

the review, the hospital may request a formal hearing under the procedures, including the expedited processing provisions, contained in Chapter 1 of this title (relating to the Texas Board of Health), except that, in the event of any conflict, the procedures contained in this section apply. Except as specified in subparagraph (C) of this paragraph, if the review or appeal is completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied to that next prospective year. If the review or appeal is not completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied only to the subsequent prospective year. The interim rate applied to the base year claims data pending the review or appeal is the interim rate established by the department or its designee.

(C) If a hospital believes that the department or its designee incorrectly computed the hospital's 1985 base year claims data as specified in subparagraph (A) of this paragraph, the hospital may submit a specific written request for review and appropriate specific documentation supporting its contention within 60 days after the effective date of this section. If a hospital believes that the department or its designee incorrectly computed the tentative or final settlement of the cost reporting period associated with the 1985 base year as specified in subparagraph (B) of this paragraph, the hospital may submit a specific written request for review and appropriate specific documentation supporting its contention within 60 days after the effective date of this section. The hospital must follow the process described in subparagraph (A) or (B) of this paragraph, as appropriate. If the review or appeal is completed by December 31, 1987, any adjustment required after the completion of the review or appeal is applied to the March 1, 1988, adjustment described in subsection (n) of this section. If the review or appeal is not completed by December 31, 1987, any adjustment required after the completion of the review or appeal is applied to the next prospective year.

(2) A hospital may not appeal the prospective payment methodology used by the department or its designee, including:

- (A) the payment division methodologies;
- (B) the DRGs established;
- (C) the methodology for classifying hospital discharges within the DRGs;
- (D) the relative weights assigned to the DRGs; and
- (E) the amount of payment as being inadequate to cover costs.

(l) Cost reports. Each hospital must submit a cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by the department or its designee. The department or its designee uses data from these reports in rebasing years, in making adjustments as described in subsections (n) and (q) of this section, and in completing cost settlements for children's hospitals.

(m) Cost settlements. If a hospital has already begun its fiscal year on September 1, 1986, cost settlement for that portion of the hospital's fiscal year which occurs before September 1, 1986, is based on reimbursement for covered inpatient hospital services under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248. Except as otherwise specified in subsection (q) of this section, there are no cost settlements for services provided to recipients admitted as inpatients to hospitals reimbursed under the prospective payment system on or after the implementation date of the prospective payment system.

(n) Adjustments to base year claims data.

(1) Beginning with 1985 hospital fiscal year cost reporting periods, the department or its designee adjusts each hospital's base year claims data and resulting payment division and standard dollar amount to reflect the interim rate established at tentative and final settlement, if applicable, of the cost reporting period associated with the base year. The adjustments are applied only to claims data for months within the base year that coincide with months within the hospital's cost reporting period. The claims data for months within the base year that do not coincide with months within the hospital's cost reporting period remain unchanged until the tentative or final settlement of the cost reporting period containing those months has been completed. The adjustments are applied to the next prospective year beginning September 1, 1988, except as specified in subparagraphs (A), (B), and (C) of this paragraph.

(A) If the tentative or final settlement is not completed and available at least 60 days before the beginning of the next prospective year, any adjustment required because of the settlement is applied to the subsequent prospective year.

(B) If a review or appeal of a tentative or final settlement is not completed at least 60 days before the beginning of the next prospective year, the interim rate applied to the claims data on which the hospital's payment division and standard dollar amount are established is the interim rate established at tentative or final settlement by the department or its designee. Any adjustment required after the completion of the review or appeal is applied only to the subsequent prospective year.

(C) The department or its designee makes a March 1, 1988, adjustment to each hospital's 1985 base year claims data and resulting payment division and standard dollar amount to reflect the interim rate established at tentative and final settlement, if applicable, of the cost reporting period associated with the 1985 base year. Any additional adjustments required as a result of reviews and appeals described in subsection (k) of this section and completed by December 31, 1987, are also reflected in the March 1, 1988, adjustment. Future adjustments as described in this subsection and subsection (k) of this section are made at the beginning of each prospective year.

(2) The HHSC or its designee updates the standard dollar amount each year for each payment division by applying a cost-of-living index to the standard dollar amount established for the base year. The cost-of-living index for state fiscal years 2003, 2004, and 2005 will not be applied to the standard dollar amount for admissions during the period September 1, 2003 through August 31, 2005. The index used to update the standard dollar amounts is the greater of:

(A) the Health Care Financing Administration's (HCFA) Market Basket Forecast (PPS Hospital Input Price Index) based on the report issued for the federal fiscal year quarter ending in March of each year, adjusted for the state fiscal year by summing one-third of the annual forecasted rate of the index for the current calendar year and two-thirds of the annual forecasted rate of the index for the next calendar year; or

(B) an amount determined by selecting the lesser of the following two measures:

(i) the change in total charges per case for the latest year available compared to total charges per case for the previous year; or

(ii) the change in the Texas medical consumer price index-urban (that is, the arithmetic mean of the Houston and Dallas/Fort Worth medical consumer price indices for urban consumers) for the latest year available compared to the Texas medical consumer price index-urban for the previous year.

(o) Reimbursement to in-state children's hospitals. The HHSC or its designee reimburses in-state children's hospitals under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248, Tax Equity and Fiscal Responsibility Act (TEFRA) except for the cost of direct graduate medical education (DGME). For cost reporting periods beginning on or after September 1, 2003, children's hospitals with allowable DGME costs as determined under TEFRA principles will receive a pro rata share of their annual TEFRA DGME cost based on appropriations or allocations from appropriations made specifically for this purpose. The amount and frequency of interim payments will also be subject to the availability of appropriations made specifically for this purpose. Interim payments are subject to settlement at both tentative and final audit of a hospital's cost report. The HHSC or its designee establishes target rates and stipulates payments per discharge, incentives, and percentage of payments. The department or its designee uses each hospital's 1987 final audited cost reporting period (fiscal year ending during calendar year 1987) as its target base period. The target base period for hospitals recognized by Medicare as children's hospitals after the implementation of this subsection is the hospital's first full 12-month cost reporting period occurring after its recognition by Medicare. The HHSC or its designee annually increases each hospital's target amount for the target base period by the cost-of-living index described in subsection (n) of this section. The HHSC or its designee selects a new target base period at least every three years. The HHSC or its designee bases interim payments to each hospital upon the interim rate derived from the hospital's most recent tentative or final Medicaid cost report settlement. If a Title XIX participating hospital is subsequently recognized by Medicare as a children's hospital after the implementation of this subsection, the hospital must submit written notification to the HHSC or its designee and include adequate documentation and claims data. Upon receipt of the written notification from the hospital, the HHSC or its designee reserves the right to take 90 days to convert the hospital's reimbursement to the reimbursement methodology described in this subsection.

(p) Day and cost outliers. Effective for inpatient hospital services provided on or after July 1, 1991, the HHSC or its designee pays day or cost outliers for medically necessary inpatient services provided to clients less than age one in all Title XIX participating hospitals and clients less than age six in disproportionate share hospitals, as defined by the HHSC, that are reimbursed under the prospective payment system. For purposes of outlier payment adjustments, disproportionate share hospitals are defined as those hospitals identified by the HHSC during the previous state fiscal year as disproportionate share hospitals. If an admission qualifies for both a day and a cost outlier, only the outlier resulting in the highest payment to the hospital is paid. (Note: This subsection does not address reimbursement for the provision of other necessary inpatient hospital services under the Early and Periodic Screening, Diagnosis, and Treatment Program, as required by the Omnibus Budget and Reconciliation Act of 1989.)

(1) To establish day outliers, the HHSC or its designee first removes from the current base year data those admissions whose actual lengths of stay are greater than or equal to plus or minus three standard deviations from the arithmetic mean length of stay for each DRG. The HHSC or its designee then recomputes the arithmetic mean length of stay and the standard deviations for each DRG. Inpatient days, which exceed two standard deviations beyond the arithmetic mean length of stay for the DRG are eligible for a day outlier. Payment is based on 70% of a per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

(2) To establish cost outliers, the HHSC or its designee first determines what the amount of reimbursement for the admission would have been if the HHSC or its designee reimbursed the hospital under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248, Tax Equity and Fiscal Responsibility Act (TEFRA). The HHSC or its designee then determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14, or the hospital's standard dollar amount multiplied by 11.14. The hospital's standard dollar amount is the amount that the HHSC or its designee uses to reimburse the hospital under the prospective payment system. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles. The HHSC or its designee multiplies any remainder by 70% to determine the actual amount of the cost outlier payment.

(3) If a recipient less than age one is admitted to and remains in a hospital past his or her first birthday, medically necessary inpatient days and hospital charges after the child reaches age one are included in calculating the amount of any day or cost outlier payment.

(q) Hospitals with 100 or fewer licensed beds and certain hospitals with more than 100 licensed beds. The policies in this subsection apply only to hospital fiscal years beginning on or after September 1, 1989 for hospitals with 100 or fewer licensed beds at the beginning of the hospital's fiscal year or hospital fiscal years beginning on or after September 1, 2003 for hospitals with more than 100 licensed beds at the beginning of the hospital's fiscal year, located in a county that is not in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget (OMB) and designated by the Center for Medicare & Medicaid Services as a Sole Community Provider (SCH) or Rural Referral Center RCC. At tentative cost settlement of the hospital's fiscal year (with subsequent adjustment at final cost settlement, if applicable), the HHSC or its designee determines what the amount of reimbursement during the fiscal year would have been if the HHSC or its designee reimbursed the hospital under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248, Tax Equity and Fiscal Responsibility Act (TEFRA). This determination is made without imposing a TEFRA cap. If the amount of reimbursement under the TEFRA principles is greater than the amount of reimbursement received by the hospital under the prospective payment system, the HHSC or its designee reimburses the difference to the hospital.

(r) Reimbursement to out-of-state children's hospitals. For admissions on or after September 1, 1991, the standard dollar amount for out-of-state children's hospitals is calculated as specified in this subsection. The department or its designee calculates the overall average cost per discharge for in-state children's hospitals based on tentative or final settlement of cost reporting periods ending in calendar year 1990. The overall average cost per discharge is adjusted for intensity of service by dividing it by the average relative weight for all admissions from in-state children's hospitals during state fiscal year 1990 (September 1, 1989 through August 31, 1990). The adjusted cost per discharge is updated each year by applying the cost-of-living index described in subsection (n) of this section. The resulting product is the standard dollar amount to be used for payment of claims as described in subsection (e) of this section. The department or its designee selects a new cost reporting period and admissions period from the in-state children's hospitals at least every three years for the purpose of calculating the standard dollar amount for out-of-state children's hospitals.

(s) Reimbursement of inpatient direct graduate medical education (GME) costs. The Medicaid allowable inpatient direct graduate

medical education cost, as specified under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248, is calculated for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report. Those inpatient direct medical education costs are removed from the calculation of the interim rate described in subsection (b)(7) of this section and not used in the calculation of the provider's standard dollar amount described in subsection (c) of this section. Those allowable inpatient direct graduate medical education costs for services delivered to Medicaid eligible patients with inpatient admission dates on or after September 1, 1997, will be subject to the cost determination and settlement provisions as described in this subsection. No Medicaid inpatient direct graduate medical education cost settlement provisions are applied to inpatient hospital admissions prior to September 1, 1997. For cost reporting periods beginning on or after September 1, 2003, providers with Medicaid allowable direct graduate medical education costs as described in this subsection will receive a pro rata share of their annual GME cost based on appropriations or allocations from appropriations made specifically for this purpose. The amount and frequency of interim payments will also be subject to the availability of appropriations made specifically for this purpose. Interim payments are subject to settlement at both tentative and final audit of a provider's cost report.

(t) Non-State Owned Urban Hospital Supplemental Inpatient Payments. Notwithstanding other provisions of this chapter, supplemental payments will be made each state fiscal year in accordance with this subsection to eligible hospitals that serve high volumes of Medicaid and uninsured patients.

(1) Supplemental payments are available under this subsection for inpatient hospital services provided by a publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Potter, Randall, Tarrant, and Travis. Supplemental payments will be made for inpatient services on or after July 6, 2001 for Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties. Supplemental payments will be made for inpatient services on or after February 7, 2004 for Midland County. Supplemental payments will be made for inpatient services on or after May 29, 2004 for Potter and Randall counties.

(2) State funding for supplemental payments authorized under this paragraph will be limited to and obtained through intergovernmental transfers of local or hospital district funds. The supplemental payments described in this paragraph will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. §447.272.

(3) In each county listed in paragraph (1) of this subsection, the publicly-owned hospital or hospital affiliated with a hospital district that incurs the greatest amount of cost for providing services to Medicaid and uninsured patients, will be eligible to receive supplemental high volume payments. The supplemental payments authorized under this paragraph are subject to the following limits:

(A) In each state fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's "hospital specific limit," as determined under §355.8065(f)(2)(E) of this chapter (relating to Reimbursement to Disproportionate Share Hospitals (DSH)); and

(B) The amount of inpatient supplemental payments and fee-for-service Medicaid inpatient payments the hospital receives in a state fiscal year may not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.271.

(4) An eligible hospital will receive quarterly supplemental payments. The quarterly payments will be limited to one-fourth of the lesser of:

(A) The difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services provided to fee-for-service Medicaid recipients. Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC; or

(B) The difference between the hospital's "hospital specific limit," as determined under §355.8065(f)(2)(E) of this chapter and the hospital's DSH payments as determined by the most recently finalized DSH reporting period.

(5) For purposes of calculating the "hospital specific limit" in paragraph (4)(B) of this subsection, the "cost of services to uninsured patients," as defined by §355.8065(b)(5) of this chapter and "Medicaid shortfall," as defined by §355.8065(b)(16) of this chapter, will be adjusted as follows:

(A) The amount of Medicaid payments (including inpatient and outpatient supplemental payments) that exceed Medicaid cost will be subtracted from the "Medicaid shortfall."

(B) The amount of the "Medicaid shortfall," as adjusted in accordance with subparagraph (A) of this paragraph, will be subtracted from the "cost of services to uninsured patients" to ensure that, during any state fiscal year, a hospital does not receive more in total Medicaid payments (inpatient and outpatient rate payments, graduate medical education payments, supplemental payments and disproportionate share hospital payments) than its cost of serving Medicaid patients and patients with no health insurance.

(u) In accordance with this subsection and subject to the availability of funds, a high volume adjustment factor will be included in the calculation of the state fiscal year 2003 (September 1, 2002 through August 31, 2003) Standard Dollar Amount described in subsection (a)(4) of this section for eligible hospitals. For purposes of this subsection, payments made in state fiscal year 2004, prior to the effective date of this subsection, may be adjusted in accordance with the methodology set out in this subsection. Notwithstanding paragraphs (1) and (2) of this subsection, all non-state owned or operated, non public, DRG reimbursed hospitals located in urban counties with a population greater than 100,000, and Medicaid days in greater than 175% of the mean Medicaid days in state fiscal year 2002 (September 1, 2001 through August 31, 2002) will be eligible for a high volume adjustment to their state fiscal year 2004 SDA. Medicaid days will be based on hospital claims data selected by HHSC. County population will be based on the 2000 United States census. Eligible hospitals in counties with a population less than 1,000,000 will receive a high volume adjustment factor of 3.25%; eligible hospitals in counties with a population greater than 1,000,000 will receive a high volume adjustment factor of 5.125%. Effective September 1, 2004, high-volume payments previously made as an add-on percentage to standard dollar amount shall be made according to paragraph (3) of this subsection.

(1) Eligible Hospitals. All non-state owned or operated, non public, DRG reimbursed hospitals located in urban counties with a population greater than 100,000, and Medicaid days greater than 175% of the mean Medicaid days in state fiscal year 2001 (September 1, 2000 through August 31, 2001) will be eligible for a high volume adjustment to their SDA. Medicaid days will be based on hospital claims data selected by HHSC. County population will be based on the 2000 United States census.

(2) All eligible hospitals in counties with a population less than 1,000,000 will receive a high volume adjustment factor of 6.50%;

eligible hospitals in counties with a population greater than 1,000,000 will receive a high volume adjustment factor of 10.25%. High-volume payments will be made to eligible hospitals that serve as a safety net in providing emergency and inpatient care.

(3) High-volume payments recognize the higher medical assistance costs and indigent care cost of hospitals that treat higher levels of low-income and indigent patients. Eligible hospitals are defined as non-state owned or operated, non-public, hospitals located in urban counties with Medicaid days greater than 160% of the mean Medicaid days. High-volume payments totaling \$22,500,000 shall be allocated in proportion to uncompensated care loss for eligible hospitals participating in the current year DSH program. High-volume payments totaling \$63,808,065 shall be made to eligible hospitals in proportion to Medicaid inpatient days of service. Payments under this provision will be made annually based on current year finalized Medicaid DSH claims data. The state shall adjust the high volume payments in accordance with applicable Medicaid charge upper limit regulations. Any adjustment shall be made on a proportional basis in order to allow eligible hospitals to participate to the fullest extent possible within the limits on disproportionate share hospital payments. HHSC shall use current year DSH data to determine Medicaid days. County population will be based on the 2000 United States census.

(v) State Owned Hospital Supplemental Inpatient Payments. Notwithstanding other provisions of this attachment, supplemental payments will be made each state fiscal year in accordance with this subsection to state government-owned or operated hospitals for inpatient services provided to Medicaid patients.

(1) Supplemental payments are available under this subsection for inpatient hospital services provided by state government-owned or operated hospitals on or after December 13, 2003. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas.

(2) The aggregate supplemental payment amount will be the annual difference between the aggregate upper payment limit and the inpatient fee-for-service Medicaid payments made to the state government-owned or operated hospitals under this attachment. The aggregate upper payment limit will be calculated, based on Medicare payment principles and in accordance with the federal upper limit regulations at 42 CFR §447.272, using the most recent cost report data available.

(3) The amount of the supplemental payment made to each state government-owned or operated hospital will be determined by:

(A) dividing each hospital's fee-for-service Medicaid payments by the sum of the Medicaid fee-for-service payments of all state government-owned or operated hospitals;

(B) multiplying the percentage calculated in subparagraph (A) of this paragraph by the aggregate supplemental payment calculated in paragraph (2) of this subsection.

(4) Supplemental payments determined under this subsection will be calculated annually and paid quarterly.

(5) Supplemental payments made under this subsection when combined with other inpatient payments made under this section shall not exceed the maximum amounts allowable under applicable federal regulations at 42 CFR §447.271.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 3, 2005.

TRD-200500502

Steve Aragón

Chief Counsel

Texas Health and Human Services Commission

Effective date: February 23, 2005

Proposal publication date: October 22, 2004

For further information, please call: (512) 424-6900



CHAPTER 373. MEDICAID ESTATE RECOVERY PROGRAM

The Texas Health and Human Services Commission (HHSC or Commission) adopts new Chapter 373, Medicaid Estate Recovery Program, Subchapter A, General, §§373.101, 373.103, 373.105; Subchapter B, Recovery Claims, §§373.201, 373.203, 373.205, 373.207, 373.209, 373.211, 373.213, 373.215, 373.217, 373.219; and Subchapter C, Notice, §§373.301, 373.303, 373.305, 373.307.

HHSC adopts §§373.101, 373.105, 373.205, 373.207, 373.217, 373.301, 373.303, and 373.305, without changes to the proposed text as published in the December 3, 2004, issue of the *Texas Register* (29 TexReg 11229) and will not be republished.

HHSC adopts §§373.103, 373.201, 373.203, 373.209, 373.211, 373.213, 373.215, 373.219, and 373.307 with changes to the proposed as text published in the December 3, 2004, issue of the *Texas Register* (29 TexReg 11229). The text of the rules will be republished. Changes in the adopted rules respond to public comments on the proposed rules or reflect a non-substantive variation from the proposed rules.

New Chapter 373, Medicaid Estate Recovery Program, sets forth the provisions for the implementation of a Medicaid Estate Recovery Program that were developed with input from the public. Subchapter A addresses the purpose and applicability of the Medicaid Estate Recovery Program and defines the terms used in the chapter. Subchapter B concerns the basis of Medicaid Estate Recovery Program claims and the program's claim procedures. Subchapter C concerns the notice provisions to be provided by the program.

Section 531.077, Government Code (as added by Acts 2003, 78th Leg., ch 198, §2.17), requires HHSC to establish a Medicaid Estate Recovery Program (MERP) in order to comply with the provisions of the applicable federal law found at 42 U.S.C. §1396p(b)(1). HHSC, which is the State Medicaid Agency, and the Department of Aging and Disability Services (DADS), will operate a Medicaid Estate Recovery Program that will seek recovery of the costs of Medicaid long-term care benefits received by certain Medicaid recipients.

Section 531.077, Government Code, requires that any funds recovered by the Medicaid Estate Recovery Program be deposited in the Medicaid account in the State's general revenue fund. Under the statute, money in the account may be appropriated only to fund long-term care, including both community-based and facility-based care.

HHSC received comments from the Texas Chapter of the National Academy of Elder Law Attorneys (NAELA); The Center for Public Policy Priorities (CPPP); Texas Rural Legal Aid, Inc.

(TRLA); Texas Senior Advocacy Coalition (TSAC); and the public. The comments received and HHSC's responses follow.

Comments on Chapter 373

General comment. The Texas Senior Advocacy Coalition (TSAC) commented in favor of the implementation of a Medicaid estate recovery program. Five members of the public commented in favor of the implementation of a Medicaid estate recovery program. Five members of the public commented against the implementation of a Medicaid estate recovery program.

Comments on §373.103

Comment. The Center for Public Policy Priorities (CPPP) commented in favor of proposed rule §373.103(a)(2), Applicability, in that the proposed rules exempted individuals from estate recovery who had applied for services before the effective date of the program, but sought the inclusion of the term "initially" for clarification purposes.

Response. The Commission agrees with the comment and has inserted the word "initially" in the beginning of the first sentence of subsection (a)(2) of §373.103.

Comment on §373.105(14)

Comment. The Texas Chapter of the National Academy of Elder Law Attorneys (NAELA), commented in favor of proposed rule §373.105(14), Definitions, Value of Real Property, but sought a modification of the language in the proposed rule to add language concerning mortgage liens, outstanding taxes or other exemptions because this modification would eliminate the punitive effect to persons who have borrowed funds against the equity of their homes to pay for the costs of their care.

Response. The Commission disagrees with the comment, as no punitive effect on persons will exist, as MERP claims will not be made until after the death of a Medicaid recipient for the costs of care paid by Medicaid.

Comments on §373.201

Comment. Texas Chapter of the National Academy of Elder Law Attorneys (NAELA), commented in favor of proposed rule §373.201, Basis for Claims, but sought the exclusion of language allowing MERP claims to be filed or presented to guardians under §805(4) of the Texas Probate Code as this would cause confusion, complications, and possible adverse effects if a claim were allowed under this provision as well as under §322 of the Texas Probate Code.

Response. The Commission agrees with the comment and has modified the language in §373.203 to clarify that that a MERP claim will be made only under the procedures outlined in §322 of the Texas Probate Code, and will not be presented or filed with a guardian under §805(4) of the Texas Probate Code.

Comments on §373.203

Comment. The Texas Chapter of the National Academy of Elder Law Attorneys (NAELA) commented in favor of proposed rule §373.203, Claims Procedures, but sought the exclusion of language related to §805(4) of the Texas Probate Code.

Response. The Commission agrees with the comment and has modified language in §373.203 to clarify that a MERP claim will be made only under the procedures outlined in §322 of the Texas Probate Code, and will not be presented or filed with a guardian under §805(4) of the Texas Probate Code.

Comments on §373.207

Comment. The Texas chapter of the National Academy of Elder Law Attorneys (NAELA), and The Center for Public Policy Priorities (CPPP) commented for proposed rule §373.207, Exemptions from Claims, and requested the addition of language under the provisions of 42 U.S.C. §1396(c)(2)(A)(iv) to exempt from transfer of assets penalties a home that is transferred to an individual's son/daughter who has lived in the home for at least two years prior to nursing home entry and who provided care that delayed nursing home entry of a Medicaid recipient.

Response. The Commission disagrees as HHSC, the State Medicaid Agency, was legislatively mandated to establish a Medicaid Estate Recovery Program (MERP) in order to comply with the provisions of the applicable federal law found at 42 U.S.C. §1396p(b)(1), and not at 42 U.S.C. §1396(c)(2)(A)(iv), to seek the recovery of the costs of Medicaid long-term care benefits received by certain Medicaid recipients.

Comments on §373.209

Comment. The Center for Public Policy Priorities (CPPP) commented in favor of proposed rule §373.209, Undue Hardship Waivers, but sought an increase in the time allowed to request undue hardship waivers from the Medicaid Estate Recovery Program from 40 days to 60 days in §373.209(a).

Response. The Commission agrees that it would benefit interested parties if more time were allowed to request undue hardship waivers and, in the second sentence of subsection (a), has changed the time to request an undue hardship waiver from 40 days to 60 days.

Comment. The Texas Chapter of the National Academy of Elder Law Attorneys (NAELA) commented in favor of §373.209, Undue Hardship Waivers, but suggested that the word "illegal" be inserted in subsection (b)(2) to clarify that legal estate planning methods were allowed.

Response. The Commission agrees with the comment that a revision of the language will assist in the clarification of this subsection and will insert the phrase "contrary to the requirements of Medicaid law" after the word "divested," and the revised subsection (b)(2) will read as follows: "The circumstances giving rise to the hardship were created by, or are the result of, estate planning methods under which assets were sheltered or divested contrary to the requirements of Medicaid law in order to avoid estate recovery."

Comment. The Texas Chapter of the National Academy of Elder Law Attorneys (NAELA), commented against proposed rule §373.209(c)(3), Undue Hardship Waivers, requiring that farms or ranches must produce 50% of the heirs' and legatees' livelihoods, as essentially negating the hardship waiver and requests that the language be revised to delete the 50% requirement and require only that the heir or legatee participate in the working farm or ranch activities.

Response. The Commission disagrees with this comment. The Centers for Medicare and Medicaid Services (CMS) commented that §373.209(c)(3), Undue Hardship Waivers, must treat exemptions for family-owned businesses and family ranches and farms equally with no disparate treatment and that the language must include criteria that reflect that the business, ranch or farm is the primary source of family income.

Comment. The Texas Chapter of the National Academy of Elder Law Attorneys (NAELA), commented against proposed

rule §373.209(d), Undue Hardship Waivers Applicable to Homesteads, and sought to delete all of the requirements in the proposed rules requiring the homestead waiver to be linked to an individual's income.

Response. The Commission disagrees with this comment. The Commission received many public comments requesting that HHSC exempt a statewide homestead value amount such as \$50,000 or \$100,000 rather than a percentage of a homestead's value due to the wide disparity among counties in the value of homesteads. The Centers for Medicare and Medicaid Services (CMS) approved a provision allowing the Commission a \$100,000 homestead undue hardship exemption for heirs whose income is below 300 percent of the federal poverty level. CMS will not allow any state to implement a statewide automatic and unconditional exempted homestead amount, as this would, under Federal law, violate the purpose of Medicaid estate recovery.

Comments on §373.211

Comment. The Center for Public Policy Priorities (CPPP) and the Texas Chapter of the National Academy of Elder Law Attorneys (NAELA) commented for proposed rule §373.211, Right to a Review of an Undue Hardship Waiver Denial, but requested that the time allowed for requesting a hardship waiver denial review be increased from 40 days to 60 days in §373.211(a).

Response. The Commission agrees this will benefit the public and will increase the time period allowed to request a review of an undue hardship waiver denial in §373.211(a) from 40 days from 60 days.

Comments on §373.213

Comment. The Center for Public Policy Priorities (CPPP) and the Texas Chapter of the National Academy of Elder Law Attorneys (NAELA) commented for proposed rule §373.213, Deduction Allowed For Home Maintenance and Costs of Care, but requested that the time allowed in §373.213(c) for obtaining these deductions be increased from 40 days to 60 days to enable families more time to collect necessary supporting documents

Response. The Commission agrees and will increase the time period in §373.213(c) from 40 to 60 days, as this will allow families more time to collect information.

Comments on §373.215

Comment. The National Academy of Elder Law Attorneys (NAELA) commented in favor of §373.215, Recovery Not Cost Effective, but sought inclusion of the term "recoverable" and the revision of §373.215(1) for clarification purposes.

Response. The Commission agrees with this comment and will insert the term "recoverable" and revise §373.215(1) to read: "the recoverable value of the estate is \$10,000 or less."

Comments on §373.307

The Center for Public Policy Priorities (CPPP) commented for proposed rule §373.307, Notice of Intent to File a Claim Upon the Death of a Medicaid Recipient, but sought an increase to 60 days from 40 days in the time allowed to request undue hardship waivers from Medicaid estate recovery in §373.307(c).

Response. The Commission agrees that it would benefit interested parties if more time were allowed to request undue hardship waivers, and, in §373.307(c), has changed the time to request the waiver from 40 days to 60 days.

Non-substantive grammar and style changes were made at the suggestion of HHSC staff to improve the rules' readability, clarity, and consistency.

SUBCHAPTER A. GENERAL

1 TAC §§373.101, 373.103, 373.105

The new sections are adopted under §531.033, Government Code, which provides the Commissioner of HHSC with broad rule making authority, and §531.033, Government Code (as added by Acts 2003, 78th Leg., ch. 198, §2.17), under which HHSC, the State Medicaid Agency, is mandated to establish a Medicaid Estate Recovery Program (MERP) in order to comply with the provisions of the applicable federal law found at 42 U.S.C. §1396p(b)(1) to seek the recovery of the costs of Medicaid long-term care benefits received by certain Medicaid recipients.

§373.103. *Applicability.*

(a) A Medicaid Estate Recovery claim may be filed against the estate of a deceased Medicaid recipient for covered Medicaid services if the recipient:

(1) Was age 55 years or older at the time the services were received; and

(2) Initially applied for covered Medicaid long-term care services on or after March 1, 2005, the effective date of these rules.

(b) For purposes of this chapter, an individual will be considered to be age 55 as of the first day of the month following the month in which the recipient attains the age of 55.

(c) Covered Medicaid long-term care services include the following services provided to a recipient age 55 years or older under the State of Texas Medicaid plan under Title XIX of the Social Security Act (SSA):

(1) Nursing facility services;

(2) Intermediate Care Facilities for the Mentally Retarded (ICF-MR);

(3) Home and Community-Based Services (§1915(c), SSA) and Community Attendant Services (§1929(b), SSA); and

(4) Related costs of hospital and prescription drug services.

(d) For the purposes of this chapter, covered services do not include services provided before the effective date of these rules.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500556

Steve Aragón

Chief Counsel

Texas Health and Human Services Commission

Effective date: March 1, 2005

Proposal publication date: December 3, 2004

For further information, please call: (512) 424-6900



SUBCHAPTER B. RECOVERY CLAIMS

1 TAC §§373.201, 373.203, 373.205, 373.207, 373.209, 373.211, 373.213, 373.215, 373.217, 373.219

The new sections are adopted under §531.033, Government Code, which provides the Commissioner of HHSC with broad rule making authority, and §531.033, Government Code (as added by Acts 2003, 78th Leg., ch. 198, §2.17), under which HHSC, the State Medicaid Agency, is mandated to establish a Medicaid Estate Recovery Program (MERP) in order to comply with the provisions of the applicable federal law found at 42 U.S.C. §1396p(b)(1) to seek the recovery of the costs of Medicaid long-term care benefits received by certain Medicaid recipients.

§373.201. *Basis for Claims.*

The acceptance of Medicaid medical assistance, as defined by Title XIX of the Social Security Act, including mandatory and optional payments under the Social Security Act, provides a basis for: A Class 7 probate claim, as defined in §322 of the Texas Probate Code, Classification of Claims against Estates of Decedents, in favor of the Medicaid Estate Recovery Program as an interested party in the estate of the deceased Medicaid recipient.

§373.203. *Claims Procedures.*

(a) The Medicaid Estate Recovery Program (MERP) may file or present a: Class 7 probate claim under §298, Claims Against Estates of Decedents, Texas Probate Code, against the estate of deceased Medicaid recipients in accordance with the priorities contained in §322, Classification of Claims against Estates of Decedents, Texas Probate Code.

(b) A claim may be filed in accordance with applicable provisions of the Texas Probate Code, including §298, Claims Against Estates of Decedents, which allows unsecured claims to be presented at any time before the estate is closed or within 4 months of receipt of notice from the estate administrator.

§373.209. *Undue Hardship Waivers.*

(a) The Medicaid Estate Recovery Program (MERP) will not recover from estates if recovery would cause undue hardship. An undue hardship waiver request form will be provided with the MERP Notice of Intent to File a Claim, and undue hardship waiver requests must be made within 60 days of the date of the MERP Notice of Intent to File a Claim.

(b) An undue hardship does not exist solely because:

(1) Recovery would prevent heirs or legatees from receiving an anticipated inheritance; or

(2) The circumstances giving rise to the hardship were created by, or are the result of, estate planning methods under which assets were sheltered or divested contrary to the requirements of Medicaid law in order to avoid estate recovery.

(c) Undue hardship waivers include:

(1) The estate property subject to recovery has been the site of the operation of a family business, farm, or ranch at that location for at least 12 months prior to the death of the decedent; is the primary income producing asset of heirs and legatees, and produces 50 percent or more of their livelihood; and recovery by the State would affect the property and result in the heirs or legatees losing their primary source of income;

(2) Heirs and legatees would become eligible for public and/or medical assistance if a recovery claim were made;

(3) Allowing one or more survivors to receive the estate will enable him or her or them to discontinue eligibility for public and/or medical assistance;

(4) The Medicaid recipient received medical assistance as the result of a crime, as defined by Texas law, committed against the recipient; or

(5) Other compelling reasons.

(d) Undue Hardship Waivers Applicable to Homesteads After receiving a Medicaid estate recovery claim, an heir may assert that recovery against a deceased Medicaid recipient's homestead would be an undue hardship and that the homestead should therefore be exempt from recovery for the cost of Medicaid long-term care services. The Health and Human Services Commission will exempt a decedent's home from estate recovery based on undue hardship when the following conditions have been established to the Commission's satisfaction:

(1) The tax appraisal district value of the homestead is less than \$100,000. If the tax appraisal district value of the homestead exceeds this amount, the first \$100,000 of the tax appraisal district value for the most recent tax year at the time of the recipients' death shall be exempt from estate recovery. Any equity value of the tax appraisal district value for the most recent tax year at the time of the recipients' death in excess of \$100,000 is subject to estate recovery.

(2) One or more siblings or direct descendants of the deceased person (lineal heir(s), such as children and grandchildren) will inherit the homestead of the deceased Medicaid recipient, provided that each sibling or lineal heir inheriting the homestead has gross family income below 300 percent of the Federal Poverty Level.

(3) When there are multiple heirs and not all heirs qualify for the hardship waiver, only that percentage of the homestead that corresponds to the qualifying heir or heirs' share of the homestead will be exempt from Medicaid estate recovery.

(4) "300 percent of the federal poverty level" is a gross income test; no exclusions or deductions are allowed.

(5) "Family" means that the Health and Human Services Commission will consider each heir separately. Heirs will not be aggregated into one family unless the heirs are minor children who are siblings. In the case of the adult heir, his or her family will be limited to the heir, the heir's spouse, and the heir's biological or legally adopted minor children and stepchildren residing in the household. In the case of the heir who is a minor, the heir's family will be the heir, his or her parent(s) or stepparent residing in the household, and the heir's minor siblings residing in the household, including half-, step-, and legally adopted siblings.

Figure: 1 TAC §373.209(d)(5)

(e) HHSC has exclusive authority to waive its Medicaid estate recovery claim and grant undue hardship waivers as determined by the Medicaid Estate Recovery Program (MERP) program on an individual case-by-case basis. An undue hardship waiver determination will be made by MERP within 40 days of the receipt of an undue hardship waiver request form and all required necessary supporting documents by MERP.

(f) Undue hardship waiver request forms must be submitted to the following address: MERP, Hardship Waiver Request, P.O. Box 13247, Austin, Texas 78711.

§373.211. *Right to a Review of an Undue Hardship Waiver Denial.*

(a) A Medicaid Estate Recovery Program (MERP) undue hardship waiver applicant may request a review of the denial of an

undue hardship waiver request within 60 days of receiving notice of the denial from MERP. The review is an informal process and is not a hearing.

(b) MERP will review the request within 40 days from the date the request is received by MERP. All requests for a review of the denial of an undue hardship waiver request must be made in writing to MERP, Hardship Waiver Denial Review Request, P.O. Box 13247, Austin, Texas 78711.

§373.213. *Deduction Allowed for Expenses for Home Maintenance and Costs of Care.*

(a) An amount equal to necessary and reasonable maintenance expenses and taxes may be deducted from the Medicaid Estate Recovery Program (MERP) claim for maintaining the home of the deceased Medicaid recipient, provided that sufficient supporting documentation of these expenditures, such as receipts, is provided to MERP by estate personal representatives, heirs, or legatees. Necessary and reasonable expenses for maintaining the home include real estate taxes, utility bills, insurance, home repairs, and home maintenance expenses such as lawn care.

(b) An amount equal to the necessary and reasonable expenses for the direct payment of the costs of care (including payment of personal attendant care) provided for a deceased Medicaid recipient that enabled the recipient to remain in his or her home and thereby delayed the institutionalization of the Medicaid recipient may be deducted from the MERP claim, provided that sufficient supporting documentation of these expenditures, such as receipts, is provided to MERP by estate personal representatives, heirs, or legatees.

(c) Requests for obtaining allowable deductions from MERP claims for expenses under subsections (a) or (b) of this section must be made in writing within 60 days after receipt of the Notice of the Intent to File a Claim by MERP. All supporting documentation must be attached to the request and sent to MERP, Home Maintenance/Costs of Care Request, P.O. Box 13247, Austin, Texas 78711.

§373.215. *Recovery Not Cost-Effective.*

No Medicaid estate recovery claim will be filed if it is not cost effective. A claim will not be cost-effective if:

- (1) the value of the recoverable estate is \$10,000 or less,
- (2) the recoverable amount of Medicaid costs is \$3,000 or less, or
- (3) the cost involved in the sale of the property would be equal to or greater than the value of the property.

§373.219. *Claim Payments.*

(a) All payments on estate recovery claims must be made payable to the "Texas Medicaid Account for Long-Term Care," and must be sent to MERP, P.O. Box 13247, Austin, Texas 78711.

(b) HHSC MERP may compromise, settle, or waive any claim that does not qualify for an undue hardship waiver upon good cause shown. Interest on the unpaid portion of any claim is the same as the amount provided under §2251.025(b), Government Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500557
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Effective date: March 1, 2005
Proposal publication date: December 3, 2004
For further information, please call: (512) 424-6900

◆ ◆ ◆
SUBCHAPTER C. NOTICE

1 TAC §§373.301, 373.303, 373.305, 373.307

The new sections are adopted under §531.033, Government Code, which provides the Commissioner of HHSC with broad rule making authority, and §531.033, Government Code (as added by Acts 2003, 78th Leg., ch. 198, §2.17), under which HHSC, the State Medicaid Agency, is mandated to establish a Medicaid Estate Recovery Program (MERP) in order to comply with the provisions of the applicable federal law found at 42 U.S.C. §1396p(b)(1) to seek the recovery of the costs of Medicaid long-term care benefits received by certain Medicaid recipients.

§373.307. *Notice of Intent to File A Claim upon the Death of a Medicaid Recipient.*

(a) The Medicaid Estate Recovery Program (MERP) will, within 30 days of the notification of the death of a Medicaid recipient, provide a Notice of Intent to File a Claim, to the following:

- (1) Estate representative;
- (2) Recipient's guardian of the person, if any; guardian of the estate, if any; or guardian of the person and estate, if any, provided that the name and address of the guardian or guardians are known by MERP;
- (3) Recipient's agent under a durable power of attorney if the name and address of the agent are known by MERP;
- (4) Recipient's agent under a medical power of attorney if the name and address of the agent are known by MERP; or
- (5) If none of the above are known, family members who have acted on behalf of the recipient provided that the name and address of those family members who have acted on behalf of the recipient are known by MERP.

(b) Contents of Notice of Intent to File a Claim. Written notice of MERP's intent to file an estate recovery claim against the estate of a deceased Medicaid recipient for covered services will be provided to individuals identified in subsection (a) of this section. The notice will include the following:

- (1) A program overview;
- (2) A questionnaire that seeks to determine whether the deceased recipient had:
 - (A) A surviving spouse;
 - (B) A surviving child under age 21;
 - (C) A surviving child of any age who is blind or disabled, as defined by 42 U.S.C. §1382c; or
 - (D) An unmarried adult child residing continuously in the decedent's homestead for at least one year prior to the time of the Medicaid recipient's death.

(c) An undue hardship waiver request form. Undue hardship request forms and supporting documentation must be submitted to MERP within 60 days of the date of the Notice of Intent to File a Claim. No action will be taken on an undue hardship request that is submitted without supporting documentation. The request form and documentation should be sent to MERP, Hardship Waiver Request, P.O. Box 13247, Austin, Texas 78711.

(d) The Notice of Intent to File a Claim will state the date that MERP received notification of the death of a Medicaid recipient and the source of the death notification of the Medicaid recipient.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500558
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Effective date: March 1, 2005
Proposal publication date: December 3, 2004
For further information, please call: (512) 424-6900

◆ ◆ ◆
TITLE 19. EDUCATION

**PART 1. TEXAS HIGHER EDUCATION
COORDINATING BOARD**

**CHAPTER 4. RULES APPLYING TO
ALL PUBLIC INSTITUTIONS OF HIGHER
EDUCATION IN TEXAS**

SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §4.7

The Texas Higher Education Coordinating Board adopts amendments to §4.7(b), concerning changing references from the former Texas Academic Skills Program to the Texas Success Initiative without changes to the proposed text as published in the November 19, 2004 issue of the *Texas Register* (29 TexReg 10669). Specifically, these amendments remove from Board rules all references to the former Texas Academic Skills Program (TASP) and replaces them with references to the current Texas Success Initiative.

No comments were received regarding the amendments to this section.

The amendments are adopted under the Texas Education Code, §61.027, which provides the Coordinating Board with general rule-making authority; §61.002, which establishes the Coordinating Board as an agency charged to provide leadership and coordination for the Texas higher education system; §61.051, which provides the Coordinating Board with authority to coordinate institutions of public higher education in promoting quality education; and §61.0651, which charges the Board to adopt and recommend management policies applicable to institutions of higher education in relation to management of human resources and physical plants.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500472

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Effective date: February 22, 2005

Proposal publication date: November 19, 2004

For further information, please call: (512) 427-6114



CHAPTER 5. RULES APPLYING TO PUBLIC UNIVERSITIES AND/OR HEALTH-RELATED INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

SUBCHAPTER C. APPROVAL OF NEW ACADEMIC PROGRAMS AND ADMINISTRATIVE CHANGES AT PUBLIC UNIVERSITIES AND/OR HEALTH-RELATED INSTITUTIONS

19 TAC §5.45, §5.46

The Texas Higher Education Coordinating Board adopts amendments to §5.45 and §5.46, concerning the academic qualifications of faculty in Texas institutions of higher education in regard to requests for new degree programs without changes to the proposed text as published in the November 19, 2004, issue of the *Texas Register* (29 TexReg 10672).

Specifically, these amendments would establish criteria for evaluating faculty credentials in regard to determining faculty members' contributions to proposed degree programs.

The following comments were received regarding the amendments:

Comments: Texas A&M University supports the Coordinating Board decision to consider only accredited U.S. degrees and degrees from international institutions that have demonstrated equivalence to U.S. degrees when evaluating faculty resources needed for new degree programs.

Response: No changes were made as a result of this comment.

The amendments are adopted under the Texas Education Code, §61.027, which provides the Board with general rule-making authority; §61.002, which establishes the Board as an agency charged to provide leadership and coordination for the Texas higher education system; §61.051, which provides the Board with authority to coordinate institutions of public higher education in promoting quality education; Texas Education Code, §51.807, which provides the Board with the authority to adopt rules relating the Uniform Admissions; Texas Education Code, §51.762(a), which provides the Board with the authority to implement the Common Admission Application, Texas Education Code, §61.074, which provides the Board with the

authority to adopt rules relating to grade-point calculation, Texas Education Code, §61.051(d) and (e), which directs the Board to develop the role and mission of each institution and periodically review the role and mission statements, Tables of Programs, and all certificate and degree programs, Texas Education Code, §61.051(j), which requires the approval of the Board for operation of off-campus educational units, and Texas Education Code, §61.055, which requires a Board finding that a new department, school, or degree or certificate program is adequately financed.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500473

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Effective date: February 22, 2005

Proposal publication date: November 19, 2004

For further information, please call: (512) 427-6114



CHAPTER 7. PRIVATE AND OUT-OF-STATE PUBLIC POSTSECONDARY EDUCATIONAL INSTITUTIONS OPERATING IN TEXAS

SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §7.4

The Texas Higher Education Coordinating Board adopts amendments to §7.4(a), concerning accrediting agencies which exempt institutions from Board oversight without changes to the proposed text as published in the November 19, 2004, issue of the *Texas Register* (29 TexReg 10674).

Specifically, the first amendment to §7.4(a) will list the new names of two accrediting agencies recognized by the Board for purposes of exemption from the statute and will clarify that one accrediting association is recognized by the Board only at the undergraduate level and not the graduate level.

No comments were received regarding the amendments to this section.

The amendments are adopted under the Texas Education Code, §61.027, which provides the Board with general rule-making authority; Texas Education Code, §61.002, which establishes the Board as an agency charged to provide leadership and coordination for the Texas higher education system; Texas Education Code, §§61.301 - 61.319, concerning regulation of private post-secondary education institutions; §61.311, which provides the Board with the authority to promulgate rules governing certificates of authority; Texas Education Code, §§61.401 - 61.405, regarding regulation of public institutions of higher education established outside the boundaries of the State of Texas; and Texas Education Code, §61.403 which provides the Board with the authority to promulgate rules regarding out of state public institutions.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500474

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Effective date: February 22, 2005

Proposal publication date: November 19, 2004

For further information, please call: (512) 427-6114



CHAPTER 17. CAMPUS PLANNING

SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §17.3

The Texas Higher Education Coordinating Board adopts amendments to §17.3, concerning Definitions, with changes to the proposed text as published in the November 26, 2004, issue of the *Texas Register* (29 TexReg 10861).

Specifically, these amendments provide definitions for the Assistant Commissioner, Parking Structure, Technical Research Building, and University System and for the delegation of project approval authority to the Assistant Commissioner.

The following comments were received regarding the proposal:

Comment: The University of Texas System made additional comments related to the rules regarding the Board's statutory authority and interpretation of the statutes related to deferred maintenance, Master Plan reports, audits, and Energy Savings Performance Contracts.

Response: These comments are related to sections not under consideration by the Board.

The amendments are adopted under Texas Education Code, §61.027, which provides the Board with the authority to adopt rules, and Texas Education Code, §61.058 and §61.0572.

§17.3. Definitions.

The following words and terms shall have the following meanings, unless the context clearly indicates otherwise.

(1) **Acquisition**--To come into possession or control of real property or facilities. This includes the acceptance, purchase, lease-purchase, transfer, or exchange of land or facilities.

(2) **Academic Facilities**--Facilities used for primary instruction, research, and public service functions of the institution. Academic facilities typically would include classrooms, libraries, administrative and faculty offices, and student and research laboratories.

(3) **Addition**--Expansion or extension of an existing facility that increases its size or capacity.

(4) **Assignable Area of a Building**--The sum of all areas within the interior walls of rooms on all floors of a building assigned to, or available for assignment to, an occupant or use, excluding unassigned space. This is also referred to as net assignable square feet (NASF).

(5) **Assistant Commissioner**--The administrative officer having oversight of the campus planning function at the Texas Higher Education Coordinating Board.

(6) **Athletic Facilities**--Facilities used for athletic programs, including intercollegiate athletics, intramural athletics, and athletically-oriented academic programs.

(7) **Auditorium or Assembly**--A room, hall, or building designed and equipped for the assembly of large groups for such events as dramatic and musical productions, devotional activities, livestock judging, faculty/staff meetings, or commencement. Included are theaters, concert halls, arenas, chapels and livestock judging pavilions. Assembly facilities may also serve instructional purposes to a minor or incidental extent.

(8) **Auxiliary Enterprise Buildings or Space**--Income-generating structures and space such as dormitories, cafeterias, student union buildings, stadiums, athletic facilities, housing or boarding facilities used by a fraternity, sorority, or private club, and alumni centers used solely for those purposes. Auxiliary space is not supported by State appropriations.

(9) **Board or Coordinating Board**--The Texas Higher Education Coordinating Board members and the agency.

(10) **Building**--A structure with at least two walls for permanent or temporary shelter of persons, animals (excluding animal caging equipment), plants, materials, or equipment that is attached to a foundation, roofed, serviced by a utility (exclusive of lighting), is a source of maintenance and repair activities, and is under the control or jurisdiction of the institution's governing board, regardless of its location.

(11) **Campus Deferred Maintenance Plan (MP2)**--A detailed report of institutional programs to address deferred maintenance and critical deferred maintenance.

(12) **Campus Master Plan**--A detailed long-range plan of institutional physical plant needs, including facilities construction and/or development, land acquisitions, and campus facilities infrastructure; the plan provides long-range and strategic analyses and facilities development guidelines.

(13) **Capital Renewal**--Includes capital improvements and changes to a facility in response to evolving needs. The changes may occur because of new programs or to correct functional obsolescence. Capital renewal needs are not part of the deferred maintenance backlog.

(14) **Certification**--Institutional attestation of reports or other submissions as being true or as represented.

(15) **Classroom**--A room used for scheduled classes. These rooms may be called lecture rooms, lecture-demonstration rooms, seminar rooms, or general purpose classrooms. A classroom may contain multimedia or telecommunications equipment, such as those used for distance learning. A classroom may be furnished with special equipment (e.g., globes, maps, pianos) appropriate to a specific area of study. A classroom does not include conference rooms, meeting rooms, auditoriums, or class laboratories.

(16) **Class Laboratory**--A room used primarily by regularly scheduled classes that require special-purpose equipment for student participation, experimentation, observation, or practice in a field of study. Class laboratories may be referred to as teaching laboratories, instructional shops, computer laboratories, drafting rooms, band rooms, choral rooms, group studios. Laboratories that serve as individual or independent study rooms are not included.

(17) Clinical Facility--A facility often associated with a hospital or medical school that is devoted to the diagnosis and care of patients in the instruction of health professions and allied health professions; medical instruction may be conducted, and patients may be examined and discussed. Clinical facilities include, but are not limited to, patient examination rooms, testing rooms, and consultation rooms.

(18) Committee or Committee on Campus Planning--The members of the Board appointed to consider facility-related issues.

(19) Commissioner--The chief executive officer of the Texas Higher Education Coordinating Board.

(20) Critical Deferred Maintenance--The physical conditions of a building or facility that places its occupants at risk of harm or the facility at risk of not fulfilling its functions.

(21) Deferred Maintenance--An existing or imminent building maintenance-related deficiency from prior years that needs to be corrected, or scheduled preventive maintenance tasks that were not performed because other tasks funded within the budget were perceived to have higher priority status. The accumulation of facility components in need of repair brought about by age, use, or damage for which remedies are postponed or considered backlogged. This may include those repairs postponed due to insufficient funding.

(22) Diagnostic Support Laboratory--the central diagnostic service area for a health care facility. Included are pathology laboratories, pharmacy laboratories, autopsy rooms, isotope rooms, etc., providing such services as hematology, tissue chemistry, bacteriology, serology, blood banks, and basal metabolism. In veterinary facilities, this includes necropsy rooms.

(23) Education and General (E&G)--Space used for teaching, research, or the preservation of knowledge, including the proportional share used for those activities in any building or facility used jointly with auxiliary enterprise, or space that is permanently unassigned. E&G space is supported by state appropriations.

(24) Emergency--An unforeseen combination of circumstances that calls for immediate action and requires an urgent need for assistance or relief that, if not taken, would result in an unacceptable cost to the state; or, an urgent need for assistance or relief due to a natural disaster; or an unavoidable circumstance whereby the delay of the project approval would critically impair the institution's function.

(25) Eminent Domain--A legal process wherein the institution takes private property for public use.

(26) Energy Systems--Infrastructure in a building that includes facility electric, gas, heating, ventilation, air conditioning, and water systems.

(27) Energy Savings Performance Contract--A contract for energy or water conservation measures to reduce energy or water consumption or operating costs of institutional facilities in which the estimated savings in utility costs resulting from the conservation measures is guaranteed to offset the cost of the measures over a specified period.

(28) Facilities Audit--Comprehensive review of institutional facility development, planning activities, and reports.

(29) Facilities Inventory--A collection of building and room records that reflects institutional space and how it is being used. The records contain codes that are uniformly defined by the Board and the United States Department of Education and reported by the institutions on an ongoing basis to reflect a current facilities inventory. The facilities inventory includes a record of property owned by or under the control of the institution.

(30) Facilities Development Plan (MP1)--A detailed formulation of institutional programs to address deferred maintenance, critical deferred maintenance, facilities construction, demolition, property acquisitions, or physical plant development.

(31) Financing Directly Derived from Students--Funds resulting from the collection of fees or other charges to students, such as designated tuition, student activities fees, housing revenue, bookstore or student union revenue, etc. Bond proceeds for which one or more of these sources provides debt service shall also be considered financing directly derived from students.

(32) Financing Indirectly Derived from Students--Funds generated from funds accumulated from students, primarily interest on funds accumulated directly from students.

(33) Gift--A donation or bequest of money or another tangible item, a pledge of a contribution, or the acquisition of real property or facilities at no cost to the state or to the institution. It may also represent a method of finance for a project.

(34) Gross Square Feet (GSF)--The sum of all square feet of floor areas within the outside faces of a building's exterior walls. This includes the areas, finished and unfinished, on all floors of an enclosed structure, i.e., within the environmentally controlled envelope, for all stories or areas which have floor surfaces.

(35) Housing Facility--A single- or multi-family residence used exclusively for housing or boarding students, faculty, or staff members.

(36) Information Resource Project--Projects related to the purchase or lease-purchase of computer equipment, purchase of computer software, purchase or lease-purchase of telephones, telephone systems, and other telecommunications and video-teleconferencing equipment.

(37) Intercollegiate Athletic Facility--Any facility used primarily to support intercollegiate athletics, including stadiums, arenas, multi-purpose centers, playing fields, locker rooms, coaches' offices, and similar facilities.

(38) Infrastructure--The underlying foundation or basic framework of a facility, including but not limited to, the utility distribution system of plumbing, heating/ventilation/air conditioning, electrical, sewage, drainage, architectural, safety and Code compliance, roads, grounds, and landscaping.

(39) Institution or institution of higher education--A Texas public institution of higher education as defined in Texas Education Code, §61.003(8), except a community/junior college.

(40) Legislative Authority--Specific statutory authorization.

(41) Lease--A contract by which real estate, equipment, or facilities are conveyed for a specified term and for a specified rent. Includes the transfer of the right to possession and use of goods for a term in return for consideration. Unless the context clearly indicates otherwise, the term includes a sublease.

(42) Lease-Purchase--A lease project that includes the acquisition of real property by sale, mortgage, security interest, pledge, gift, or any other voluntary transaction at some future time.

(43) Net Assignable Square Feet (NASF)--The sum of all areas within the interior walls of rooms on all floors of a building assigned to, or available for assignment to, an occupant or use, excluding unassigned areas. NASF includes auxiliary space and E&G space.

(44) New Construction--The creation of a new building or facility, the addition to an existing building or facility, or new infrastructure that does not currently exist on campus. New construction would add gross square footage to an institution's existing space.

(45) Non-student Sources--Funds generated from athletic department operations, gifts and grants, facility usage fees, related revenue, and appropriated funds.

(46) NCAA Football Bowl Championship Series--A program of the NCAA under which certain NCAA Division I-A football universities share proceeds of college bowl games.

(47) Parking Structure--A facility or garage used for housing or storing vehicles. Included are garages, boathouses, airport hangars, and similar buildings. Barns or similar field buildings that house farm implements and surface parking lots are not included.

(48) Phased Project--A project that has more than one part, each one having fixed beginning and ending dates, specified cost estimates, and scope. Phased projects consider future phase needs in the project plan; each phase is able to stand alone as an individual project.

(49) Private Funding--Gifts, grants, or other funds to be used for facilities development projects that are provided by persons or entities other than the university or institution requesting consideration of the project.

(50) Project--The process that includes the construction, repair, renovation, addition, alteration of a campus, building, or facility, or its infrastructure, or the acquisition of real property.

(51) Real Property--Land with or without improvements such as buildings.

(52) Repair and Renovation (R&R)--Construction upgrades to an existing building, facility, or infrastructure that currently exists on campus; this includes the finish-out of shell space. R&R may add E&G NASF space.

(53) Replacement Value--The value of an institution's overall campus facilities, as determined annually by the Board. The method of calculation is based upon recently approved Board project costs, with adjustments based upon room types and the institution's location within the state. Replacement values for public universities, the Lamar State Colleges, and the Texas State Technical Colleges are calculated only for E&G space. Replacement values for public health-related institutions are calculated for the NASF space. Replacement values are used to measure the validity of construction projects that are submitted to the Board for approval and are not recommended for insurance purposes.

(54) Research Facility--A facility used primarily for experimentation, investigation, or training in research methods, professional research and observation, or a structured creative activity within a specific program. Included are laboratories used for experiments or testing in support of instructional, research, or public service activities.

(55) Shell Space--An area within a building with an unfinished interior designed to be converted into usable space at a later date.

(56) Space Need--The result of the comparison of an institution's actual space to the predicted need as calculated by the Board's Space Projection Model.

(57) Standard--Basis, criteria, or benchmark used for evaluating the merits of a project request or an institutional comparison to a benchmark.

(58) Technical Research Building--Space used for research, testing, and training in a mechanical or scientific field. Special

equipment is required for staff and/or student experimentation or observation. Included are specialized laboratories for new technologies that have stringent environmental controls on air quality, temperature, vibration, and humidity. Facilities generally include space for specialized technologies, semiconductors, biotechnology, advanced materials, quantum computing and advanced manufacturing quantum computing technology, nanoscale measurement tools, integrated microchip-level technologies for measuring individual biological molecules, and experiments in nanoscale disciplines.

(59) Tracking Report--Institutional reports indicating the status of approved projects.

(60) Tuition Revenue Bonds Project--A project for which an institution has legislative authority to finance a construction or land acquisition project as provided for in Texas Education Code, §§55.01 - 55.25.

(61) Unimproved Real Property--Real property on which there are no buildings or facilities.

(62) University System--The association of one or more public senior colleges or universities, medical or dental units, or other agencies of higher education under the policy direction of a single governing board.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500475
Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Effective date: February 22, 2005
Proposal publication date: November 26, 2004
For further information, please call: (512) 427-6114



SUBCHAPTER B. BOARD APPROVAL

19 TAC §17.12

The Texas Higher Education Coordinating Board adopts amendments to §17.12, concerning Campus Planning with changes to the proposed text as published in the November 26, 2004, issue of the *Texas Register* (29 TexReg 10864).

Specifically, these amendments provide for the delegation of project approval authority to the Assistant Commissioner. The amendments adjust thresholds for delegated authority from the Board to the Committee on Campus Planning, the Commissioner of Higher Education, and the Deputy Commissioner when acting on behalf of the Commissioner, to expedite processing facilities development applications.

The following comments were received regarding the section:

Comment: Texas Tech University commented on the threshold levels proposed in the rules suggesting clarification of the approval thresholds to ensure that there was no overlap by using the phrase "but less than" in lieu of the proposed term "but not more than" in all of §17.12 of Board rules regarding Delegation of Approval Authority.

Response: The Board concurs with this comment and has proposed clarifying language for the thresholds.

Comment: The University of Texas System commented on the threshold levels proposed in the rule indicating that the proposal is a positive step in the right direction.

Response: The Board appreciates the positive comment.

Comment: One commenter asked if the agency reorganization in process would affect the approval authority of the Assistant Commissioner, Finance, Campus Planning, and Research.

Response: The Board amends the definition in §17.3(5) and §17.12 to read only "Assistant Commissioner".

Comment: The University of Texas System made additional comments related to the rules regarding the Board's statutory authority and interpretation of the statutes related to deferred maintenance, Master Plan reports, audits, and Energy Savings Performance Contracts.

Response: These comments are related to sections not under consideration by the Board.

The amendments are adopted under Texas Education Code, §61.027, which provides the Board with the authority to adopt rules, and Texas Education Code, §61.058 and §61.0572.

§17.12. Delegation of Approval Authority.

(a) Commissioner. The Board authorizes the Commissioner, and the Deputy Commissioner when acting on behalf of the Commissioner, to review or approve the following types of projects upon certification of authority by the proposing institution's governing board that the project meets all of the specified Board standards for that project type.

(1) New construction with a total project cost of \$15 million but less than \$25 million;

(2) Repair and renovation of existing buildings or facilities with a total project cost of \$15 million but less than \$25 million;

(3) Gifts or acquisition of improved real property with E&G space having a value of \$5 million but less than \$10 million;

(4) Purchase of real property having a value of \$5 million but less than \$10 million;

(5) Evaluation of projects funded more than 50 percent with tuition revenue bond proceeds that meet Board standards having a total projected cost of \$25 million or more;

(6) Auxiliary enterprise projects being acquired, constructed, or renovated without the use of state general revenue funds and with a total project cost of \$10 million but less than \$25 million;

(7) Projects previously reviewed or approved by the Commissioner but requiring first or second reconsideration under the provisions of §17.14 of this title (relating to Re-approval of Projects), providing they continue to be eligible for Commissioner approval;

(8) Projects previously reviewed or approved by the Board, Committee, or Commissioner that require reconsideration under the provisions of §17.14 of this title (relating to Re-approval of Projects) relating to any change in the funding source of an approved project with a total projected cost of \$25 million or more; and

(9) New construction, major repair and renovation, or property acquisition that affects only the University System and not a member institution, and has a total projected cost of \$15 million but less than \$25 million;

(10) Emergency requests eligible for Commissioner approval under the provisions of §17.22 of this title (relating to Emergency Approval of Projects); and

(11) Any project referred to the Commissioner by the Assistant Commissioner.

(b) Assistant Commissioner. The Board authorizes the Assistant Commissioner to approve the following types of projects, upon certification of authority by the proposing institution's governing board that the project meets all of the specified Board standards for that project type:

(1) New construction with a total project cost less than \$15 million;

(2) Repair and renovation of existing buildings or facilities with a total project cost less than \$15 million;

(3) Gifts or acquisition of improved real property with E&G space having a value less than \$5 million;

(4) Purchase of real property having a value less than \$5 million;

(5) Evaluation of projects funded more than 50 percent with tuition revenue bond proceeds that meet Board standards with a total projected cost less than \$25 million;

(6) Auxiliary enterprise projects being acquired, constructed, or renovated without the use of state general revenue funds and with a total project cost less than \$10 million;

(7) Projects previously reviewed or approved by the Assistant Commissioner but requiring first or second reconsideration under the provisions of §17.14 of this title (relating to Re-approval of Projects), providing they continue to be eligible for Assistant Commissioner approval;

(8) Projects previously reviewed or approved by the Board, Committee, Assistant Commissioner that require reconsideration under the provisions of §17.14 of this title (relating to Re-approval of Projects) relating to any change in the funding source of an approved project with a total projected cost less than \$25 million; and

(9) New construction, major repair and renovation, or property acquisition that affects only the University System, and not a member institution, and has a total projected cost less than \$15 million.

(c) Committee on Campus Planning. The Board authorizes the Committee to approve the following types of projects, upon certification of authority by the proposing institution's governing board:

(1) New construction projects having a total project cost of \$25 million but less than \$50 million;

(2) Repair and renovation of existing buildings or facilities having a total project cost of more than \$25 million;

(3) Purchase of real property having a value of \$10 million but less than \$25 million;

(4) Gifts or acquisition of improved real property with E&G space having a value of \$10 million but less than \$25 million;

(5) Evaluation of projects funded more than 50 percent with tuition revenue bond proceeds and not qualifying for Commissioner approval;

(6) Auxiliary enterprise projects having a total project cost of \$25 million but less than \$50 million;

(7) Projects previously approved but requiring re-approval under the provisions of §17.14 of this title (relating to Re-approval of Projects) and not eligible for re-approval by the Commissioner;

(8) Any new construction, major repair and renovation, or property acquisition submitted by a University System that only affects the system, and not a component institution with a total projected cost of \$25 million or more;

(9) Emergency requests eligible for Committee approval under the provisions of §17.22 of this title (relating to Emergency Approval of Projects).

(10) Any project referred to the Committee by the Commissioner, or the Assistant Commissioner; and

(11) Any project requiring a third re-approval under the provisions of §17.14 of this title (relating to Re-approval of Projects).

(d) Board. The following types of projects shall be approved by the Board:

(1) New construction with a total project cost of \$50 million or more;

(2) Purchase of real property having a value of \$25 million or more;

(3) Gifts or acquisition of improved real property with E&G space having a value of \$25 million or more;

(4) Auxiliary enterprise projects costing \$50 million or more; and

(5) Any project referred to the Board by the Committee or the Commissioner.

(e) The Commissioner may refer projects to the Committee or the Board. The Committee may refer projects to the Board. The Assistant Commissioner may refer projects to the Committee.

(f) Decisions of the Committee on Campus Planning are final. Decisions of the Commissioner may be appealed to the Board.

(g) Decisions of the Assistant Commissioner may be appealed to the Committee.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500476

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Effective date: February 22, 2005

Proposal publication date: November 26, 2004

For further information, please call: (512) 427-6114



SUBCHAPTER D. RULES APPLYING TO NEW CONSTRUCTION AND ADDITION PROJECTS

19 TAC §17.30

The Texas Higher Education Coordinating Board adopts amendments to §17.30 concerning Campus Planning with changes to the proposed text as published in the November 26, 2004, issue

of the *Texas Register* (29 TexReg 10866). Specifically, these amendments provide for efficiency thresholds for clinical facilities, technical research buildings, and parking structures.

The following comments were received regarding the sections:

Comment: Texas Tech University questioned the use of a standard for parking structures, suggesting that the parking industry does not use efficiency in the form of a percent for these facilities, but uses a measure of square feet (SF) per car. It was suggested that 300 SF per car would be an excellent structure on a perfect site, with an average structure achieving an efficiency of 350 to 400 SF per car. The commenter recommended that the efficiency of a parking garage be eliminated from the rules.

Response: As a result of this review, the Board agrees with this comment and establishes the standard for parking structures at an efficiency of 300 SF per parking space for automobile facilities; 325 SF per parking space for boathouses; and 1,000 SF per parking space for airplanes. The rule provides that if the parking structure does not meet this standard, the project may be approved if the institution demonstrates that the lower efficiency is due to the shape of the available land or site or other conditions that warrant the lower efficiency.

Comment: The University of Texas System made a general comment on the standards section of the rules and asks for an impartial opinion regarding the statutory authority of the agency and greater input into developing all standards.

Response: Involvement by the universities, colleges, and health-related institutions has been paramount in recommending changes to the rules. Several Working Groups and generous informal communications have been evident in the development of the Campus Planning rules. Changes to rules requested by this university system have been considered and the Board recommends that dialog continues. No specific change to the rules is proposed by the university system.

Comment: The University of Texas System made additional comments related to the rules regarding the Board's statutory authority and interpretation of the statutes related to deferred maintenance, Master Plan reports, audits, and Energy Savings Performance Contracts.

Response: These comments are related to sections not under consideration by the Board.

The amended section is adopted under Texas Education Code, §61.027, which provides the Board with the authority to adopt rules, and Texas Education Code, §§61.058 and 61.0572.

§17.30. Standards for New Construction and/or Addition Projects.

To obtain Board approval for a new construction and/or addition project, an institution shall demonstrate that the project complies with the following standards:

(1) Institutional Standards. The institution shall demonstrate that a new construction and/or addition project complies with the following institutional standards:

(A) Deferred Maintenance.

(i) The Board standard for deferred maintenance shall be the ratio of campus deferred maintenance costs to replacement value of 5 percent or less.

(ii) If the ratio of campus deferred maintenance costs to replacement value is more than 5 percent, a project may be approved if the institution demonstrates that:

(I) the project is intended to reduce the deferred maintenance on the campus, or

(II) the institution has demonstrated a reduction in its deferred maintenance to replacement value ratio 10 percent or more for the immediate prior three years.

(iii) Alternatively, if the deferred maintenance to replacement value ratio is greater than 5 percent, a project may be approved if the institution:

(I) submits a written plan on a form specified by the Board for substantial progress toward meeting the standard; and

(II) provides the Board with a statement signed by the president of the institution, regarding its ability to support and maintain the proposed facility while continuing to address current institutional facility maintenance needs. The president of the institution may not delegate this authority.

(B) Critical Deferred Maintenance.

(i) The Board standard for critical deferred maintenance is zero.

(ii) If the critical deferred maintenance is greater than zero, a project may be approved if the institution:

(I) Develops an acceptable plan in place to address any critical deferred maintenance reported on the master plan; and

(II) the institution shall demonstrate progress towards meeting the plan goals; and

(III) the institution shall provide the Board with a statement signed by the president of the institution regarding its ability to support and maintain the proposed facility while continuing to address current institutional facility maintenance needs. The president of the institution may not delegate this authority.

(2) Project Standards. The institution shall demonstrate that a new construction or addition project complies with the following project standards:

(A) Space Need--The project shall not create a campus space surplus, or add to an existing surplus, as determined by the Board's space projection model report, required by § 17.100 of this title (relating to Board Reports).

(i) If the institution has a predicted surplus of space in the current Space Projection Model report and the project is required to accommodate future predicted enrollment growth, the Board may consider a written plan from the institution, on a form specified by the Board, for substantial progress toward meeting the standard. The plan must include:

(I) an explanation of the expected growth and how the predicted growth will impact the institution;

(II) a demonstration of progress towards eliminating the surplus;

(III) a statement regarding the ability of the institution to support and maintain the proposed facility while continuing to address current institutional facility needs; and

(IV) a demonstration that, upon completion of the project, the institution will comply with the Board standard and eliminate the space surplus.

(V) The plan shall be signed by the president of the institution. The president of the institution may not delegate this authority within the requesting institution.

(ii) If more than one project is submitted for an agenda, all projects submitted for the current agenda will be considered in the determination of a campus surplus or deficit.

(B) Cost--The construction building cost per gross square foot shall be within the range of similar projects approved by the Board within the last five years, adjusted for inflation as described in the board's Construction Cost report (§ 17.100 of this title relating to Board Reports). If the construction cost per gross square foot exceeds the maximum cost of similarly approved projects, the cost per gross square foot shall not exceed the highest actual construction cost per gross square foot reported to R.S. Means unless the institution can demonstrate that the higher cost is due to market conditions or other circumstances that warrant the higher cost.

(C) Efficiency--The ratio of NASF to GSF for the space in projects for classrooms and general purpose facilities shall be 0.60 or greater. Where the following specialized space is predominant in the project, the ratios of NASF to GSF shall be as follows:

(i) Office space: 0.65 or greater;

(ii) Clinical facility; 0.50 or greater;

(iii) Diagnostic support laboratories: 0.50 or greater; and

(iv) Technical research buildings: 0.50 or greater; and

(v) Parking structure: and

(I) 300 Square Feet per parking space for automobile facilities;

(II) 325 Square Feet per parking space for boathouses; and

(III) 1,000 Square Feet per parking space for airplanes.

(IV) If the parking structure does not meet this standard, the project may be approved if the institution demonstrates that the lower efficiency is due to the shape of the available land or site or other conditions that warrant the lower efficiency.

(vi) For mixed-use facilities, the ratio of NASF to GSF shall be calculated for each space type and considered separately.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500477

Jan Greenberg

General Counsel

Texas Higher Education Coordinating Board

Effective date: February 22, 2005

Proposal publication date: November 26, 2004

For further information, please call: (512) 427-6114



CHAPTER 22. GRANT AND SCHOLARSHIP PROGRAMS

SUBCHAPTER F. PROVISIONS FOR THE SCHOLARSHIP PROGRAMS FOR VOCATIONAL NURSING STUDENTS

19 TAC §22.112

The Texas Higher Education Coordinating Board adopts an amendment to §22.112 concerning the Provisions for the Scholarship Programs for Vocational Nursing Students, without changes to the proposed text as published in the November 19, 2004, issue of the *Texas Register* (29 TexReg 10674). Specifically, on February 1, 2004, the Board of Vocational Nurse Examiners, which regulated the practice of licensed vocational nurses in Texas, ceased to exist as a separate agency. Licensed vocational nurses are now regulated by the Board of Nurse Examiners. The amendment reflects the change and eliminates any confusion regarding the licensing agency for vocational nurses.

No comments were received regarding the amendments.

The amendment is adopted under the Texas Education Code, §61.656, which allows the Coordinating Board the authority to make rules regarding the establishment and administration of a scholarship program for vocational nursing students.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 2, 2005.

TRD-200500478

Jan Greenberg
General Counsel

Texas Higher Education Coordinating Board

Effective date: February 22, 2005

Proposal publication date: November 19, 2004

For further information, please call: (512) 427-6114



PART 2. TEXAS EDUCATION AGENCY

CHAPTER 101. ASSESSMENT

SUBCHAPTER BB. COMMISSIONER'S RULES CONCERNING THE STUDENT SUCCESS INITIATIVE

19 TAC §§101.2003, 101.2005, 101.2007, 101.2011, 101.2013

The Texas Education Agency (TEA) adopts amendments to §§101.2003, 101.2005, 101.2007, 101.2011, and 101.2013, concerning assessment. The amendments to §§101.2003, 101.2005, and 101.2011 are adopted without changes to the proposed text as published in the October 22, 2004, issue of the *Texas Register* (29 TexReg 9788) and will not be republished. The amendments to §101.2007 and §101.2013 are adopted with changes to the proposed text. The sections address the Student Success Initiative (SSI). The adopted amendments provide clarifications on grade advancement testing requirements,

test administration and schedule, role of grade placement committees, alternate assessment, and accelerated instruction.

The 76th Texas Legislature, 1999, mandated a new testing program of increased rigor, size, and scope that was implemented in the 2002-2003 school year. The 76th Texas Legislature also mandated new grade advancement testing requirements as part of this new testing program; these requirements were enacted as the SSI and are specified in TEC, §28.0211.

The SSI mandates new passing requirements to be phased in as follows: beginning in school year 2002 - 2003 for the reading test at Grade 3, beginning in school year 2004 - 2005 for the reading and mathematics tests at Grade 5, and beginning in school year 2007-2008 for the reading and mathematics tests at Grade 8. As specified by these requirements, a student may advance to the next grade level only by passing these tests or by unanimous decision of his or her grade placement committee (GPC) as likely to perform at grade level after accelerated instruction. TEC, §28.0211, provides that admission, review, and dismissal (ARD) committees will determine the manner of participation in accelerated instruction of special education students who do not perform satisfactorily on one or more of the specified assessment instruments. ARD committees will also make decisions about promotion/retention of these special education students.

The adopted amendments to 19 TAC Chapter 101, Assessment, Subchapter BB, Commissioner's Rules Concerning the Student Success Initiative, are in accordance with TEC, §28.0211. These changes were guided by agency commitment to the following policy: to support student academic achievement of the essential knowledge and skills at each grade level to enable a student to succeed at the next grade level.

The purpose of these rule changes is to ensure that the grade advancement testing requirements are part of an overall system of support for student academic achievement. The following is a summary of the adopted amendments to 19 TAC Chapter 101, Subchapter BB.

Section 101.2003, Grade Advancement Testing Requirements, is amended by adding a new subsection (b) relating to criteria that identifies eligible students subject to all of the grade advancement requirements. A new subsection (c) is added to clarify the conditions under which a student is subject to the automatic retention component of SSI and to ensure that a student not subject to the automatic retention policy still receives the benefits of SSI (targeted or accelerated instruction, for example). Subsequent subsections are reordered accordingly. Subsection (d), formerly subsection (c), is modified to reflect the inclusion of all eligible students enrolled in Grades 3, 5, or 8 who are receiving special education services. Subsection (e), formerly subsection (d), is modified to correct a TAC reference. No changes were made to this section since published as proposed.

Section 101.2005, Test Administration and Schedule, is amended by adding a new subsection (d) to require a campus or district to accommodate the request of an out-of-district student to participate in the third administration of an SSI test if that campus or district is testing one or more local students on the applicable test and if the out-of-district student has registered to take the test by a date determined by the agency. A minor editorial change is made in subsection (c)(2). No changes were made to this section since published as proposed.

Section 101.2007, Role of Grade Placement Committee, is amended by adding language to subsection (f)(1) to ensure

that districts are aware that performance on past state-mandated assessments may be used as one indicator of student performance in the grade placement committee deliberations. Language is added to subsection (f)(3) to clarify that grade placement committees can consider extenuating circumstances that may have had adverse effects on the student. A new subsection (f)(4) is added to reinforce through rule that the grade placement committee may consider the period of enrollment in making grade placement decisions. A minor technical edit is made in subsection (b). In response to public comments from the Texas Classroom Teachers Association (TCTA), the following changes were made to this section since published as proposed. Language in subsection (b) was revised to clarify that the teacher selected to be included on a student's grade placement committee must be a certified teacher of the subject of the assessment on which the student failed to perform satisfactorily and must be familiar with the student in that subject area. Language in subsection (f)(3) was revised to clarify that the grade placement committee may consider the student's ability to participate in regular instruction as well as his or her ability to participate in testing or accelerated instruction when making a decision about whether to promote the student.

Section 101.2011, Alternate Assessment, is amended in subsection (c) to require the reporting of results of alternate assessments to the Texas Education Agency in a format specified by the agency. No changes were made to this section since published as proposed.

Section 101.2013, Accelerated Instruction, is amended by adding a new subsection (d) that requires districts to accommodate the request of an out-of-district student to participate in any established, on-campus summer accelerated instruction program, provided the student is living away from his or her home district and the program matches the accelerated instruction prescribed by the Grade Placement Committee. The subsequent subsection is reordered accordingly. In response to public comment from the TCTA, this section was revised slightly since published as proposed. Language in subsection (a) was revised to clarify that any accelerated instruction for students who have failed the test must maintain a ratio of no more than ten students to each teacher per class.

The following is a summary of public comments received on the proposed amendments to 19 TAC Chapter 101, Subchapter BB, and corresponding agency responses.

Comment. The Texas Classroom Teachers Association (TCTA) requested that §101.2007(b) be modified to clarify that the teacher selected for the grade placement committee must be a teacher of the subject of the assessment instrument on which the student failed to perform satisfactorily and should be most familiar with the student in that subject area.

Agency Response. The agency agrees and has revised the language in this section accordingly.

Comment. The TCTA suggested that the language in §101.2013(a) be revised to clarify that accelerated instruction is intended to be a pull-out program for students who have failed the test, with no more than ten of these students per teacher per class as specified in law.

Agency Response. The agency agrees and has modified the language in this section accordingly.

Comment. The TCTA suggested that this subchapter be revised to specify in rule that the grade placement committees are required to develop written reports documenting the decisions of the committee with respect to issues discussed at the meeting.

Agency Response. The agency agrees that it is important to document GPC decisions; however, the section will not be modified to add this specification at this time. The agency spoke with the Texas Statewide Network of Assessment Professionals (TSNAP) to get feedback on what grade placement committees are doing currently. The feedback that the agency received from TSNAP was that districts are currently documenting their decisions using formats determined at the district level. The agency will solicit further input on this issue for potential inclusion next year so that any change would be effective in a timely manner and may be incorporated into the appropriate test administration manual.

The amendments are adopted under the Texas Education Code, §28.0211, which authorizes the commissioner of education to adopt rules and procedures necessary to implement grade advancement testing requirements to support student academic achievement of the essential knowledge and skills.

The amendments implement the Texas Education Code, §28.0211.

§101.2007. Role of Grade Placement Committee.

(a) In accordance with the Texas Education Code (TEC), §28.0211, the superintendent of each school district and chief administrative officer of each charter school shall establish procedures for convening a grade placement committee (GPC) for each student who fails to demonstrate proficiency on the second administration of the test required for grade advancement. Decisions by the GPC shall be made on an individual student basis to ensure the most effective way to support the student's academic achievement on grade level.

(b) The GPC shall be composed of the principal or principal's designee, the student's parent or guardian, and the student's teacher(s) of the subject of the grade advancement test(s) on which the student has failed to demonstrate proficiency. If this teacher is unavailable, the principal shall designate, to serve on the GPC, a teacher certified in the subject of the assessment on which the student failed to perform satisfactorily and who is most familiar with the student's performance in that subject area. If more than one parent or guardian has the authority to make educational decisions regarding the student, a good faith effort must be made to notify both parents, but participation of any one parent or guardian is sufficient. Either parent or only one guardian may initiate an appeal. If both parents or guardians serve on the GPC but do not agree, either may agree to promote the student (if the remaining members of the GPC also agree to the promotion). The district may accept a parent's or guardian's written designation of another individual to serve on the GPC for all purposes. The district may accept a parent's or guardian's written and signed waiver of participation in the GPC and designation of the remaining members of the GPC as the decision-making entity for all purposes.

(1) If a parent or guardian or designee is unable to attend a meeting, the district may use other methods to ensure parent participation, including individual and conference telephone calls. The district may designate an individual to act on behalf of the student in place of a parent, guardian, or designee if no such person can be located. A surrogate parent named to act on behalf of a student with a disability shall be considered a parent for purposes of TEC, §28.0211.

(2) The district shall make a good faith effort to notify a parent or guardian to attend the GPC. If a parent or guardian is unavailable, the remaining members of the GPC must convene as required by

this section and take any actions required, except that the GPC may not agree to promote a student under TEC, §28.0211(e), unless a parent, guardian, or designee has appealed. A district may allow an appeal to be filed in writing in lieu of attending the GPC.

(c) Within five working days of receipt of student test results for the second administration of the test required for grade advancement, the district shall notify (for each student who fails to demonstrate proficiency) the campus principal of student test results. Upon receipt of this notice, the principal shall notify the teacher and parent or guardian of the test results. This notice shall include a description of the purpose and responsibilities of the GPC and the time and place for the GPC to hold its first meeting.

(d) The GPC is responsible for prescribing the accelerated instruction the student is to receive before the third testing opportunity. The GPC shall also decide at this time whether the student shall take the assessment specified in §101.2003 of this title (relating to Grade Advancement Testing Requirements) or the alternate assessment, as authorized by §101.2011 of this title (relating to Alternate Assessment). In the absence of unanimous agreement, the student shall take the assessment specified in §101.2003 of this title.

(e) The GPC must convene again if a student fails to demonstrate proficiency on the third administration of a test required for grade advancement and is thereby automatically retained at the same grade level. Within five working days of receipt of student test results for this administration, the district shall notify (for each student who fails to demonstrate proficiency) the principal or principal's designee of student test results. Upon receipt of this notice from the district, the principal shall inform the teacher and parent or guardian of the time and place for the GPC to hold a meeting. This notice shall inform the parent or guardian of the opportunity to appeal the automatic retention of the student. The district shall establish a procedure to ensure a good faith effort is made toward securing the parent's or guardian's receipt of the retention notification. The parent or guardian may appeal the retention by submitting a request to the GPC within five working days of receipt of this retention notification.

(f) If an appeal has been initiated by the parent or guardian, the GPC may decide in favor of promotion only if the GPC concludes, upon review of all facts and circumstances and in accordance with standards adopted by the local school board, that the student is likely to perform on grade level given additional accelerated instruction during the next school year. A student may be promoted only if the GPC's decision is unanimous. The review and final decision of the GPC must be appropriately documented as meeting the standards adopted by the local school board. These standards may include but are not limited to the following:

(1) evidence of satisfactory student performance, including grades, portfolios, work samples, local assessments, previous state assessments, and individual reading and mathematics diagnostic tests or inventories;

(2) improvement in student test performance over the three testing opportunities;

(3) extenuating circumstances that may have adversely affected the student's participation in instruction, the student's participation in the required assessments, or the student's participation in accelerated instruction; and

(4) consideration of whether a student was not enrolled in a Texas public school for part of the school year.

(g) In accordance with TEC, §28.0211(e), the placement decision by the GPC shall be made before the start of the next school year or, if applicable, upon reenrollment of a student after this date.

(h) A student who has been promoted upon completion of a school year in a school other than a Texas public school may be enrolled in that grade without regard to whether the student has successfully completed an assessment required under TEC, §28.0211. This subsection does not limit the authority of a district to appropriately place a student under TEC, Chapter 25, Subchapter B.

(i) In addition to the placement decision, the GPC shall develop an accelerated educational plan for each student who does not pass after three testing opportunities, regardless of whether the student has been promoted or retained. This plan shall include the accelerated instruction that the district must provide during the next school year. The plan must be designed to enable the student to perform at the appropriate grade level by the end of the next school year. The district shall establish a policy for monitoring the student during the school year to ensure that the student is progressing in accordance with the plan. The accelerated education plan must provide for interim progress reports to the student's parent or guardian and the opportunity for consultation with the teacher and/or principal as needed.

§101.2013. Accelerated Instruction.

(a) Each time a student fails to demonstrate proficiency on an assessment required for grade advancement, the school district or charter school shall provide the student with accelerated instruction in the applicable subject. Accelerated instruction should be consistent with previous diagnostic testing and intervention activities, if any, the student has received. Accelerated instruction for students who have failed an assessment may not have a ratio of more than ten students to each teacher per class.

(b) Accelerated instruction required after the first and second testing opportunities should be designed to address student needs to the greatest extent possible before the next respective testing opportunity.

(c) Each school district and each charter school shall be responsible for providing transportation to students required to attend accelerated programs if these programs occur outside of regular school hours.

(d) A school district must accommodate the request of an out-of-district student to participate in any established, on-campus summer accelerated instruction program, provided the student is living away from his or her home district and the program matches the accelerated instruction prescribed by the student's Grade Placement Committee.

(e) Accelerated instruction shall be based on but not limited to the following:

(1) assessment of specific student needs, which may include as appropriate the following: teacher observations and evaluations; academic progress reports; previous identification of student needs and corresponding interventions; and performance on previous assessment instruments in the applicable subject.

(2) best instructional practices identified through research that the district may obtain and implement through technical assistance from the Texas Education Agency and education service centers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500513

Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: February 24, 2005
Proposal publication date: October 22, 2004
For further information, please call: (512) 475-1497



TITLE 22. EXAMINING BOARDS

PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 107. DENTAL BOARD PROCEDURES

SUBCHAPTER B. PROCEDURES FOR INVESTIGATING COMPLAINTS

22 TAC §107.101

The Texas State Board of Dental Examiners (Board) adopts amendments to §107.101, concerning guidelines for the conduct of investigations, without changes to the proposed text published in the December 10, 2004, issue of the *Texas Register* (29 TexReg 11456). The text will not be republished.

The amendments alter the process by which investigations are tracked for possible consideration of emergency suspension proceedings. The section as amended also contains revisions to clarify and standardize language, and to improve organization.

Subsection (c) currently requires the director of enforcement to determine "upon receipt" of a complaint whether temporary suspension of the licensee should be considered. The language as amended allows that determination to be made at any point in an investigation of a complaint. This allows for that determination to be made with the benefit of some level of supporting evidence. The amendment also links this determination to the next steps of the temporary emergency suspension process, by reference to §107.102(c). The Board has adopted the corresponding amendments to §107.102.

No comments were received.

The section is adopted under Texas Government Code §2001.021 et seq., Texas Civil Statutes; the Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted section affects Title 3, Subtitle D of the Occupations Code and Title 22, Texas Administrative Code, Chapter 101-125.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500504

Bobby D. Schmidt, M.Ed.
Executive Director
State Board of Dental Examiners
Effective date: February 24, 2005
Proposal publication date: December 10, 2004
For further information, please call: (512) 475-0972



22 TAC §107.102

The Texas State Board of Dental Examiners (Board) adopts amendments to §107.102, concerning guidelines for the conduct of investigations, without changes to the proposed text published in the December 10, 2004, issue of the *Texas Register* (29 TexReg 11457). The text will not be republished.

The amendments alter the process by which investigations are submitted for possible consideration of emergency suspension proceedings. The section as amended also contains revisions to clarify and standardize language, and to improve organization.

Specifically, the amendments to subsection (c) allow for the referral of a case for consideration of emergency temporary suspension proceedings at any point in the investigation, rather than upon the initial review, as mandated by the current language.

The amendment also changes the standard for consideration of such cases from "possible threat" to the more specific "imminent threat", which more accurately mirrors the "clear, imminent, or continuing threat" requirement of Occupations Code, Chapter 263, §263.004.

Finally, the amendment routes those cases in which the investigation has revealed an imminent threat to the executive director, who then determines whether or not the case should be referred to the chairperson of the executive committee of the board, which ultimately bears the responsibility under Occupations Code, Chapter 263, §263.004 of determining whether or not to temporarily suspend the license involved. The introduction of this intermediate step helps to ensure proper controls over the use and efficacy of temporary emergency suspensions.

The Board has adopted the corresponding amendments to §107.101.

No comments were received.

The section is adopted under Texas Government Code §2001.021 et seq., Texas Civil Statutes; the Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted section affects Title 3, Subtitle D of the Occupations Code and Title 22, Texas Administrative Code, Chapter 101-125.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500505

Bobby D. Schmidt, M.Ed
Executive Director
State Board of Dental Examiners
Effective date: February 24, 2005
Proposal publication date: December 10, 2004
For further information, please call: (512) 475-0972



PART 6. TEXAS BOARD OF PROFESSIONAL ENGINEERS

CHAPTER 131. ORGANIZATION AND ADMINISTRATION

SUBCHAPTER F. ADMINISTRATION

22 TAC §131.81

The Texas Board of Professional Engineers adopts an amendment to §131.81, relating to Definitions, without changes to the proposed text as published in the December 3, 2004, issue of the *Texas Register* (29 TexReg 11248) and will not be republished.

The current rules include the term Good Standing in several locations, and the adopted amendment defines this term as a license or registration that is up to date with payments and is eligible for renewal.

No comments were received regarding the board's adoption of the amended section.

The amendment is adopted pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500548
Dale Beebe Farrow, P.E.
Executive Director
Texas Board of Professional Engineers
Effective date: February 24, 2005
Proposal publication date: December 3, 2004
For further information, please call: (512) 440-7723



CHAPTER 133. LICENSING

SUBCHAPTER B. PROFESSIONAL ENGINEER LICENSES

22 TAC §133.13

The Texas Board of Professional Engineers adopts an amendment to §133.13, relating to Branches of Engineering, without changes to the proposed text as published in the December 3,

2004, issue of the *Texas Register* (29 TexReg 11249) and will not be republished.

The current rules include a list of engineering branches and three letter codes related to those branches. The adopted rule places the branches in alphabetical order and removes the three letter codes. The codes were used in the past in relation to an agency database that is no longer in place.

No comments were received regarding the board's adoption of the amended section.

The amendment is adopted pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500549
Dale Beebe Farrow, P.E.
Executive Director
Texas Board of Professional Engineers
Effective date: February 24, 2005
Proposal publication date: December 3, 2004
For further information, please call: (512) 440-7723



SUBCHAPTER C. APPLICATION REQUIREMENTS

22 TAC §133.21

The Texas Board of Professional Engineers adopts an amendment to §133.21, relating to items required for an application for licensure as a Professional Engineer, without changes to the proposed text as published in the December 3, 2004, issue of the *Texas Register* (29 TexReg 11250) and will not be republished.

The current rules include a verification of engineering experience as an item that is accepted by the board from NCEES. The adopted rule change removes the NCEES verification of experience as an application item that is accepted by the board. The board only accepts original documents verifying engineering experience from the applicant and reference providers.

No comments were received regarding the board's adoption of the amended section.

The amendment is adopted pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500550

Dale Beebe Farrow, P.E.

Executive Director

Texas Board of Professional Engineers

Effective date: February 24, 2005

Proposal publication date: December 3, 2004

For further information, please call: (512) 440-7723



CHAPTER 137. COMPLIANCE AND PROFESSIONALISM

SUBCHAPTER A. INDIVIDUAL AND ENGINEER COMPLIANCE

22 TAC §137.17

The Texas Board of Professional Engineers adopts an amendment to §137.17, relating to the Continuing Education Program, without changes to the proposed text as published in the December 3, 2004, issue of the *Texas Register* (29 TexReg 11251) and will not be republished.

The current rules include the term "qualifying" in relation to seminars and programs that are accepted for Continuing Education credit. The board does not pre-approve or qualify any activities, so the term "qualifying" has been removed in the adopted rules. The adopted rule clarifies language concerning activities that may count in relation to participation in an organization. The adopted rule also adds language specifying that failure to comply with the Continuing Education Program is a violation of board rules and subject to sanctions.

No comments were received regarding the board's adoption of the amended section.

The amendment is adopted pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500551

Dale Beebe Farrow, P.E.

Executive Director

Texas Board of Professional Engineers

Effective date: February 24, 2005

Proposal publication date: December 3, 2004

For further information, please call: (512) 440-7723



SUBCHAPTER D. FIRM, SOLE PROPRIETORSHIP AND GOVERNMENTAL ENTITY COMPLIANCE

22 TAC §137.73

The Texas Board of Professional Engineers adopts an amendment to §137.73, relating to the modification of registered firm records, without changes to the proposed text as published in the December 3, 2004, issue of the *Texas Register* (29 TexReg 11251) and will not be republished.

The adopted rule adds a requirement that registered firms report to the board within 30 days any additions or dissolutions of branch or subsidiary offices.

No comments were received regarding the board's adoption of the amended section.

The amendment is adopted pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and by-laws consistent with the Act as necessary for the performance of its duties, the governance of its own, proceedings, and the regulation of the practice of engineering in this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500552

Dale Beebe Farrow, P.E.

Executive Director

Texas Board of Professional Engineers

Effective date: February 24, 2005

Proposal publication date: December 3, 2004

For further information, please call: (512) 440-7723



PART 29. TEXAS BOARD OF PROFESSIONAL LAND SURVEYING

CHAPTER 661. GENERAL RULES OF PROCEDURES AND PRACTICES

SUBCHAPTER D. APPLICATIONS, EXAMINATIONS, AND LICENSING

22 TAC §661.41

The Texas Board of Professional Land Surveying (TBPLS) adopts an amendment to §661.41(a), concerning Applications, without changes to the proposed text as published in the December 31, 2004, issue of the *Texas Register* (29 TexReg 12078) and will not be republished. This section changes the need for a sworn affidavit during the application process.

The amendment deletes a portion of the rule that states that a sworn affidavit must be submitted as part of the application process.

No comments were received regarding adoption of the amendment.

The amendment is adopted pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500515

Sandy Smith

Executive Director

Texas Board of Professional Land Surveying

Effective date: February 24, 2005

Proposal publication date: December 31, 2004

For further information, please call: (512) 452-9427



SUBCHAPTER E. CONTESTED CASES

22 TAC §661.95

The Texas Board of Professional Land Surveying (TBPLS) adopts the repeal of §661.95, concerning the failure to attend hearings and the judgments that will occur if the respondent fails to appear. The repeal is adopted without changes to the proposal as published in the December 31, 2004 issue of the *Texas Register* (29 TexReg 12078) and will not be republished.

The language in §661.95 has been incorporated into §661.62, therefore it needs to be repealed. Repealing this portion of the Rule will take away language that is currently included in another rule.

No comments were received regarding the adoption of the repeal.

The repeal is adopted pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500517

Sandy Smith

Executive Director

Texas Board of Professional Land Surveying

Effective date: February 24, 2005

Proposal publication date: December 31, 2004

For further information, please call: (512) 452-9427



22 TAC §661.99

The Texas Board of Professional Land Surveying (TBPLS) adopts a new rule §661.99, concerning Sanctions and Penalty Matrix, with changes to the graphics chart as published in the

December 24, 2004, issue of the *Texas Register* (29 TexReg 11895).

The new rule outlines sanctions and penalties to be followed in response to a complaint.

No comments were received within the specified time frame regarding adoption of the rule. However one comment was received late and the Board did consider the comment. After discussion it was determined that the subject of the comment was addressed in the rule as written. The commenter was satisfied.

The new rule is adopted pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

§661.99. Sanctions and Penalty Matrix.

The Board, the Executive Director, Investigator, Administrative Law Judge or the participants in an Informal Conference may arrive at a greater or lesser sanction and penalty than suggested in this Rule. The minimum administrative penalty is \$100 per violation. The maximum administrative penalty shall be \$1500 per violation. In addition to the sanctions and penalties noted below, the Board may order restitution, suspension, probation and/or additional educational courses. Allegations and disciplinary actions will be set forth in the final Board Order and the severity of the disciplinary action will be based on the following factors:

- (1) the seriousness of the violation, including the nature, circumstances, extent and gravity of any prohibited acts;
- (2) the economic damage to property caused by the violation;
- (3) the history of previous violations;
- (4) the amount necessary to deter a future violation;
- (5) efforts to correct the violation; and
- (6) any other matter that justice may require.

Figure: 22 TAC §661.99(6)

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500514

Sandy Smith

Executive Director

Texas Board of Professional Land Surveying

Effective date: February 24, 2005

Proposal publication date: December 24, 2004

For further information, please call: (512) 452-9427



CHAPTER 663. STANDARDS OF RESPONSIBILITY AND RULES OF CONDUCT

SUBCHAPTER A. ETHICAL STANDARDS

22 TAC §663.8

The Texas Board of Professional Land Surveying (TBPLS) adopts an amendment to §663.8(2), concerning adherence to Statutes and Codes, without changes to the proposed text as

published in the December 31, 2004 issue of the *Texas Register* (29 TexReg 12079) and will not be republished.

The amendment to this rule explains in greater detail what the requirements are in regard to subdividing land into tracts and what actions should be taken by the surveyor.

No comments were received regarding adoption of the amendment.

The amendment is adopted pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500518

Sandy Smith

Executive Director

Texas Board of Professional Land Surveying

Effective date: February 24, 2005

Proposal publication date: December 31, 2004

For further information, please call: (512) 452-9427



SUBCHAPTER B. PROFESSIONAL AND TECHNICAL STANDARDS

22 TAC §663.20

The Texas Board of Professional Land Surveying (TBPLS) adopts an amendment to §663.20(a)(2), concerning the Application process, without changes to the proposed text as published in the December 31, 2004, issue of the *Texas Register* (29 TexReg 12080) and will not be republished. As currently written, §663.20(a)(2) states that a sworn affidavit is required to attest to whether he or she has ever been convicted of a felony or a misdemeanor.

Deletion of this portion of the Rule will clarify that the board will no longer require a sworn affidavit regarding criminal convictions.

No comments were received regarding adoption of the amendment.

The amendment is adopted pursuant to §1071.151, Title 6, Occupations Code, Subtitle C, which authorizes the Board to adopt and enforce reasonable and necessary rules to perform its duties.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500516

Sandy Smith

Executive Director

Texas Board of Professional Land Surveying

Effective date: February 24, 2005

Proposal publication date: December 31, 2004

For further information, please call: (512) 452-9427



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 §§741.65, 741.141, 741.161, 741.162, 741.181, and 741.195, concerning speech-language pathology and audiology. Section 741.65 is adopted with changes to the proposed text as published in the August 20, 2004, issue of the *Texas Register* (29 TexReg 8078). Sections 741.141, 741.161, 741.162, 741.181, and 741.195 are adopted without changes, and therefore the sections will not be republished.

The amendments are necessary to implement House Bill 2985, 78th Legislature, 2003, which added Occupations Code, Chapter 101, Subchapter G, which established the Office of Patient Protection and requires additional fees to fund it; Senate Bill 1152, 78th Legislature, 2003, which amends Government Code, Chapter 2054, to require participation in Texas Online; and Senate Bill 161, 78th Legislature, 2003, which amends Occupations Code, Chapter 401, relating to emergency suspensions and administrative penalties. The two year licensing fee amendments are required as a result of revisions to the Health and Safety Code, Chapter 12, §§12.0111 and 12.0112, pursuant to House Bill 2292, 78th Legislature, 2003. The amendments to §741.65 are necessary to clarify the duties of experienced speech pathology assistants working in a school setting.

These sections provide for the efficient and effective regulation and licensure of speech-language pathologists, audiologists, and speech pathology assistants.

The board received public and staff comments during the comment period for these amendments.

Comment: Concerning §741.65, eight commenters expressed support of the amendments regarding speech pathology assistants. These commenters generally agreed that the amendment will benefit school districts and students.

Response: The board agrees. No change was made as a result of the comments.

Comment: Concerning §741.65, two commenters expressed opposition to the amendments regarding speech pathology assistants. The commenters generally felt that the stipulations regarding assistants attending admission, review, and dismissal (ARD) meetings were too restrictive.

Response: The board disagrees and believes that the stipulations are appropriate for speech pathology assistants who participate in ARD meetings. No change was made as a result of the comments.

Comment: Concerning §741.65, one commenter expressed opposition to the amendments regarding the role of speech pathology assistants. The commenter believes that assistants are inadequately prepared for these duties.

Response: The board disagrees and believes that the parameters it has set out for speech pathology assistants are appropriate in relation to their training and education. No change was made as a result of the comment.

Comment: Regarding rule §741.65(h)(4)(l)(i)(IV), one commenter suggested that the wording "present Individual Educational Plan" be replaced by "share a draft of Individual Educational Plan."

Response: The board agrees and has incorporated the suggested modification.

Eleven individuals and staff provided comments on the rules. Several commenters expressed opposition to the proposal and other commenters expressed support of the proposal.

SUBCHAPTER E. REQUIREMENTS FOR LICENSURE AND REGISTRATION OF SPEECH-LANGUAGE PATHOLOGISTS

22 TAC §741.65

The amendment is adopted under the 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 the Texas Occupations Code, Chapter 401.

§741.65. Requirements for an Assistant in Speech-Language Pathology License.

(a) An applicant for an assistant in speech-language pathology license shall meet the requirements set out in the Texas Occupations Code, §401.312, and this section within 10 years of the date of application for the assistant license. The applicant for the assistant license must:

(1) possess a baccalaureate degree with an emphasis in communicative sciences and disorders;

(2) have acquired no fewer than 24 semester hours in speech-language pathology and/or audiology, at least 18 of which must be in speech-language pathology core curriculum as follows:

(A) at least three semester hours in language disorders;

(B) at least three semester hours in speech disorders; and

(C) excludes clinical experience and course work such as special education, deaf education, or sign language; and

(3) have earned no fewer than 25 hours of clinical observation in the area of speech-language pathology and 25 hours of clinical assisting experience in the area of speech-language pathology obtained within an educational institution or in one of its cooperating programs.

(b) The baccalaureate degree shall be completed at a college or university which has a program accredited by the American Speech-Language-Hearing Association Council on Academic Accreditation or holds accreditation or candidacy status from a recognized regional accrediting agency.

(1) Original or certified copy of transcripts shall be submitted and reviewed as follows:

(A) only course work completed within the past 10 years with a grade of "C" or above is acceptable;

(B) a quarter hour of academic credit shall be considered as two-thirds of a semester credit hour; and

(C) academic courses, the titles of which are not self-explanatory, shall be substantiated through course descriptions in official school catalogs or bulletins or by other official means.

(2) In the event the course work and clinical experience set out in subsection (a) of this section were earned more than 10 years before the date of application for the assistant license, the applicant shall submit proof of current knowledge of the practice of speech-language pathology to be evaluated by the board's designee. Within 15 working days of receipt, the board's designee shall evaluate the documentation and shall either approve the application, request additional documentation, or require that additional coursework or continuing professional education be earned. If an applicant is required to earn additional course work or continuing professional education hours, §741.193 of this title (relating to Formal Hearings; Surrender of License or Registration) shall not apply. If necessary, the applicant may reapply for the license when the requirements of this section are met.

(c) An applicant who possesses a baccalaureate degree with a major that is not in communicative sciences and disorders may qualify for the assistant license. The board's designee shall evaluate transcripts on a case-by-case basis to ensure equivalent academic preparation and shall determine if the applicant satisfactorily completed 24 graduate hours in communicative sciences or disorders which may include some leveling hours. Within 15 working days of receipt, the board's designee shall approve the application, request additional documentation, or require that additional coursework or continuing professional education be earned. If an applicant is required to earn additional coursework or continuing professional education hours, §741.193 of this title (relating to Formal Hearings; Surrender of License or Registration) shall not apply. If necessary, the applicant may reapply for the license when the requirements of this section are met.

(d) Degrees and/or course work received at foreign universities shall be acceptable only if such course work and clinical practicum hours may be verified as meeting the requirements of subsection (a) of this section. The applicant must bear all expenses incurred during the procedure. The board's designee shall evaluate the documentation within 15 working days of receipt of all documentation which shall include an original report from a credential evaluation services agency acceptable to the board.

(e) An applicant who has not acquired the hours referenced in subsection (b)(3) of this section shall not meet the minimum qualifications for the assistant license. Other than acquiring the 25 hours of clinical observation and the 25 hours of clinical assisting experience through an accredited college or university, there are no other exemptions in the Texas Occupations Code, Chapter 401, for an applicant to acquire the hours. The applicant shall first obtain the assistant license by submitting the forms, fees, and documentation referenced in §741.112(e) of this title (relating to Required Application Material) and include a clinical deficiency plan to acquire the clinical observation and clinical assisting experience hours lacking.

(1) The licensed speech-language pathologist who will provide the assistant with the training to acquire these hours shall submit:

(A) the supervisory responsibility statement form; and

(B) a clinical deficiency plan that shall include the following:

- (i) name and signature of the assistant;
- (ii) name, qualifications, and signature of the licensed speech-language pathologist trainer;
- (iii) number of hours of observation and/or assisting experience lacking;
- (iv) statement that the training shall be conducted under 100% direct, face-to-face supervision of the assistant; and
- (v) list of training, consistent with subsection (h) of this section, that shall be completed.

(2) The board office shall evaluate the documentation and fees submitted to determine if the assistant license shall be issued. Additional information or revisions may be required before approval is granted.

(3) The clinical deficiency plan shall be completed within 60 days of the issue date of the license or the assistant shall be considered to have voluntarily surrendered the license.

(4) Immediately upon completion of the clinical deficiency plan, the trainer identified in the plan shall submit:

(A) a supervision log that verifies the specific times and dates in which the hours were acquired with a brief description of the training conducted during each session;

(B) a rating scale of the assistant's performance; and

(C) a signed statement that the assistant successfully completed the clinical observation and clinical assisting experience under his or her 100% direct, face-to-face supervision of the assistant. This statement shall specify the number of hours completed and verify completion of the training identified in the clinical deficiency plan.

(5) In addition to paragraph (4) of this subsection, the assistant shall submit an original signed statement listing the duties that an assistant may and may not perform and acknowledge understanding that the supervisory responsibility statement form shall be received and approved by board staff in order for the assistant to practice.

(6) Board staff shall evaluate the documentation required in paragraphs (4) and (5) of this subsection and inform the assistant and trainer if acceptable.

(7) An assistant may continue to practice under supervision of the trainer while the board office evaluates the documentation identified in paragraphs (4) and (5) of this subsection.

(8) In the event, another licensed speech-language pathologist shall supervise the assistant after completion of the clinical deficiency plan, a supervisory responsibility statement form shall be submitted to the board office seeking approval for the change in supervision. If the documentation required by paragraphs (4) and (5) of this subsection has not been received and approved by the board office, approval for the change in supervision shall not be granted.

(f) A supervisory responsibility statement form shall be completed and signed by both the applicant and the licensed speech-language pathologist who agrees to assume responsibility for all services provided by the assistant. Effective August 1, 2004, the supervisor shall have practiced for at least three years and shall submit a signed statement verifying he or she has met this requirement.

(1) Approval from the board office shall be required prior to practice by the assistant. The form shall be submitted upon:

- (A) application for a license;
- (B) license renewal;

(C) changes in supervision; and

(D) when other supervisors are added.

(2) In the event more than one licensed speech-language pathologist agrees to supervise the assistant, the primary supervisor shall be identified and separate forms submitted by each supervisor.

(3) An assistant may renew the license but may not practice without submitting a new supervisory responsibility statement form.

(4) In the event the supervisor ceases supervision of the assistant, the supervisor shall notify the board, in writing, and shall inform the assistant to stop practicing immediately. The board shall hold the supervisor responsible for the practice of the assistant until written notification has been received in the board office.

(5) Should the assistant practice without approval from the board office, disciplinary action shall be initiated against the assistant. If the supervisor had knowledge of this violation, disciplinary action against the supervisor shall also be initiated.

(g) A licensed speech-language pathologist shall assign duties and provide appropriate supervision to the assistant.

(1) Diagnostic contacts shall be conducted by the supervising licensed speech-language pathologist. This contact may include evaluation of the client.

(2) Following the diagnostic contact, the supervising speech-language pathologist shall determine whether the assistant has the competence to perform specific duties before delegating tasks.

(3) The supervising speech-language pathologist shall provide the minimum of no less than two hours per week, at least half of which is face-to-face supervision, at the location where the assistant is employed. This applies whether the assistant's practice is full or part-time.

(4) Indirect methods of supervision may include audio and/or video tape recording, telephone communication, numerical data, or other means of reporting.

(5) An exception to paragraph (3) of this subsection may be requested. The supervising speech-language pathologist shall submit a proposed plan of supervision for review by the board's designee. Within 15 working days of receipt of the request, the board's designee shall accept or reject the plan. The plan shall be for not more than one year's duration and shall include:

- (A) the name of the assistant;
- (B) the name and signature of the supervisor;
- (C) the proposed plan of supervision;
- (D) the exact time frame for the proposed plan;
- (E) the length of time the assistant has been practicing under the requestor's supervision; and
- (F) the reason the request is necessary.

(6) If the exception referenced in paragraph (5) of this subsection 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 reject the plan.

(7) Supervisory records shall be maintained by the licensed speech-language pathologist which verify regularly scheduled monitoring, assessment, and evaluation of the assistant's and client's performance. Such documentation may be requested by the board.

(A) An assistant may conduct assessments which include data collection, clinical observation and routine test administration if the assistant has been appropriately trained and the assessments are conducted under the direction of the supervisor. An assistant may not conduct a test if the test developer has specified that a graduate degreed examiner should conduct the test.

(B) An assistant may not conduct an evaluation which includes diagnostic testing, test and observation interpretation, diagnosis, decision making, statement of severity or implication, case selection or case load decisions.

(h) Although the licensed supervising speech-language pathologist may delegate specific clinical tasks to an assistant, the responsibility to the client for all services provided cannot be delegated. The licensed speech-language pathologist shall ensure that all services provided are in compliance with this chapter.

(1) The licensed speech-language pathologist need not be present when the assistant is completing the assigned tasks; however, the licensed speech-language pathologist shall document all services provided and the supervision of the assistant.

(2) The licensed speech-language pathologist shall keep job descriptions and performance records. Records shall be current and made available to the board within 30 days of the date of the board's request for such records.

(3) The assistant may execute specific components of the clinical speech, language, and/or hearing program if the licensed speech-language pathologist determines that the assistant has received the training and has the skill to accomplish that task, and the licensed speech-language pathologist provides sufficient supervision to ensure appropriate completion of the task assigned to the assistant.

(4) Examples of duties which an assistant may be assigned by the speech-language pathologist who agreed to accept responsibility for the services provided by the assistant, provided appropriate training has been received, are to:

(A) conduct or participate in speech, language, and/or hearing screening;

(B) implement the treatment program or the individual education plan (IEP) designed by the licensed speech-language pathologist;

(C) provide carry-over activities which are the therapeutically designed transfer of a newly acquired communication ability to other contexts and situations;

(D) collect data;

(E) administer routine tests as defined by the board if the test developer does not specify a graduate degreed examiner and the supervisor has determined the assistant is competent to perform the test;

(F) maintain clinical records;

(G) prepare clinical materials; and

(H) participate with the licensed speech-language pathologist in research projects, staff development, public relations programs, or similar activities as designated and supervised by the licensed speech-language pathologist.

(I) May represent special education and speech pathology at Admission, Review and Dismissal (ARD) meetings with the following stipulations:

(i) the Speech-Language Pathology assistant shall:

(I) have written documentation of approval from the licensed, board approved SLP supervisor;

(II) have three years experience as a speech pathology assistant in the school setting;

(III) attend only annual review ARD meetings for students with a sole diagnosis of articulation disorder and are conducted by the school administrator;

(IV) share a draft of Individual Educational Plan (IEP) goals and objectives that have been developed by the supervising SLP and reviewed with the parent by the SLP;

(V) discontinue participation in the ARD meeting, and contact the supervising SLP, when questions or changes arise regarding the IEP document.

(ii) the licensed, board approved supervisor of the assistant, prior to the ARD, shall:

(I) notify the parents of students with speech impairments that services will be provided by an SLP assistant and that the SLP will represent Speech Pathology at the ARD;

(II) review student's progress on the previous Individual Education Plan (IEP); and

(III) develop the student's new IEP goals and objectives and review them with the SLP assistant.

(iii) the licensed, board approved SLP supervisor of the assistant maintains undiminished responsibility for the services provided and the actions of the assistant.

(5) The assistant shall not:

(A) conduct evaluations even under supervision since this is a diagnostic and decision making activity;

(B) interpret results of routine tests;

(C) interpret observations or data into diagnostic statements, clinical management strategies, or procedures;

(D) represent speech-language pathology at staff meetings or on an admission, review and dismissal (ARD), except as specified in paragraph (4)(I) of this subsection;

(E) attend staffing meeting or ARD without the supervisor being present, except as specified in paragraph (4)(I) of this subsection;

(F) design or alter a treatment program or individual education plan (IEP);

(G) determine case selection;

(H) present written or oral reports of client information;

(I) refer a client to other professionals or other agencies;

(J) use any title which connotes the competency of a licensed speech-language pathologist;

(K) practice as an assistant in speech-language pathology without a valid supervisory responsibility statement on file in the board office;

(L) perform invasive procedures;

(M) screen or diagnose patient or clients for feeding and swallowing disorders;

(N) use a checklist or tabulated results of feeding or swallowing evaluations;

(O) demonstrate swallowing strategies or precautions to patients, family, or staff;

(P) provide patient or family counseling; or

(Q) write or sign any formal document (e.g., treatment plans, diagnostic reports, reimbursement forms, reports).

(i) Any reference to the licensee's title shall state clearly that the license status is that of an assistant in speech-language pathology.

(j) The board shall audit 10% of licensed assistants each month for compliance with this section and §741.41 of this title (relating to the Code of Ethics).

(1) The board shall notify an assistant by mail that he or she has been selected for an audit.

(2) Upon receipt of an audit notification, the assistant and the licensed speech-language pathologist who agreed to accept responsibility for the services provided by the assistant shall mail the requested proof of compliance to the board.

(3) A licensee and supervisor shall comply with the board's request for documentation and information concerning compliance with the audit.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500565
Cheryl Sancibrian
Presiding Officer
State Board of Examiners for Speech-Language Pathology and Audiology
Effective date: February 27, 2005
Proposal publication date: August 20, 2004
For further information, please call: (512) 458-7236



SUBCHAPTER K. ISSUANCE AND DISPLAY OF LICENSE AND REGISTRATION

22 TAC §741.141

The amendment is adopted under the 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 the Texas Occupations Code, Chapter 401.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500566

Cheryl Sancibrian
Presiding Officer
State Board of Examiners for Speech-Language Pathology and Audiology
Effective date: February 27, 2005
Proposal publication date: August 20, 2004
For further information, please call: (512) 458-7236



SUBCHAPTER L. LICENSE AND REGISTRATION RENEWAL

22 TAC §741.161, §741.162

The amendments are adopted under the 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 the Texas Occupations Code, Chapter 401.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500567
Cheryl Sancibrian
Presiding Officer
State Board of Examiners for Speech-Language Pathology and Audiology
Effective date: February 27, 2005
Proposal publication date: August 20, 2004
For further information, please call: (512) 458-7236



SUBCHAPTER M. FEES AND PROCESSING PROCEDURES

22 TAC §741.181

The amendment is adopted under the 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 the Texas Occupations Code, Chapter 401.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500568
Cheryl Sancibrian
Presiding Officer
State Board of Examiners for Speech-Language Pathology and Audiology
Effective date: February 27, 2005
Proposal publication date: August 20, 2004
For further information, please call: (512) 458-7236

◆ ◆ ◆

SUBCHAPTER N. DENIAL, PROBATION, SUSPENSION, OR REVOCATION OF A LICENSE OR REGISTRATION

22 TAC §741.195

The amendment is adopted under the 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 the Texas Occupations Code, Chapter 401.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500569

Cheryl Sancibrian

Presiding Officer

State Board of Examiners for Speech-Language Pathology and Audiology

Effective date: February 27, 2005

Proposal publication date: August 20, 2004

For further information, please call: (512) 458-7236

◆ ◆ ◆

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

The Commissioner of Insurance adopts amendments to §§11.1, 11.2, 11.101, 11.201 - 11.206, 11.301 - 11.303, 11.502 - 11.506, 11.508, 11.509, 11.512, 11.602, 11.603, 11.801 - 11.803, 11.806, 11.810, 11.901, 11.904, 11.1001, 11.1301 - 11.1306, 11.1401 - 11.1404, 11.1500, 11.1600 - 11.1602, 11.1604 - 11.1607, 11.1702 - 11.1704, 11.1801 - 11.1806, 11.1901, 11.1902, 11.2101 - 11.2103, 11.2200, 11.2201, 11.2203, 11.2204, 11.2303, 11.2311, 11.2314, 11.2402, 11.2405, 11.2501 - 11.2503, 11.2601, and 11.2602, and new §§11.902, 11.2207, 11.2208, and 11.2406, concerning regulation of health maintenance organizations (HMOs). Sections 11.2, 11.205, 11.303, 11.506, 11.901, 11.1600, 11.1601, 11.1605, 11.1607, 11.1806, 11.1902, 11.2207 and 11.2208 are adopted with changes to the proposed text as published in the November 12, 2004 issue of the *Texas Register* (29 TexReg 10357). Sections 11.1, 11.101, 11.201 - 11.204, 11.206, 11.301, 11.302, 11.502 - 11.505, 11.508, 11.509, 11.512, 11.602, 11.603, 11.801 - 11.803, 11.806, 11.810, 11.902, 11.904, 11.1001, 11.1301 - 11.1306, 11.1401 - 11.1404, 11.1500, 11.1602, 11.1604, 11.1606, 11.1702 - 11.1704, 11.1801 - 11.1805, 11.1901, 11.2101 - 11.2103, 11.2200, 11.2201, 11.2203, 11.2204, 11.2303, 11.2311, 11.2314, 11.2402, 11.2405, 11.2406, 11.2501 - 11.2503, 11.2601, and 11.2602 are adopted without changes.

These amendments and new sections are necessary to implement statutory changes from prior legislative sessions and to update procedures and requirements to conform to certain nationally recognized standards. In addition, because these sections have not undergone comprehensive revision for a number of years, the department believes it is necessary to streamline and consolidate requirements to reflect more accurately acceptable HMO practices and TDI's policies and procedures, and to clarify statutory requirements. The department also believes rule revision is necessary to respond to regulatory concerns that have arisen since the last revision.

The commissioner held a public hearing on the proposed sections on December 9, 2004. Subsequently, the department received comments regarding changes within these proposed sections. In response to comments, the department has changed several of the proposed sections as published; however, none of the changes introduce new subject matter or affect additional persons than those subject to the proposal as originally published.

The department is not adopting the proposed language concerning payment for out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) in order to appropriately defer the issue pending possible action in the current legislative session. However, the department has adopted a notice requirement at §11.1600(b)(11)(D) that requires an HMO to notify an enrollee to contact the HMO upon receipt of a bill from any provider. The originally proposed language related to the issue of payment for services received by enrollees outside of an HMO's provider network due to emergencies or the unavailability of a network provider. Comments received by the department, both written and at the hearing, placed a great deal of emphasis on this issue and generally focused on two possible effects of the proposed language. First, commenters were concerned that the proposal would have a negative effect on an HMO's ability to contract with certain types of specialty providers. These commenters noted current difficulties for HMOs attempting to contract with certain types of providers due to a variety of factors. Commenters specifically identified arrangements between hospitals and providers that make certain providers the exclusive provider of that type in a hospital. If a hospital operating under such an arrangement is a network facility, the commenters feel that the providers working within the hospital have little incentive to contract with an HMO because any steerage that commonly results from a provider's contract with an HMO already exists due to the hospital's exclusive arrangement with the provider. The commenters opined that the proposal would make it even more difficult to contract with these providers for a rate other than the provider's full billed charges.

Other commenters representing HMOs expressed concern that their ongoing efforts to negotiate with out-of-network providers for payment of necessary out-of-network services would be hindered by the proposed language because it would operate as a disincentive to accept an amount lower than the billed charge. These commenters are describing situations in which they are not seeking to contract with the provider in order to bring the provider into the HMO's network, but rather are attempting to negotiate a price for services rendered by an out-of-network provider due to an emergency or the unavailability of a network provider.

The causes of the contracting and negotiating issues identified by commenters merit further consideration to determine adequate and appropriate solutions. Health care coverage through

a managed care carrier depends upon a network of providers who have, in general, contracted with the managed care carrier for discounts in return for steerage of patients. The HMO model of managed care is especially reliant upon a provider network, as enrollees are not allowed to receive covered services from out-of-network providers unless it becomes necessary due to an emergency or the unavailability of a network provider for a specific service. If HMOs are unable to contract with providers for discounts, the cost model on which HMOs are based most likely fails or requires significant premium increases from current levels. Comments received in this rulemaking process have highlighted the increasing difficulty that HMOs are having in contracting with certain specialty providers that provide hospital-based services. This trend results in an increased likelihood that enrollees will receive out-of-network services in a network facility, which hampers the ability of an HMO to exercise cost control.

The inability of HMOs and providers to agree on a usual and customary or other acceptable payment amount for necessary out-of-network services essentially places enrollees in a position of paying a greater amount than would have been required were services available from a network provider. The reported difficulties that HMOs are experiencing in attempting to contract with hospital-based specialty providers should not result in a shifting of costs to enrollees under the current statutory scheme. The proposal expresses the department's interpretation of the HMO Act, which prohibits enrollees from exposure to additional costs for necessary out-of-network services, despite the reported increased frequency of such services.

One aspect of the current statutory scheme appears to receive improper emphasis as a remedy for the difficulties associated with contracting with facility-based providers. With respect to the issue of enrollees that are forced to receive services outside the network, the HMO commenters look to the language in Article 20A.09(f) to limit an HMO's responsibility to a usual and customary amount as determined by the HMO. The amount determined by the HMO is often lower than the provider's billed charges, which may result in the provider looking to the enrollee for the balance. Use of Article 20A.09(f) as a solution for reported current difficulties in contracting with certain types of providers is not consistent with certain protections afforded enrollees in the HMO Act, such as requirements related to network adequacy. The commenters' interpretations create an exception to the network adequacy requirements that circumvents the rule and would allow enrollees to be routinely exposed to additional costs for services that should be available through network providers. Enrollees receiving these out-of-network services are rarely aware of the contracting status of the provider and have no opportunity to ensure that services are not received from out-of-network providers. The department understands Article 20A.09(f) to apply more appropriately to unusual situations in which the HMO's network would not likely have the type of specialist necessary.

The issue of who is appropriately responsible for the costs of necessary out-of-network services is at the heart of the subject of balance billing. Although the department believes that the HMO Act requires enrollees to be protected from additional cost exposure for unavoidable out-of-network services, the evolving state of the market may yield cost consequences that the legislature could not have anticipated when the HMO Act was originally enacted. Deference to the legislature on this issue is therefore both appropriate and timely.

Payment for out-of-network services and balance billing have recently become the focus of legislative interest, as evidenced by

the interim charge to the Senate State Affairs Committee to study payments by insurers and HMOs for out-of-network services. The Committee's report includes several recommendations for further study and consideration, stating "the issue begs for legislative action, [but] the degree of action should be fully vetted and debated." Because of the possibility of legislative attention to this matter, the department is not adopting the proposed language relating to payment of necessary out-of-network services. Should the legislature decline to take any action, the department may revisit the issue.

Despite the department's decision to defer additional action on this issue, the adopted rule includes a notice requirement so that enrollees receive proper guidance regarding steps to take when they receive a bill from any provider. Of all the parties involved in the issue of out-of-network payments, enrollees have the least ability to exercise control over circumstances that result in out-of-network services. Consequently, the department has adopted a notice requirement at §11.1600(b)(11)(D) that requires an HMO to notify an enrollee to contact the HMO upon receipt of a bill from any provider.

In response to comments, the department has made the following changes to the language as proposed: The definition of "consumer choice health benefit plan" has been revised to restore original language regarding applicable rules. The definition of "copayment" in §11.2(b)(17) is changed to include the language: "which may be expressed in terms of a dollar amount or a percentage of the contracted rate." The department changed the definition of "premium" in §11.2(b)(33) by replacing the reference to "small and large employer and eligible employees" with the term "contract holder" to take into account individual coverage. In §11.303(d)(1) and (3), the department restored the words "or their designee" after "key management staff," in two places to clarify that a key manager's designee may attend the entrance and exit conferences in the event a given key manager is not available. The department deleted the phrase "on HMO's behalf" in §11.901(a)(1)(C) because physicians and providers do not collect copayments on behalf of the HMO. The department revised the notice in §11.1600(b)(11)(D) to require HMOs to include a notice in the plan description advising enrollees to notify the HMO of any bill received from any provider. The department added language to §11.1600(f) requiring that internet provider directory information be easily accessible from the home page of the site. In §11.1607(g)(1)(B), the department changed back the availability requirement for urgent behavioral health care from 48 hours to 24 hours. The department changed the time frames concerning the annual reports in §11.1806(a) to be consistent with the time frames set by the Health and Human Services Commission. In §11.1902(4)(C)(iv) the department added language to clarify that the only individual providers for which site visits are required are individual behavioral health providers, as well as clarify that the provision applies to the relocation and opening of additional office sites of certain providers. The department added language in §11.2208(c) to clarify that the requirement for contracting with an inpatient facility applies only to single service HMOs that provide inpatient care. In addition to the foregoing changes, the department changed the reference in §11.1600(f) from "this paragraph" to "subsection (b)(11)" and the reference in §11.508(d) from "this section" to "this subchapter" to correct inaccurate cite references, and included a reference to Insurance Code §843.102 in §§11.204(14) and 11.301(5)(N) to more accurately reflect applicable statutory authority. The

department also changed the former names of the state agencies in §11.506(10)(F)(ii) to the name of the appropriate existing state agency. The department made other changes for purposes of consistency and clarity, as well as to correct clerical and typographical errors. The department also withdrew the proposed amendments to §11.809 (29 TexReg 11945, December 24, 2004), and instead proposed comprehensive amendments to the section in a separate proposal that was published in the same issue of the *Texas Register*.

The amendment to §11.1 revises the section's title. Amendments to §11.2(b) add a new definition for clinical director, revise the existing titles of the definitions of consumer choice plan, referral specialists, and state-mandated plan, and revise the text of the existing definitions of agent, consumer choice plan, copayment, premium, and state-mandated plan.

Amendments to §11.101 update the contact information for obtaining forms.

The amendments to §§11.202(a), 11.203(a) and 11.204 reduce the number of additional copies required at the time of application for a certificate of authority and for revised filings to expedite review and eliminate filing of unnecessary copies. The amendment to §11.202(f) reflects a requirement for one original application, and deletes an original signature requirement to accommodate electronic filings. The amendments to §11.204(13)(B) and §11.205(a)(7) clarify that the contracts between the HMO and delegated entities and/or delegated networks be provided as part of the application process and that such agreements be available during qualifying examinations. The amendment to §11.204(14) clarifies the required quality improvement plan description. The amendments to §11.204(18) add a requirement that the HMO provide network configuration information, including maps demonstrating the location and distribution of the physician and provider network within the service area upon initial filing of an application for a certificate of authority. Amendments to §§11.205(a)(6), 11.302(b)(3), and 11.303(c)(7) incorporate the requirement for this network configuration information. The amendments are adopted to ensure full compliance with §843.078(k), which requires network configuration information to demonstrate network adequacy. The maps, by indicating where particular providers are located, are much more demonstrative of network sufficiency and accessibility than written descriptions. In addition, the amendments also require that the HMO provide lists of physicians and individual and institutional providers, along with license type and specialization, and information concerning whether such physicians or individual providers are accepting new patients. The license type and specialization information allows TDI to more readily distinguish primary care physicians from specialists in determining network adequacy to support all types of covered services.

Section 11.204(23) clarifies that the applicant must demonstrate appropriate operational structure and adequate management and staff to operate an HMO and fully comply with all statutory and regulatory requirements applicable to the HMO and any contracting entities. The amendments to §11.205 clarify that referenced documents must be available for review at the HMO's Texas office at the time of examination, but may be physically maintained at a different site; add language about qualifications of management and staff; clarify complaints and appeals policies; and set out prescribed categories of complaints to facilitate analysis and provide for uniform categorization. These complaint categories require greater detail in, and expand on,

the four categories of complaints HMOs are currently required to maintain. These complaint categories are also referenced in Subchapter D (§11.303(c)(4)). TDI believes these amendments are necessary to facilitate review of complaints during examinations and to allow TDI and the industry to more specifically monitor problems and concerns in the face of marketplace changes that could impact enrollees. Recognizing that these changes may require additional time to implement, TDI solicited and received commenters' input on appropriate compliance dates. Based on the comments received, TDI has specified January 1, 2006, as the date by which HMOs shall comply with these requirements. The amendments also clarify and simplify the reference to health information systems records, clarify the reference to network configuration documents, and consolidate the categories of executed agreements to be available during examination. The amendments to §11.205 also change the requirement that the entire physician or provider contract be made available for review during examination; because of confidentiality concerns, the provision requires that only the first page and signature page be made available.

Section 11.205(a)(14), concerning claims systems, determines the HMO's capacity to comply with all applicable statutes and rules addressing claims payment. The amendment to §11.205(a)(16) requires the HMO, at the time of the qualifying examination, to demonstrate compliance with applicable laws, including audits or examination reports by other entities, which will provide TDI a more complete picture of the applicant and help the agency to pinpoint any areas requiring particular attention prior to licensing.

To make departmental review and storage of documents more efficient, the amendments to §11.301 add requirements for filings; clarify that, consistent with insurance form filing requirements, each form must have a printed unique form number; reduce the number of required form filings; and add the requirement that the HMO include a cover letter with such filings. The amendments to §11.301 also add references to delegated entities and delegated networks and clarify that a filing must include a reconciliation of benefits to schedule of charges form. The amendments to §§11.301(5)(G) and 11.303(c)(8)(C) clarify that contracts between the HMO and delegated entities and/or delegated networks are included in the documents that an HMO must file pursuant to Insurance Code Article 20A.18C and 28 TAC §11.2611 for examinations, and subsequent to issuance of the certificate of authority. The amendments to §11.302 clarify that, consistent with §§843.080 and 843.078(h), a request for any modification of the service area, including a reduction, must be filed with and approved by the department. The amendments to §§11.302 and 11.303 also require the filing of network configuration information. The amendments to §11.303 clarify that: the department may conduct complaint examinations in addition to other types of examinations; quality of care examinations, except those made pursuant to Insurance Code Article 1.15, may take place off-site; examinations may be conducted by examination teams rather than single examiners; and examination teams may conduct interviews of key management staff or their designee in connection with such examinations. Amendments to §11.303 also identify the documents that should be available for review during examinations to include those documents that have been deleted from §11.205(a) as more appropriate for review after issuance of a certificate of authority. The amendments change the timeframe for correcting serious deficiencies from 10 business days to 12 calendar days.

To expedite review and eliminate the filing of unnecessary copies, the department reduced the number of copies of documents an HMO must file relating to an evidence of coverage in §§11.502 and 11.503. Section 11.503 is changed to correct mail codes and clarify procedures for notifying HMOs of approval or disapproval. Section 11.505 clarifies that each form will have a different number, and expands the categories of variable language that can be included in form filings to include optional benefits and provisions. This flexibility will increase efficiency in form filings and facilitate greater speed to market. Section 11.506 clarifies the statutory directive in Article 20A.09(a)(1) that every enrollee residing in this state is entitled to an evidence of coverage, implements HB 1798 and HB 1800 (78th Legislature), which permit an HMO to deliver plan evidences of coverage electronically, and removes the reference to "standard language" because TDI reviews all forms for compliance. The amendments to that section also clarify that cancellation of an enrollee in a group cannot be based on health status related factors, consistent with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191.

The amendment to §11.506(2)(A) deletes the word "nominal" as an inaccurate description of a 50% copayment. Section 11.506(3)(A) is amended to conform to Insurance Code Articles 26.23 and 26.86 and to HIPAA. Section 11.506(3)(B) deletes the 60-day timeframe for prior notice to the group because there are no circumstances under which the 60-day notice would apply. Section 11.506(6)(C) clarifies that conversion coverage is an option; the continuation provision is mandatory. Section 11.506(9)(E) conforms to Insurance Code Article 20A.09H (Children and Grandchildren), which refers to "enrollee." Section 11.506(16) implements HB 508 (78th Legislature) by increasing from 30 to 60 the number of days prior notice an HMO is required to give regarding a group plan premium rate increase. Section 11.506(19) increases the age for dependent coverage for a child from 21 to 25 years as required by HB 1446 (78th Legislature). Throughout §11.506(23) the reference to an enrollee's choice of an obstetrician is changed from "designated" to "selected." Amended §11.506(25) refers to Article 21.52J rather than listing its requirements.

Amendments to §11.901(a)(1) add provisions from Subchapter L, §11.1102. The repeal of Subchapter L is published elsewhere in this issue of the *Texas Register*. Consistent with Insurance Code §843.361, the amendments require physician and provider contracts to include a hold harmless provision. Amendments to §11.901(a)(4) clarify that written notice to enrollees of termination of their physician or provider is governed by Insurance Code §§843.308 and 843.309 and the amendments to §11.901(a)(5) clarify that written notice of termination to a physician or provider is governed by §§843.306 and 843.307. Amendments to §11.901(a)(5)(B) and (C) change the time allowed for a physician or provider to request an appeal of the termination from 60 days to 30 days from the notice of termination. This amendment will give the review panel enough time to review the termination within the 60 days mandated by Insurance Code §843.306(b). Amendments to §11.901(a)(5)(C) require the review panel to review the physician or provider's termination within 60 days of the physician or provider's request for review.

Amendments to §11.901(a)(12) add new language required by SB 781 (76th Legislature), as it amended Insurance Code Article 20A.18A (now §843.311(3)) relating to podiatrists. Amendments to §11.901(a)(13) add language from SB 418 (78th Legislature), which added Insurance Code Article 21.52Z, §2 relating to electronic health care transactions. Amendments to §11.902(a) add language from HB 606 (77th Legislature) that added new §18D to Insurance Code Article 20A (now §843.320) relating to hospitalists. Amendments to §11.902(b) and (c) add language from HB 803 (77th Legislature) that added subsection (o) to Insurance Code Article 20A.14 (now §843.3045) relating to nurse first assistants. Amendments to §11.902(d) add language from HB 1163 (78th Legislature) that added Insurance Code §843.319 (Certain Required Contracts) relating to podiatrists. Section 11.902(e) adds language that implements Insurance Code §843.312 relating to physician assistants and advance practice nurses. Where appropriate, the amendments refer to the statute rather than restating particular statutory requirements.

Amendments to §11.1001 update the contact information for obtaining forms and update form numbers.

The amendment to §11.1302(a)(1) clarifies that leaving the HMO, rather than leaving a particular plan within the HMO, triggers termination of appointment to the Solvency Surveillance Committee (SSC). The amendment to §11.1302(b) clarifies what constitutes a quorum. It also clarifies the circumstances requiring a majority vote of the total committee membership. The amendment to §11.1302(c) changes the maximum interval between SSC meetings by providing for a regular annual meeting, rather than quarterly, as presently required. This change will provide greater scheduling flexibility for better responsiveness to specific concerns regarding an HMO, while eliminating requirements for meetings that were not always necessary. The amendments to §11.1302(d) harmonize the subsection with the Open Meetings Act, remove the provision allowing meetings by telephone conference call, incorporate provisions concerning emergency meetings, and add a provision permitting a majority of members to call a special meeting. The amendment to §11.1302(e) adds the Open Meetings Act reference for notice requirements. The amendment to §11.1302(f) makes clear that SSC meetings are generally open, and adds language setting out circumstances under which a closed meeting may be held. The amendment to §11.1304(a) clarifies that the written record of SSC proceedings is subject to pertinent confidentiality laws.

The amendment to §11.1403 updates the toll-free telephone number and the agency organizational reference. The amendment to §11.1404(a) deleting certain language relating to Article 21.52B reflects the decision in *Texas Pharmacy Assoc. v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997). The department is aware that there is uncertainty regarding the enforceability of Article 21.52B following the decision in *Texas Pharmacy Assoc.* and the subsequent U.S. Supreme Court case concerning *Employee Retirement Income Security Act* preemption and a Kentucky any willing provider statute similar to Article 21.52B. See *Kentucky Association of Health Plans v. Miller*, 123 S.Ct. 1471 (2003). Should the statute be determined to be enforceable without additional legislative action, the absence of this language from the rule will not prevent the department from enforcing Article 21.52B.

The amendments to §11.1500 incorporate in substance the federal standards for the term "similarly situated." The amendments to §11.1600(a) and (b) implement HB 1800 (78th

Legislature), which allows HMOs to provide plan descriptions electronically to enrollees and contract holders. Amendments to this section also consolidate notice requirements regarding current and prospective female enrollees' choice of an obstetrician-gynecologist (OB-GYN) and clarify that female enrollees may select an OB-GYN without the requirement for formal designation. Because the OB-GYN notice requirements in §11.1600 and §11.1608 are similar, the §11.1608 requirements have been repealed. The adoption of the repeal of §11.1608 is published elsewhere in this issue of the *Texas Register*. The amendments also remove unnecessarily restrictive requirements for the provider directory that are not required by statute. Section 11.1600(b)(11) adds language requiring notice advising enrollees to contact the HMO if they receive a bill from any physician or provider. The amendment to §11.1600(c) reiterates that HMOs are prohibited from making untrue or misleading statements to either current or prospective enrollees. The amendment to §11.1600(d) clarifies that an HMO may use its handbook to satisfy the plan description requirements if it discloses information adequately and in accordance with §11.1600. The amendment to §11.1600(e) requires the plan description to include a disclosure that the enrollee may receive care from a physician other than a primary care physician while in an inpatient facility. While this disclosure is already required in the Evidence of Coverage under §11.506(26), to ensure awareness of this critical provision, the department has added this requirement to the plan description. Section 11.1600(f) implements SB 494 (78th Legislature), which requires HMOs with an internet site to maintain a list of physicians and providers and to provide the same information that is required in a paper directory, and adds language requiring that the internet notices related to an HMO's current list of physicians and providers be easily accessible from the home page of the HMO's site.

Section 11.1601(b) implements SB 418 (78th Legislature) regarding identification cards that must comply with §21.2820. Section 11.1601(c) implements Insurance Code Article 21.53L regarding standards for prescription drug identification cards. Section 11.1600(d) implements SB 473 (78th Legislature), which restricts the use of social security numbers on identification cards. Section 11.1605(b), (c), (d) and (e) consolidates all pharmacy services requirements and implements HB 2382 (77th Legislature) enacting Insurance Code Article 21.52L, which relates to health benefit plan coverage for prescription contraceptive drugs and devices.

Amendments to §11.1606(b) and (c), concerning an HMO's chief executive officer, operations officer and clinical director (formerly "medical director"), change the emphasis from full-time status and residence in the service area to detailed functional and practical requirements of the positions. The change reflects the department's understanding that executives can be responsible for operations in several states or several different service areas on less than a full-time basis in this state. The amendments to §11.1607 consolidate accessibility and availability requirements from Subchapter U, §11.2001 et. seq. The adoption of the repeal of the remaining provisions of Subchapter U is published elsewhere in this issue of the *Texas Register*. These provisions are repealed because some have been moved to other sections of this rule, and some were changed to comply with certain national and industry standards, as detailed herein. Subsections (a) - (h) of §11.1607, concerning accessibility and availability requirements, add standards for availability of medical care consistent with national industry standards. In accordance with the most recent National Committee on Quality Assurance (NCQA)

and industry standards, §11.1607(g) changes the availability requirements for routine behavioral health care from three weeks to two weeks. Also consistent with industry standards, the requirements for availability of routine dental care were changed from three weeks to eight weeks, and the availability of preventive dental health services was changed from two or three months to four months. Section 11.1607(h) clarifies that an HMO must have a network that encompasses the entire service area, and that access radii are to be measured from providers to the boundaries of the service area, not from current enrollees to providers. This is to clarify the expectation that an HMO have a network that encompasses its entire service area, not just the current enrollee population or area in which the plan is marketing.

Section 11.1607(j) clarifies that certain health care services, such as transplants or treatment for cancer, burns, or cardiac disease, may be provided outside the service area; however, an HMO may not require an enrollee to travel outside of the service area to receive such services unless it provides the enrollee with a written explanation of the benefits and detriments of in-area and out-of-area options.

Section 11.1801(c) has been deleted as it is fully executed. Amendments to §11.1802 prescribe a more comprehensive method for assessing the minimum capital or net worth requirements of a Medicaid managed care organization (MCO) and refer to amounts established by statute for required minimum capital and surplus, rather than stating specific amounts in the rule. Obsolete language that was superseded by §11.809 is deleted from paragraph §11.1802(a)(2) and replaced by Risk Based Capital (RBC) requirements as the method, developed in coordination with the National Association of Insurance Commissioners (NAIC), for assessing capital adequacy. The method will be phased in over three years. All HMOs, including those that are MCOs, must already comply with the RBC formula currently required in §11.809. Insurance Code Article 1.61 requires TDI, in conjunction with the Texas Health and Human Services Commission (HHSC), to establish fiscal solvency standards for MCOs, and these amendments are meant to ensure that MCOs that contract with the state operate in a fiscally sound manner. The amendment to §11.1803(b) clarifies that the deposit is used to protect the interests of the enrollees.

Section 11.1804 allows a reduction in the special statutory deposit required for MCOs, taking into account certain guarantees from sponsoring organizations. The amendment clarifies that the reduction relates only to the amount of the statutory deposit held under §11.1803 and does not relate to other requirements or unrelated non-Medicaid business. Section 11.1806(a) removes the automatic requirement for filing certain financial information with TDI and instead requires the information be filed only upon the department's request, and changes the time frames concerning the annual reports to be consistent with the time frames set by HHSC. Section 11.1806(b) clarifies that, concurrently with filing a Medicaid participation request with HHSC, Medicaid MCO candidates must file with TDI the financial projections related to that request; it also deletes the term "RFA" because it is not commonly used. Section 11.1806(c) clarifies that an MCO must notify TDI of any financial or statistical reports filed with other state agencies, but is not required to file such reports with TDI except upon TDI's request.

The amendments to the titles of §§11.1901 and 11.1902 clarify that the sections apply to both basic and limited service HMOs. The amendment to §11.1901(c)(1)(B) clarifies that the subcommittee is responsible for reporting to the quality improvement

committee (QIC), which in turn is responsible for reporting to the governing body. Amendments throughout §11.1902 implement Insurance Code Article 21.58D, as amended by HB 1095 (78th Legislature), relating to standardized forms for verification of certain credentials including those for advanced practice nurses and physician assistants; fully update credentialing requirements to comply with NCQA standards as required by Insurance Code Article 20A.39; and add requirements relating to initial credentialing site visits and tracking the opening of new offices to comply with NCQA requirements applicable to primary care physicians and individual primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers. Although the NCQA standards do not specifically address primary care dentists, the department, pursuant to the direction of Article 20A.39, has applied those standards to dentists to ensure consistent quality in all areas of health care.

The amendments to §11.1902(2) more accurately state criteria the work plan must meet. The amendments to §11.1902(2)(B) expand updating intervals for those clinical guidelines that change more or less frequently, allow practicing physicians and providers to have input into clinical practice guidelines, and in accord with NCQA requirements, delete the requirement that practice guidelines be communicated to providers in a particular way. The amendment to §11.1902(2)(B) adds clauses (xi) through (xiii) to include program areas that are essential to any quality improvement (QI) work plan. The amendments to §11.1902(4)(B) add a reference to the provider directory to indicate which physicians and providers must be credentialed, and clarify that hospital-based physicians and providers, if they are not listed in the provider directory, and opticians would not be required to be credentialed by the HMO. Section 11.1902(4)(B)(ii) adds language to comply with NCQA standards concerning physician and practitioner rights. Section 11.1902(4)(B) requires appropriate, timely notice to applicants concerning credentialing and recredentialing to comply with NCQA standards and adds a specific timetable associated with NCQA-required monitoring of certain sanctions. The amendment to §11.1902(4)(B)(viii) provides additional discrimination prohibitions to be included in HMO credentialing and recredentialing procedures to ensure compliance with NCQA requirements and other applicable law. The amendment to §11.1902(4)(C)(iv) clarifies that site visits apply only to certain physicians and providers, more clearly states that the HMO may conduct a single visit to accomplish on-site visit requirements for multiple providers, and adds language requiring the HMO to have a process to track the relocation of and opening of additional office sites for primary care physicians and individual primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers. Section 11.1902(4)(D) provides that the items to be gathered at the time of recredentialing and the recredentialing timeframes are the same as for an original credentialing. The amendment to §11.1902(4)(F) deletes reference to clause (v) because site visits for evaluation are no longer required at the time of recredentialing. Section 11.1902(7) restates the provisions for the delegation of credentialing functions from former §11.1902(4)(B)(vi).

Section 11.2207 is adapted from revised Subchapter T to add specific QI requirements for single service HMOs, to clarify that the same QI standards apply to all HMOs. In addition, the amendments incorporate the single health care services availability and accessibility requirements from Subchapter U,

§11.2006, so that all requirements relating to single service HMOs are contained in one subchapter.

Amendments to §11.2314 add the words "opportunity for" to clarify that under §843.461(a)(1) only notice and an opportunity for a hearing must be available before the commissioner may suspend or revoke a certificate of authority.

Section 11.2406 specifies the statutory and regulatory standards for a limited service HMO providing long-term care services and benefits.

Amendments to the subchapters, including Subchapters G, I, R, Z and AA, make editorial or grammatical changes for ease of reading or for clarity; update references to statutory authority; change specific references to more general references to avoid constant updating and revisions; add consistent abbreviations; eliminate redundant or unnecessary wording; and reflect accurate terminology.

§11.2(b)(17): Some commenters suggest that the department clarify that a copayment may be expressed either in terms of a dollar amount or a percentage.

Agency Response: The department agrees to add the language "which may be expressed in terms of a dollar amount or a percentage of the contracted rate," to reflect the position the department has historically taken.

§11.2(b)(33): A commenter believes the modifications to the definition of "premium" do not take into account individual coverage because the definition refers to only large and small employers and large and small employer carriers.

Agency Response: The department agrees and has changed the rule to encompass individual as well as employer coverage.

§11.204(18): A commenter agrees with language requiring HMOs to submit lists of various physicians, specialties, and individual and institutional providers and whether or not they are accepting new patients. The commenter also recommends that the HMOs be required to submit lists of any specialty groups the HMO was unsuccessful in bringing into their network because having this information during the application process would allow a more comprehensive representation of the network's adequacy or inadequacy.

Agency Response: The department declines to make the requested change. The HMO Division determines network adequacy based on an HMO's contracted physicians and providers, not on non-contracted physicians and providers. The list of contracted physicians and providers, along with maps showing their locations, are evaluated against TDI access requirements to ascertain whether an adequate number of physicians and providers with the appropriate skill levels are available to provide the covered services. If deficiencies are noted in the network, the HMO will be required to submit an access plan for approval unless the network deficiencies are so severe that they cannot be adequately addressed by an access plan. In such case, the network will not be approved.

§11.204(23): A commenter feels the requirement for a description of the management structure and personnel to demonstrate an applicant's capacity to meet the needs of providers and enrollees, and to meet the requirements of regulatory and contracting entities, is vague and may exceed the agency's statutory authority.

Agency Response: The department disagrees. This provision is not new but rather clarifies and expands the previous language

in §11.204(23) that required applicants for an HMO certificate of authority to provide information demonstrating their ability to comply with statutory requirements. Further, §843.078(n) provides that an application for a certificate of authority must include "any other information that the commissioner requires to make the determinations required by this chapter and Chapter 20A" of the Insurance Code.

§§11.204, 11.205, 11.506, 11.901, 11.1600, 11.1601, and 11.1607: Some commenters strongly support the department's position and encourages adoption of these sections.

Agency Response: The department appreciates the comments.

§11.205: A commenter understands the department's rationale for requiring greater detail regarding complaints to facilitate monitoring problems and concerns that may impact enrollees. However, some commenters believe the proposed changes to the complaint categories will necessitate change to complaint and appeal policies and procedures and the current complaint log format. These commenters feel that substantial lead time will be required to design enhancements, re-program and test impacted databases and systems, and train coordinators. One commenter suggests an effective date of enhanced categories be January 1, 2006 or later. Another proposed nine months lead time. A commenter also asked the department for additional guidance on the use of these categories, as one complaint could fall into more than one category.

Agency Response: The department agrees with the need for a delayed compliance date. Therefore, the department has determined that compliance with this provision is required as of January 1, 2006. The department recognizes that a single complaint may fall under multiple categories, and expects that reporting will distinguish clearly between number of complaints and number of categories. For example, a report of complaints might state that there were a certain number of complaints within a time period, but the total number of complaints within the complaint categories during the same time period may be larger due to the multiple categories that apply.

§11.303(c): A commenter requests adding "or applicable sample documents" to this subsection for out of state HMOs because having all provider contracts in this state should not be necessary.

Agency Response: The department declines to make this change to subsection (c) since it reflects current department procedures. A form contract is not an adequate substitute for a copy of an executed contract because it does not contain evidence of actual agreements in effect.

§11.303(c)(5): A commenter asks whether enrollee disenrollment logs and provider termination logs are information that an HMO is currently required to maintain. If not, the commenter says that the regulations should elaborate on the form of these logs.

Agency Response: The rules do not require that provider termination logs be provided. The requirement for enrollee disenrollment and termination logs is not new, as former 28 TAC §11.205(a)(5) required HMOs to maintain such logs.

§11.303(d)(1) and (3): A commenter suggests that the rule be revised to clarify that a key manager's designee may attend the entrance and exit conferences in the event a given key manager is not available.

Agency Response: The department agrees and will restore the words "or their designee."

§11.303(d)(5): A commenter states that the department has modified the timeline in the event the exam team cites serious deficiencies. The commenter states that an HMO is required to provide the exam team with a signed plan to correct deficiencies within one business day, instead of the previous 10 business days, and to submit a plan of corrective action within 10 days instead of the previous 30 days, in accordance with the severity of the deficiency. The commenter says that one business day to provide TDI with a signed plan to correct deficiencies is extremely onerous, especially when there is no definition of what a "serious" deficiency is. The commenter recommends returning to the original language.

Agency Response: The department declines to make this change. The commenter may not be distinguishing between the requirements for "serious deficiency" and "potentially serious deficiency," which, in the previous rules, had different time frames. The proposed and adopted rule eliminates the category of "potentially serious deficiency" but continues to give the HMO one business day to submit a plan to correct serious deficiencies. However, the proposed and adopted version allows 12 calendar days (rather than 10 business days) to correct the deficiencies. In most cases, however, this will result in identical time frames. One example of a serious deficiency is an HMO with an unlicensed medical director or no medical director.

§11.505(f): A commenter suggests that to provide plans with additional flexibility in filing of EOCs with ranges of benefits, exclusions, and other provisions, the phrase "is limited to" be replaced with "such as."

Agency Response: The department disagrees. The adopted rule expands the types of variable information that can be included in an EOC, but the department declines to make the list open-ended at this time. However, the department is receptive to suggestions regarding variability that may be appropriate for consideration in future rulemaking.

§11.506(2)(A): Some commenters suggest that the department delete the reference to the 200% of total premium limit on copayments, as this maximum came from federal minimum requirements for HMOs, and SB 541 (78th Legislature) deleted the reference to federal minimum qualifications. A commenter believes that doing so will allow for increased cost sharing and more flexibility in HMO products. To be comparable to other benefits provided in the market, a commenter suggests "the department place limitation the same as for PPOs, which do not allow a cost differential less than 30% co-insurance for an insured and the insurer must pay 70%."

Agency Response: The "federal minimum requirements" the commenter references are found in the Public Health Service Act (42 U.S.C. Section 300e et seq.). SB 541 deleted only the requirement that the basic health care services an HMO must provide include at least the services designated as basic health services under Section 1302, Title XIII, Public Health Service Act (42 U.S.C. Section 300e-1(1)). The bill made no other change to the application of the Public Health Service Act in Texas law. SB 541 does address the commenter's concern by authorizing an HMO to offer plans generally not subject to limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts. An HMO may thus offer a consumer choice health benefit plan that is not subject to the §11.506(2)(A) limit on copayments, and

the increased cost sharing and flexibility in HMO products the commenter seeks are already available pursuant to SB 541. The department thus declines to make this change.

§11.506(2)(B): A commenter suggests that consumer choice plans specifically be exempted from the general prohibition against deductibles.

Agency Response: The department declines to make this change. While this adoption revises the definition of consumer choice health benefit plans, generally it does not seek to identify provisions that may be exempt from regulation under, or otherwise subject to, SB 541. The regulations specifically applicable to consumer choice plans are located at Subchapter AA, Chapter 21 of this title.

§11.506(9)(E)

Comment: A commenter states that there are two Articles 20A.09H dealing with grandchildren, and that it would be helpful to clarify which controls.

Agency Response: The caption of the applicable statute ("Children and Grandchildren") was included in the rule to distinguish between the two articles.

Comment: A commenter suggests that rather than changing the term from "subscriber" to "enrollee" with regard to grandchild coverage, the phrase "or subscriber's spouse" be added after "subscriber."

Agency Response: The department declines to make this change, since Article 20A.09H uses the term "enrollee."

§11.506(23)(F): A commenter suggests inserting "which does not allow open access to participating obstetricians/gynecologists" after "An HMO" in the first line.

Agency Response: The department disagrees, as there should be no instance where an HMO does not allow open access. In the interest of standardization, the HMO must include the space on the enrollment form for selection.

§11.901(a)(1)(A) and (C): A commenter suggests that this language confine the hold harmless provisions in these sections to services that are covered under the HMO plan. The commenter also observes that subparagraph (C) incorrectly states that providers can collect supplemental charges or copayments on behalf of the HMO. Providers collect copayments on their own behalf, not on behalf of the HMO.

Agency Response: The department disagrees that the first suggested change is necessary, as the rule already states that it applies to covered services. The department agrees to delete language concerning the collection of copayments "on HMO's behalf."

§11.901(a)(5): A commenter says that this section could arguably eliminate the ability of HMOs to terminate the provider on less than 90 days' notice for the reasons stated in §843.306 (imminent harm, fraud, etc.). The commenter doubts that was the intent, but expressed concern that the section does not clearly permit such terminations. The commenter stressed health plans' need to terminate a provider immediately for such good cause.

Agency Response: The department understands the commenter's concerns. However, the exceptions for cases of imminent harm to a patient; action by a licensing board, or other governmental agency; and provider fraud or malfeasance are

referenced in the rule by citation to §843.306 and do not need to be restated.

§11.902: A commenter requests that this section be revised to clarify that nurse first assistants must comply with the terms established by the HMO for participation in the network including, but not limited to, meeting credentialing standards and network need.

Agency Response: The department declines to make this change, as this provision mirrors the statute.

§11.1600(a): A commenter requests inserting "with the contract holder" after "By agreement" in the last sentence.

Agency Response: The department declines to make the requested change, as Article 20A.09(a) says the agreement may be between the HMO and the subscriber, or the person entitled to receive the evidence of coverage.

§11.1600(b)(11): A commenter agrees with the language, but suggests that the HMO also be required to provide a list of any non-contracted specialists in the service area that are pertinent to the provision of medical benefits to enrollees; this would provide a more comprehensive representation of the network and provide enrollees a better understanding of the circumstances under which a non-network physician or provider may be involved in their care.

Agency Response: The department declines to make the requested change. While the department understands the commenter's interest in enrollees having a better understanding of the circumstances under which a non-network physician or provider may be involved in their care, the department disagrees that providing enrollees with a list of all non-contracted specialists in a service area would accomplish that goal. The enrollee may obtain the same information that the commenter suggests be available by reviewing the list of contracted physicians and providers that the HMO is required to provide. The enrollees can assume that any physician or provider not on the list is not in the network. In addition, a list of all non-network physicians and providers may confuse enrollees and be difficult for HMOs to assemble and maintain.

§11.1600(b)(11)(E): A commenter states that HMO and health plan internet sites are often quite large and difficult to navigate, and suggests that internet notice must be "conspicuous," "prominent," and "no deeper than one page below the HMO main home page." Other commenters applaud the enrollee notice in this section, and feel that it ensures that enrollees have more information to make healthcare decisions, but request that the information be more easily accessed on the website, and suggest no more than three "clicks" to get to the information.

Agency Response: The department agrees that clarification would be useful, and has added clarifying language in §11.1600(f), which refers to the entire provider directory, rather than in (b)(11)(E), which is limited to the notice provisions that must be included in the provider directory.

§11.1600(d): A commenter notes that the plan description still requires the HMO to hand out paper provider directories but, along with another commenter, believes that web site directories are more accurate and up-to-date than paper directories. Consequently, the commenters believe, the department should allow HMOs to direct members to the HMO website for provider lists and to provide written hard copy directories upon request.

A commenter believes Insurance Code §843.2015 gives the department the authority to allow carriers to provide such directories in this manner and points out that allowing carriers to do so will save costs.

Agency Response: The proposal does not require issuance of a paper directory. Section 11.1600(d) concerns only situations where an HMO seeks to provide plan descriptions and provider directories along with the handbook. Subsections (a) and (b), which address an HMO's publication of a plan description, allows an HMO to furnish a plan description, including a provider directory, electronically upon agreement. Pursuant to TIC §843.2015, electronic distribution includes publishing the directory on the HMO's internet site. The electronic option may not work for all enrollees or potential enrollees, as internet access is not universal. Moreover, some electronic directories pull up only one provider at a time or a limited provider list at one time based upon search criteria such as ZIP code, which lists providers available in a certain ZIP code. Accordingly, while electronic distribution is permitted, if the enrollee does not agree to accept an electronic version, the HMO must furnish a paper copy of the plan description or directory.

§11.1605(b): A commenter suggests adding language to permit an HMO to contract with a mail order pharmacy vendor who is located outside of Texas and who may not be licensed in Texas (unless a pharmacy providing mail order services to Texas residents must be licensed under Texas State Board of Pharmacy requirements).

Agency Response: The department declines to make the requested change, as the Texas Pharmacy Act, Texas Occupations Code Subtitle J, requires a pharmacy vendor who ships medications into Texas through mail order arrangements to become licensed as a Class E Pharmacy.

§11.1606(b): A commenter believes that the department should not dictate the responsibilities of the Chief Operating Officer (COO) or Chief Executive Officer (CEO) other than general oversight and responsibility for the operations of the HMO, and notes that the list contained in this section doesn't fit all organizational structures. Another commenter asks that the CEO or COO definition not include responsibility for "marketing operations" and "medical management" because medical management decisions should be made by doctors, and recommends that the CEO or COO be responsible instead for "the general oversight of the plan."

Agency Response: The department disagrees and does not believe the recommended change is necessary. If in a particular organizational structure, an executive at an equal or higher level than the CEO or COO oversees portions of the functions, and informs the CEO or COO of the status of the functions on a regular basis, the department would take this structure into account during an examination. Oversight of medical management functions does not imply that the CEO/COO makes medical management decisions; rather, the CEO/COO oversees the administrative functions of the medical management department such as staffing, equipment and other resources, and ensuring compliance with all applicable statutes and rules pertaining to the operations of the HMO.

§11.1606(c) and (d): A commenter supports the revised requirements for clinical director as more flexible and more reflective of the current operations of national health plans.

Agency Response: The department appreciates the comment.

§11.1606(c)(1): A commenter feels this provision should state, "shall be currently licensed in the United States or otherwise authorized to practice in the United States..."

Agency Response: The department declines to change the existing requirement because a clinical director, as a health care professional, must logically be a physician or provider. Texas Insurance Code, at §843.002(22), defines "physician" as "an individual licensed to practice medicine in this state." Likewise, §843.002(24) defines "provider" as "a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state."

§11.1607(g): Some commenters support changing the availability of routine behavioral health care from three to two weeks. Another commenter is concerned about this change, and asks about the disposition of the provisions in 28 TAC §11.2001. The commenter says that change from three weeks to two weeks for appointment times for behavioral health providers is particularly troublesome in a Medicaid context, where it is difficult to find qualified providers willing to accept patients for that program at rates that are competitive, given HHSC's capitation rates to HMOs.

Agency Response: The change from three weeks to two weeks is consistent with NCQA requirements. The department clarifies that the referenced provision was formerly located at §11.2001, Subchapter U, which is being repealed simultaneously with this adoption order. Regarding Medicaid patients, the department notes that HHSC has authority over the Medicaid product, except as specifically provided for in the Texas Insurance Code and other applicable laws, and therefore the provision does not apply other than by reference, if any, in the HHSC contract with the HMO.

§11.1607(g)(1)(B): Some commenters oppose changing the availability requirements for urgent behavioral health care from 24 hours to 48 hours from time of request. They feel the change would be dangerous to patients who need urgent treatment and that unnecessary delays will cause the patient's health to deteriorate and lead to the need for more and more expensive services.

Agency Response: The department agrees that urgent behavioral health care should be available on a timely basis and is retaining the 24 hour requirement.

§11.1607(h): A commenter feels the language change to "travel distances from any point in the service area to a point of service..." would require a change to current software mapping programs, which measure distances from where actual enrollees live or work. Another commenter requests confirmation of its understanding that the mileage requirements of the rule refer to the given mileage radius rather than actual road mileage.

Agency Response: While changes to current software programs may be required to meet the clarified standard, the department believes the change was necessary to ensure that HMOs have networks that encompasses the entire service area. In addition, the department notes that a variety of software or manual methods of demonstrating compliance is available. The department clarifies that the mileage requirements are measured as radii from provider and physician locations within the HMO service area. This change should better demonstrate access to the particular type of provider throughout the service area.

§11.1607(j): A commenter feels the requirement to provide an enrollee with a written explanation of the out-of-area options

seems onerous. The commenter says that HMOs arrange for access to providers based on the medically appropriate services needed by the member, and questions how often an HMO would "force" an enrollee to go outside the service area when in-area services are available. The criteria for going outside would be based on the need for the higher skill level.

Agency Response: Treatments or services that require a "higher level of skill or specialty" may be rare. However, these services may still be needed in such instances and the requirement should not be onerous or burdensome for HMOs. The rule allows HMOs the flexibility to provide quality care in a cost-effective manner, while balancing the need for appropriate notice to enrollees. The department is familiar with one situation in which an HMO contracted with a network of "centers of excellence" for transplant services. In some service areas, the contracted facility was located outside the service area, although another transplant facility was also located within the service area. In this instance, the HMO filed an access plan to demonstrate that the in-area facility did not meet the quality standards for the particular transplant services, or else was inaccessible because it did not enter into a contract. In the event that an enrollee had required the transplant services in this instance but wished to stay in the service area, the department expects that the HMO will give the enrollee written information regarding the benefits and detriments of the in-area and out-of-area facilities, allowing the enrollee to make the decision after full disclosure. The HMO has the option of authorizing out-of-network services in such a situation, and may even negotiate a single-member contract with the in-area facility.

§11.1806(a): A commenter suggests that the requirement that the second (final) Medicaid Financial Statistical Report be accompanied by a CPA opinion creates issues of timing (for the report to be prepared, and then audited, before submission) and expense (the audit fees). The 30-day period between 270 and 300 days after the contract period is not only insufficient for this new requirement, but also is not consistent with the Medicaid requirement that the report reflect data through the 334th day and be submitted by the 365th day.

Agency Response: This provision was not changed from that originally adopted in 1998, which was consistent with the requirements of the Texas Department of Health at that time. Upon consultation with the Health and Human Services Commission (HHSC), who has changed the requirement to the time period the commenter referenced, this section was changed to the time frames of the annual reports as set by HHSC.

§11.1902(4)(B)(i): A commenter states that this section requires each provider of a Group/Independent Physician Association to be individually credentialed by the HMO but does not make allowance for delegation, although delegation is listed in many areas.

Agency Response: The provision distinguishes between individual credentialing of members of a group, as opposed to a group credentialing process. To the extent that an HMO delegates credentialing, the same requirements would apply to the delegate. However, as set forth in 28 TAC §11.2601, the HMO remains ultimately responsible for compliance with all applicable laws, including credentialing requirements.

§11.1902(4)(B)(v): A commenter states that clause (v) should be changed so that applicants must be notified only if the credentialing or recertification decision is adverse. The commenter says that every plan has network management procedures for

welcoming new providers upon initial credentialing and that it would be redundant and burdensome to require separate notification of a positive decision. For recertification, the process for providers successfully recertified is seamless so that notification of a positive recertification decision would serve no useful purpose. The commenter also says that NCQA has eliminated this requirement for notification of positive actions and only requires notification of adverse actions.

Agency Response: The department declines to make the change because the language is consistent with NCQA standard CR1 (2004).

§11.1902(4)(C)(iv)

Comment: A commenter is concerned about the use of the term "individual provider" and asks that the department clarify that site visits are required only for primary care providers, OB/GYNs and high-volume specialists.

Agency Response: To clarify, the department will add the words "behavioral health" when referring to "individual provider," where appropriate.

Comment: A commenter urges deletion of the language requiring HMOs to have a process to track the opening of new physician and individual provider offices, and to perform a site visit of each new office site of the stated physicians and providers. The commenter says that the language implies that the plan would have an obligation to continuously monitor the status of new office openings, which would be extremely costly and burdensome. The commenter suggests alternative language that says opening of a new provider office is considered a material change in a provider's participation status that must be reported to the HMO, which will perform a site visit when so informed.

Agency Response: The site visit requirement is only applicable to relocation and opening of additional sites for primary care physicians, OB/GYNs, and high-volume behavioral health physicians or individual behavioral health providers. Because HMOs are already required to maintain a current provider directory, tracking should impose no additional burden. To clarify, the section has been changed as follows: "The HMO shall have a process to track the relocation and the opening of additional office sites for primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers."

§11.1902(7)(A)(iv): A commenter states that the language of this clause is not consistent with NCQA standards. The commenter could find no requirements for a procedure for termination of the delegation agreement for non-performance in the standards for NCQA accreditation.

Agency Response: The language is consistent with current NCQA standard CR12 (2004). A written delegation agreement is required for the delegation of any function required by the HMO Act, including credentialing, under Article 20A.18C. One of the required provisions of such agreement is an acknowledgment and agreement by the delegated entity that if it fails to meet standards established to ensure that delegated functions are in full compliance with all statutory and regulatory requirements, the HMO may cancel delegation of any or all delegated functions.

§11.1902(7)(B) and (C)(iii): A commenter says it did not find any requirements for semi-annual reports received from the delegated entities in the standards for NCQA accreditation.

Agency Response: This requirement is consistent with NCQA standard CR12 (2004).

§11.2201(c): One commenter says that some single service HMOs only contract with full service HMOs and therefore would never produce an evidence of coverage (EOC). The commenter accordingly recommends adding the words "if applicable" after the term "evidence of coverage."

Agency Response: The department disagrees that this is necessary, since the provision applies only to an HMO that issues an EOC.

§11.2207(d)(2)(B)(xiii): A commenter recommends adding "as applicable" after "pharmacy," as not all single service HMOs cover this benefit.

Agency Response: The department disagrees that the suggested phrase is necessary, as the language would only be applicable to those HMOs that offer pharmacy benefits.

§11.2207(d)(4)(G): A commenter disagrees with linking department rules to NCQA requirements for categories of health plans that are not accredited by NCQA, and suggests that the language in this subparagraph be revised to exempt categories of health plans that NCQA does not accredit, i.e., stand-alone dental plans.

Agency Response: The department disagrees, as this requirement comes from Insurance Code Article 20A.39, which applies to all HMOs without exception.

§11.2208(b): A commenter asks that this subsection clarify the exclusion of non-emergency conditions (such as routine eye care and dental checkups).

Agency Response: The department does not believe this change is necessary. Sections 11.2203 and 11.2204 specifically address minimum standards for dental care and vision care services and benefits, and §11.2208(b) already requires an HMO to make services available only "as appropriate."

§11.2208(c): A commenter says that this requirement could severely limit the business of health plans that hold the contract with ambulatory surgical centers and hospitals and not with single service HMOs. Presently none of the commenter's business with full service HMOs carve out both provider and hospital services.

Agency Response: To clarify that this section applies only to single service HMOs that provide inpatient care, the department has changed the subsection as follows: "If a service offered by a single health care service HMO requires inpatient status...."

Payment for Out-Of-Network Services

§11.506(10)(D) and §11.1607(i)(4): A commenter generally supports the rules as published, and believes the amendments to these sections are necessary to ensure that enrollees receive covered services by paying only the deductibles and copayments stated in their contracts. The commenter agrees that this language does not address an HMO's ability to negotiate rates; instead the amendments clarify that HMOs must provide care on a pre-paid basis in accordance with accessibility and availability standards of the statute.

Agency Response: The department appreciates the comment. However, as previously noted, the department acknowledges concerns that the proposed language may have some effect on an HMO's ability to negotiate with certain providers which may

not have been anticipated at the time of the original enactment of the HMO Act. As a result of the possibility of legislative action, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) in order to appropriately defer the issue during the current legislative session.

§11.506(10)(D) and §11.1600(b)(11): A commenter feels that these sections should be changed to include not only the term "network" but also "network facilities," as contained in §11.1607(i)(4), to maintain consistency and clarify the intent that enrollees are protected from paying amounts that may be balance billed whether benefits are received from a network provider or a non-contracted physician.

Agency Response: The department is not adopting the proposed language relating to payment of necessary out-of-network services. However, the department disagrees that this change would be necessary because it is generally understood that a network would include any providers who contract with the HMO, including facilities. "Provider" is defined in Insurance Code §843.002(24) as "a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including . . . a pharmacy, hospital or other institution or organization."

§11.506 and 11.1607: Some commenters feel that the term "usual and customary," as stated in Texas Insurance Code Article 20A.09Y, refers to the fee a particular physician charges for a particular service. The commenters believe that defining the term in this manner is necessary to protect the enrollee from balance billing, as there will undoubtedly be a difference between the amount the plan is willing to pay and the physician's actual charge. A commenter believes this position is supported by Insurance Code Article 21.60 which, when referring to the amount the plan is willing to pay, does not use the phrase "usual and customary." Another commenter feels that to allow plans to define "usual and customary" as their contracted rate confuses the issue and violates the statute.

Another commenter notes that the language of the 1997 Patient Protection Act relating to ER providers came from the department's rules and asserts that the "usual and customary" language was included to address those instances when the HMO and provider could not agree on a rate. A commenter notes that §11.204(20), concerning contents of an application, continues to require that the HMO demonstrate that it will pay for emergency care services rendered by non-network providers at either a negotiated rate or the "usual and customary" rate. The commenter asserts that "usual and customary" rates are established as a means of providing fair and reasonable compensation for services rendered while protecting health plans and members from "price gouging."

Agency Response: The different approaches from the commenters on this issue demonstrate the complexity involved in payment for necessary out-of-network services. Defining "usual and customary" would likely have more far-reaching effects on other elements of the health care industry than ensuring enrollees are protected from additional charges for out-of-network services. As a result of the possibility of legislative action on the issue of payment for necessary out-of-network services, the department is not adopting the proposed language relating to payment of necessary out-of-network services and declines to define "usual and customary" as suggested.

§11.506(10)(D): Some commenters oppose the requirement that an HMO ensure enrollees are indemnified or otherwise held harmless if they receive out-of-network emergency care services. Some commenters state that this issue is currently not addressed by statute and, as one commenter notes, there is presently no Texas law to prohibit non-contracted providers from balance billing patients. The commenters believe that the rules exceed the department's statutory authority in Article 20A.09Y, which allows HMOs to pay for emergency services through a negotiated rate or, in the event the HMO cannot negotiate a rate, a usual and customary rate.

Agency Response: While the commenters are correct that there is no law preventing out-of-network providers from balance billing an enrollee, the proper focus for these rules is the department's authority over HMOs and their payment obligations for necessary out-of-network services. Some HMOs indicate they rely upon the term "usual and customary" in the statute in order to pay an amount that is sometimes less than what a provider is willing to accept. This, in turn, creates the potential for additional cost exposure to enrollees, which is inconsistent with other provisions of the statute. As a result of the possibility of legislative action, the department is not adopting the proposed language concerning payment for necessary out-of-network services in §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

§11.506(10)(D)(ii): Some commenters are concerned that emergency care providers may terminate existing contracts in order to maximize their revenue by forcing payment of billed charges by HMOs. A commenter suggests that, as applied to consumer choice plans that have copayments that are a percentage of the billed charges, this requirement could actually result in additional out-of-pocket liability for enrollees.

Agency Response: As discussed previously, the department received comments regarding the effects the proposed language may have on an HMO's future ability to negotiate with providers, including emergency providers, to create a network. The department also recognizes that creating a network of contracted providers is crucial to the concept of managed care, including consumer choice plans offered by an HMO. Because of the potential effects that the proposed language may have on HMOs' ability to create networks of contracted providers, as well as legislative interest in the issue of payment for necessary out-of-network services, the department is not adopting the proposed language.

§11.506(10)(D): Some commenters request that this provision be removed because the current statutory framework allows HMOs to negotiate with non-contracted emergency service providers for a rate lower than billed charges. If the provision remains, it will essentially remove the incentive for emergency care providers to negotiate and, as one commenter notes, may embolden already aggressive emergency care providers into absolute refusal to negotiate rates. Without rate negotiation, providers will be free to set exorbitant charges, which will only serve to make health plan coverage more unaffordable in Texas. They note that currently if their negotiations are unsuccessful most HMOs will make certain that their enrollees are held harmless.

Agency Response: As discussed previously, the department received comments regarding the possible effects the proposed language may have on an HMO's ability to negotiate with out-of-network emergency providers and the potential associated

costs. Because of this, as well as legislative interest in the issue of payment for necessary out-of-network services, the department is not adopting the proposed language.

§§11.506, 11.1600 and 11.1607

Comment: A commenter notes that balance billing is a nationwide problem but, along with others, does not believe the rule amendments are the appropriate way to address the problem. Some commenters believe the rule seeks to treat the problem of network adequacy, especially with facility-based providers, with a solution that guarantees to increase the network adequacy problem. Because the amendments take away the HMO's ability to negotiate with providers, the commenters assert, the rule amendments make the term "usual and customary" effectively the same as billed charges. The commenters assert that if HMOs are required to fully indemnify members for use of out-of-network providers rather than to be able to negotiate or pay a reasonable and customary fee, providers will leave HMO networks so that they can be paid full billed charges. This result is contrary to the requirement that HMOs provide adequate networks. A commenter asserts that facility-based providers have no incentive to contract with health plans under current laws and believes the proposed amendments further encourage providers to not contract with HMOs or to leave the networks. A commenter notes that those that stay in network will be able to exact increased contract rates because of the threat of going out-of-network. The result is an upward pressure on contract pricing that must inevitably be passed on to employers and employees, as well as any state plan that does not have a mandatory fee schedule and automatic hold harmless requirement, i.e., CHIP and others. The commenter believes that the rules are inconsistent with the cost-saving purpose of HMOs, and will result in an extreme cost increase to employers in the form of rate increases, which will result in higher costs ultimately paid by enrollees. Thus, the commenter concludes, the rules threaten the very existence of the fully-insured HMO market in Texas, and limit insurance availability, resulting in an increase in the number of uninsured in Texas. Some commenters recommend that the department not address the issue, as often non-contracted providers will negotiate and many times the carrier will pay billed charges if necessary to hold the member harmless.

Agency Response: The department recognizes the concern that the proposed language may hinder contract negotiation efforts, but the absence of protections for enrollees seeking services in a network facility highlights a potential network adequacy problem that the commenter is not addressing. The cost-saving aspect of HMOs, as mentioned by the commenters, depends upon the ability to contract with providers for discounted fees. However, another aspect essential to HMOs, to deliver covered services to enrollees without additional costs other than applicable copayments and deductibles, depends upon the ability of enrollees to access covered services in a network facility. This issue was a subject of the Senate Committee on State Affairs Interim Report and, as stated in the report, "begs for legislative action." Due to the upcoming legislative session and the expressed interest in the subject, the department is not adopting the proposed language.

Comment: Some commenters take issue with the statements in the preamble of the proposed rules which indicate that the revisions requiring indemnification of health plan members who obtain out-of-network services are necessary to comply with existing statutory requirements and are basically a restatement of

Insurance Code Article 20A.09(f). The commenters feel that Article 20A.09(f) clearly states that an HMO may pay either an agreed rate or, absent an agreement, may pay a usual and customary rate. A commenter notes that the language of the 1997 Patient Protection Act came from the department's rules and was included to address the fact that insurance companies may not be able to reach an agreement with providers on a rate. Some commenters feel that the regulation would make the statutory reference to "usual and customary" meaningless as it essentially mandates the payment of full billed charges. The commenters further note that the requirement of a hold harmless provision found in Subchapter K, §843.361 of the Insurance Code only applies to contracted providers and would be rendered meaningless if the department's interpretation is correct. Under the department's interpretation, there would be no need for the hold harmless provision because all health care costs other than co-payments would be borne by the HMO, regardless of whether there was a provider network contract. Rules of statutory construction do not support this result. Thus, the commenters assert that the rule not only exceeds statutory authority but actually conflicts with existing statutes.

Agency Response: The commenter is correct that the hold harmless language found in §843.361 specifically relates to contracted providers. The provision is made a part of the provider contract and is an important enrollee protection in the HMO Act. When enrollees must receive services outside the provider network due to the unavailability of services through a network provider, the statute continues to protect enrollees by requiring HMOs to "fully" reimburse the out-of-network provider. Although unrelated to the requirement in §843.361, the department views this directive as a requirement that enrollees be held harmless when forced to receive services outside of the network. This provision, combined with the §843.361 requirement for a contractual hold harmless provision for contracted providers, protects enrollees from additional costs when attempting to access covered services.

The department disagrees with the commenters' characterization of the statute and its requirements concerning out-of-network payments by HMOs. Paying a provider at the HMO's usual and customary amount and thereby subjecting the enrollee to additional costs is inconsistent with the statutory directive to "fully" reimburse the provider. A fundamental concept of a managed care plan is that enrollees in the HMO Act, such as requirements related to network adequacy. The commenters' interpretations create an exception to the network adequacy requirements that circumvents the rule and would allow enrollees to be routinely exposed to additional costs for services that should be available through network providers. The HMOs' reported difficulty contracting with facility-based providers and the resulting possibility of out-of-network services is an issue that has become

more prominent since the legislature originally enacted this provision. Due to potential legislative action, as evidenced by the Senate Committee on State Affairs Interim Report, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter believes the legislature should address the balance billing problem and has asked the legislature to do so.

Agency Response: The department acknowledges that the legislature has expressed its intent to address this issue, and therefore is not adopting these provisions pending such action.

Comment: Some commenters feel that physicians will always have an incentive to contract with HMOs who negotiate in good faith, and thus will continue to contract with HMOs. A commenter disagrees that the steering of patients is the only incentive for a physician to contract, as other incentives exist, including: application of prompt pay to contracted providers; facility-based physicians who want to maintain a relationship with a hospital; and a hospital preferring a group who will contract over one who does not.

Agency Response: The department notes that many factors may influence providers' decisions to contract with HMOs, including those mentioned by the commenter, but acknowledges the concerns regarding the potential effect of the proposed provisions on negotiations between HMOs and providers for discounted rates. The department recognizes the challenge concerning the fundamental HMO concept of providing covered services through a closed network of providers and the HMOs' stated inability to contract to provide those services. Given the expressed legislative interest in addressing this issue, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: One commenter estimates costs for a health plan under existing market participation to be about \$15 million (using 2003 figures) and says costs will go up as providers leave the network. These costs will ultimately be borne by the enrollee. Another commenter estimates that 95,000 of its members will be affected and that paying billed charges would cost an additional \$8.87 million. The amount will go up as providers leave the network. The commenter is concerned that there is no limit to billed charges and has seen one as high as 1800 percent of Medicare in 2002. The same commenter says the average for billed charges in West Texas in 2002 was 300 percent of Medicare and now it is 400 percent.

Agency Response: The department acknowledges the concerns regarding potential cost effects the proposed language may have on an HMO's ability to contract or negotiate with providers. Given these concerns and the competing consideration of enrollee protection, as well as the expressed legislative interest in addressing this issue, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: Some commenters assert that the proposed provisions are contrary to previous positions taken by the department.

Agency Response: Regardless of the department's previous statements on this issue, the proposal sought to clarify an HMO's out-of-network payment obligations consistent with existing statutory requirements through the rulemaking process. As a result of the considerations regarding HMOs' ability to negotiate and contract with providers and a clear legislative interest in this subject, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter states that they currently have over 53,000 CHIP members and if the proposed rules go into effect, they will have to request a premium increase from HHSC, which will probably hurt their ability to increase CHIP membership. The commenter notes that they had paid billed charges in the past but recognized that doing so took away their ability to negotiate. They then changed to paying a usual and customary rate based on Medicaid, which increased their ability to contract and saved \$2.7 million for the plan and HHSC. If a non-contracted provider balance bills a member, they try to reach agreement, but if they are unsuccessful they will sometimes pay billed charges to protect the member. Because they pay non-contracted providers at a usual and customary rate, they have the ability to negotiate with providers. To take this ability away will cost more than \$2.7 million. The commenter believes things are working now and has received few complaints on this issue. A commenter believes the proposed rule amendments will have a huge impact on HHSC, and will be asking for a premium increase if the amendments are adopted.

Agency Response: The proposed language sought to clarify the issue of payment of necessary out-of-network services due to some confusion regarding HMOs' responsibilities for payment of such services. The department is aware of the competing considerations concerning costs and enrollee protections, as well as the expressed legislative interest in addressing them. As a result, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: Some commenters note that if an HMO is meeting its statutory duty to maintain an adequate network, payment to non-network physicians is not an issue. One commenter believes that adequate provider networks actually decrease health care costs and promote continuity of care and health management, and reduce hassles for the patient, health plan, and provider. Thus, these commenters believe the department is correct in stating that the root of the balance billing issue is the failure of HMOs to have an adequate network and provide the basic health care services they promise to provide on a prepaid basis. The commenters believe HMOs should be held to their obligations. A commenter notes that only HMOs that continue to fail to meet their obligations will see increased costs, which are "currently borne on the backs of patients and non-network physicians- both of whom are innocent parties." A commenter also feels that the cost of an inadequate network is a risk an HMO takes when it applies for a certificate of authority to offer HMO services in Texas. Some commenters applaud the department's efforts to protect patients by monitoring network adequacy and ensuring patients do not incur additional financial liability as a result of accessing care when a contracted provider is unavailable. The commenters note that the proposal merely states current state law, and thank

the department for its continued efforts in resolving issues that plague insurance.

Agency Response: The proposal sought to clarify an HMO's out-of-network payment obligations consistent with existing statutory requirements through the rulemaking process. The department recognizes that HMOs are reporting difficulties in contracting with certain facility-based providers, which impacts network adequacy and makes balance billing or increased costs to HMOs more likely. For the reasons stated previously, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: Some commenters express concern about reimbursement of non-network providers at "usual and customary" in absence of an agreed-to rate. One commenter notes that the term "usual and customary" is "all over the board." Some commenters state that some health plans have used this as an opportunity to cap out-of-network expenses without regard to actual billed charges or market rates for the services. Although the Attorney General has made clear that a non-network physician may balance bill for the services not covered by the health plan, it is unreasonable for a health plan to determine a "usual and customary" amount from another negotiated discount. A commenter encourages patients to use mechanisms already in place through the Texas State Board of Medical Examiners (TSBME) for review to address excessive billing. Under current antitrust law, physicians cannot survey other area physician's charges to determine appropriateness. A commenter discusses testimony at the hearing regarding overcharging and improper billing and notes that there are ample tools available to combat the very few who improperly bill. Current law states that it is illegal pursuant to Article 21.79F to charge a higher price based solely on the fact that an insurer will pay all or part of the price, and TSBME can enforce the Texas Medical Practice Act relating to improper billing.

Agency Response: The department encourages the use of all legal means to ensure that health care charges are reasonable and proper. However, as the comments reveal, the issue of "usual and customary" has been the subject of varying interpretations. The conflicting comments received on this issue demonstrate the complexity involved in payment for necessary out-of-network services. Defining "usual and customary" would likely have more far-reaching effects on elements of the health care industry other than protecting enrollees from additional charges for out-of-network services. Comments received from HMOs indicate that routine payment of out-of-network providers' billed charges, even if not excessive, will have a substantial impact on costs and, as a result, on premiums. The department acknowledges the considerations concerning costs, as well as the need for enrollee protections when forced to seek out-of-network services. Due to these competing considerations and the possibility of legislative action on the issue of payment of out-of-network services, the department is not adopting the proposed language relating to payment of necessary out-of-network services and declines to define "usual and customary."

Comment: A commenter is dismayed at some testimony at the hearing and feels that testimony of several health plan representatives that the proposed rule will increase premiums is untrue. The commenter asserts that TDI policy has for years provided that non-contracted providers may bill patients and notes that an AG opinion on this subject was issued over a year and a half

ago. Consequently, the HMOs' argument that costs for treatment by non-contracted physicians has not already been included in premiums is not credible. The commenter believes that costs for treatment by out-of-network providers should already be included in HMO premiums due to the inevitability of such treatment.

Agency Response: The department notes that comments concerning the proposed language highlight existing confusion regarding the issue and competing considerations concerning costs and enrollee protections. Due to these considerations, and the expressed legislative interest in addressing them, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter disagrees with the proposed rules requiring "indemnification" of all costs of out-of-network care incurred by enrollees. Some commenters believe the statutory and regulatory basis relied on in implementing the indemnification requirement is unsupportable. The department relies on the fact that HMO insurance is purchased on a "prepaid basis" to suggest a requirement that all costs other than copayments are the responsibility of the health plan. It would follow that if all costs other than copayments are borne by the health plan, the health plans must indemnify the costs of out-of-network services that are incurred by the member. A commenter believes that the use of the phrase "prepaid basis" in the relevant statutory sections was never intended to provide a requirement of indemnification. Rather, the commenter states, it was intended to distinguish a prepaid plan from a plan that indemnified for medical costs as is made clear by Insurance Code §843.002(12), which defines a "health care plan" as a plan "that consists in part of providing or arranging for health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of health care services." The commenter believes the department is acting outside its rulemaking authority in promulgating the particular provisions relating to indemnification of out-of-network costs.

Agency Response: A fundamental element of an HMO's health plan is the requirement that an enrollee receive covered services from network providers that have agreed to hold enrollees harmless for such services. This entitles enrollees to receive basic health care services from network providers without being subject to any costs beyond applicable copayments and deductibles. However, if an enrollee is forced, due to the unavailability of a network provider, to receive services from an out-of-network provider and is subject to additional costs, this basic principle fails. The proposal placed enrollees in the same position they would have been had they been treated by a network provider and used the term "indemnify" to ensure this outcome. The department is aware of the competing considerations concerning costs and enrollee protections and the expressed legislative interest in addressing them. Therefore, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter contends that the out-of-network and balance billing rules do not apply to Children's Health Insurance Program (CHIP) HMOs by operation of Texas Health and Safety Code §62.152(3), which exempts the CHIP program from state

insurance laws that require "the use of a particular policy or contract form or of particular language in a policy or contract form." TDI's proposed rules would require specific language in the evidence of coverage and notices to HMO enrollees. The commenter believes that these rules do not apply to CHIP by virtue of the program's statutory exemption and requests that the rules state that they are not applicable to CHIP HMOs.

Agency Response: The department declines to adopt the suggested exclusion for CHIP HMOs. Although the department is not making the proposed changes relating to payment for necessary out-of-network services in §§11.506(10)(D), 11.1600(b)(11)(D) and 11.1607(i)(4), the insurance laws and rules of this state, in general, apply to CHIP, except as otherwise provided in the Insurance Code and Texas Health and Safety Code §62.152. The department points out that the current CHIP/Medicaid RFP requires that "[t]he Member will not be responsible for any payment for Medically Necessary Covered Services, other than HHSC-specified co-payments for CHIP Members, where applicable."

Comment: A commenter feels language should be adopted like that contained in rules implementing the prompt payment provisions of SB 418 at 28 TAC §21.2826, and suggests: "These rules are not applicable to Medicaid and CHIP provided by an HMO or preferred provider carrier to persons enrolled in the medical assistance program established under Chapter 32, Human Resources Code, or the child health plan established under Chapter 62, Health & Safety Code."

Agency Response: The department adopted §21.2826 pursuant to Insurance Code Article 21.30, which requires the Commissioner of Insurance to exempt Medicaid if, after consulting with the Commissioner of Health and Human Services, he determines that the provisions of SB 418 would have a negative fiscal impact on the Medicaid program. Because the Commissioner of Health and Human Services indicated that the bill would have a negative fiscal impact, the Commissioner of Insurance adopted §21.2826, which exempts both traditional Medicaid and Medicaid HMO plans from the provisions of SB 418. While federal law, Health and Safety Code §62.152, and certain provisions of the Insurance Code provide certain exemptions to CHIP and Medicaid coverages, the department does not believe the law authorizes the requested blanket exemption.

Comment: A commenter states that, given the Texas Health and Human Services Commission's exclusive authority to administer Texas Medicaid contracts, the rules should not be applicable to HMOs with whom HHSC contracts because it could result in forcing such HMOs to cover the cost of billed charges, rather than an amount substantially less than billed charges, as the commenter understands is current practice. The commenter requests that the department's rules explicitly not apply to Medicaid HMOs. Another commenter expresses concern that the rules are in conflict with HHSC's plan to limit reimbursement.

Agency Response: The department agrees that HHSC has authority over the Medicaid product, except as specifically provided in the Insurance Code, and therefore the provision does not apply other than by reference, if any, in the HHSC contract with the HMO.

§11.1600(b)(11)(D): A commenter supports this proposal but recommends requiring the HMO to inform the enrollee of the possibility that professional and ancillary services delivered in a contracted hospital or facility might be provided by non-network physicians or providers. This would give enrollees a better

understanding as to when they might receive a bill for services provided by a non-network physician or provider and better understanding of their recourse under the indemnification requirements of the HMO.

Agency Response: The department agrees that a notice is appropriate, but declines to require the recommended notice. While the department recognizes the importance of informed decision-making, it notes that patients may not always be in a position to make informed choices about which doctors may provide services in a hospital setting, nor may they be able to require that the hospital honor the enrollee's choice of doctors. Instead, the department is adopting a notice requirement that HMOs inform enrollees to contact the HMO whenever they receive a bill from a provider, whether contracted or non-contracted.

For With Changes: Office of Public Insurance Counsel, Texas Medical Association, Texas Hospital Association, Dallas County Medical Society, Texas Medical Group Management Association, Harris County Medical Society, Against: Texas Association of Health Plans, Scott & White Health Plan, Texas Society of Psychiatric Physicians, Texas Health and Human Services Commission, Cigna Health Care, Humana, Inc., Community First Health Plans, Inc., Texas Association of Business, Unicare, Firstcare HMO, Texas Children's Health Plan, and Pacificare.

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §11.1, §11.2

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain

a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.2. Definitions.

(a) The definitions found in the Texas Health Maintenance Organization Act, Texas Insurance Code §843.002, are incorporated into this chapter.

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

(1) Act--The Texas Health Maintenance Organization Act, codified as the Texas Insurance Code Chapters 20A and 843.

(2) Admitted assets--All assets as defined by statutory accounting principles, as permitted and valued in accordance with §11.803 of this title (relating to Investments, Loans, and Other Assets).

(3) Adverse determination--A determination upon utilization review that the health care services furnished or adopted to be furnished to a patient are not medically necessary or not appropriate.

(4) Affiliate--A person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(5) Agent--A person who may act as an agent for the sale of a health benefit plan under a license issued under Insurance Code Chapter 21.

(6) ANHC or approved nonprofit health corporation--A nonprofit health corporation certified under §162.001 of the Occupations Code.

(7) Annual financial statement--The annual statement to be used by HMOs, as promulgated by the NAIC and as adopted by the commissioner under Insurance Code Article 1.11 and §§802.001, 802.003 and 843.155.

(8) Authorized control level--The number determined under the RBC formula in accordance with the RBC instructions.

(9) Basic health care service--Health care services which an enrolled population might reasonably require to maintain good health, as prescribed in §§11.508 and 11.509 of this title (relating to Mandatory Benefit Standards: Group, Individual and Conversion Agreements, and Additional Mandatory Benefit Standards: Group Agreement Only).

(10) Clinical director--Health professional who meets the following criteria:

(A) is appropriately licensed;

(B) is an employee of, or party to a contract with, a health maintenance organization; and

(C) is responsible for clinical oversight of the utilization review program, the credentialing of professional staff, and quality improvement functions.

(11) Code--The Texas Insurance Code.

(12) Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Article 3.80 or Article 20A.09N, and as described in Subchapter AA of Chapter 21 of this title (relating to Consumer Choice Health Benefit Plans).

(13) Contract holder--An individual, association, employer, trust or organization to which an individual or group contract for health care services has been issued.

(14) Control--As defined in Insurance Code §§823.005 and 823.151.

(15) Controlled HMO--An HMO controlled directly or indirectly by a holding company.

(16) Controlled person--Any person, other than an HMO, who is controlled directly or indirectly by a holding company.

(17) Copayment--A charge, which may be expressed in terms of a dollar amount or a percentage of the contracted rate, in addition to premium to an enrollee for a service which is not fully prepaid.

(18) Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a physician or provider to determine eligibility to deliver health care services.

(19) Dentist--An individual provider licensed to practice dentistry by the Texas State Board of Dental Examiners.

(20) General hospital--A licensed establishment that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(B) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

(21) HMO--A health maintenance organization as defined in Insurance Code §843.002(14).

(22) Health status related factor--Any of the following in relation to an individual:

(A) health status;

(B) medical condition (including both physical and mental illnesses);

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability (including conditions arising out of acts of domestic violence, including family violence as defined by Insurance Code Article 21.21-5); or

(H) disability.

(23) Individual provider--Any person, other than a physician or institutional provider, who is licensed or otherwise authorized to provide a health care service. Includes, but is not limited to, licensed doctor of chiropractic, dentist, registered nurse, advanced practice nurse, physician assistant, pharmacist, optometrist, registered optician, and acupuncturist.

(24) Institutional provider--A provider that is not an individual. Includes any medical or health related service facility caring for the sick or injured or providing care or supplies for other coverage which may be provided by the HMO. Includes but is not limited to:

(A) General hospitals,

(B) Psychiatric hospitals,

(C) Special hospitals,

(D) Nursing homes,

(E) Skilled nursing facilities,

(F) Home health agencies,

(G) Rehabilitation facilities,

(H) Dialysis centers,

(I) Free-standing surgical centers,

(J) Diagnostic imaging centers,

(K) Laboratories,

(L) Hospice facilities,

(M) Infusion services centers,

(N) Residential treatment centers,

(O) Community mental health centers,

(P) Urgent care centers, and

(Q) Pharmacies.

(25) Limited provider network--A subnetwork within an HMO delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations and/or physician groups which limit the enrollees' access to only the physicians and providers in the subnetwork.

(26) Limited service HMO--An HMO which has been issued a certificate of authority to issue a limited health care service plan as defined in Insurance Code §843.002.

(27) NAIC--National Association of Insurance Commissioners.

(28) Out of area benefits--Benefits that the HMO covers when its enrollees are outside the geographical limits of the HMO service area.

(29) Pathology services--Services provided by a licensed laboratory which has the capability of evaluating tissue specimens for diagnoses in histopathology, oral pathology, or cytology.

(30) Pharmaceutical services--Services, including dispensing prescription drugs, under the Pharmacy Act, Occupations Code, Subtitle J, that are ordinarily and customarily rendered by a pharmacy or pharmacist.

(31) Pharmacist--An individual provider licensed to practice pharmacy under the Pharmacy Act, Occupations Code, Subtitle J.

(32) Pharmacy--A facility licensed under the Pharmacy Act, Occupations Code, Subtitle J.

(33) Premium--All amounts payable by a contract holder as a condition of receiving coverage from a carrier, including any fees or other contributions associated with a health benefit plan.

(34) Primary care physician or primary care provider--A physician or individual provider who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(35) Primary HMO--An HMO that contracts directly with, and issues an evidence of coverage to, individuals or organizations to arrange for or provide a basic, limited, or single health care service plan to enrollees on a prepaid basis.

(36) Provider HMO--An HMO that contracts directly with a primary HMO to provide or arrange to provide health care services on behalf of the primary HMO within the primary HMO's defined service area.

(37) Psychiatric hospital--A licensed hospital which offers inpatient services, including treatment, facilities and beds for use beyond 24 hours, for the primary purpose of providing psychiatric assessment and diagnostic services and psychiatric inpatient care and treatment for mental illness. Such services must be more intensive than room, board, personal services, and general medical and nursing care. Although substance abuse services may be offered, a majority of beds must be dedicated to the treatment of mental illness in adults and/or children.

(38) Qualified HMO--An HMO which has been federally approved under Title XIII of the Public Health Service Act, Public Law 93-222, as amended.

(39) Quality improvement (QI)--A system to continuously examine, monitor and revise processes and systems that support and improve administrative and clinical functions.

(40) RBC--Risk-based capital.

(41) RBC formula--NAIC risk-based capital formula.

(42) RBC Report--Health Risk-Based Capital Report including Overview and Instructions for Companies published by the NAIC and adopted by reference in §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank).

(43) Recredentialing--The periodic process by which:

(A) qualifications of physicians and providers are reassessed;

(B) performance indicators, including utilization and quality indicators, are evaluated; and

(C) continued eligibility to provide services is determined.

(44) Reference laboratory--A licensed laboratory that accepts specimens for testing from outside sources and depends on referrals from other laboratories or entities. HMOs may contract with a reference laboratory to provide clinical diagnostic services to their enrollees.

(45) Reference laboratory specimen procurement services--The operation utilized by the reference laboratory to pick up the lab specimens from the client offices or referring labs, etc. for delivery to the reference laboratory for testing and reporting.

(46) Schedule of charges--Specific rates or premiums to be charged for enrollee and dependent coverages.

(47) Service area--A geographic area within which direct service benefits are available and accessible to HMO enrollees who live, reside or work within that geographic area and which complies with §11.1606 of this title (relating to Organization of an HMO).

(48) Single service HMO--An HMO which has been issued a certificate of authority to issue a single health care service plan as defined in the Insurance Code §843.002.

(49) Special hospital--A licensed establishment that:

(A) offers services, facilities and beds for use for more than 24 hours for two or more unrelated individuals who are regularly admitted, treated and discharged and who require services more intensive than room, board, personal services, and general nursing care;

(B) has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities or other definitive medical treatment;

(C) has a medical staff in regular attendance; and

(D) maintains records of the clinical work performed for each patient.

(50) Specialists--Physicians or individual providers who set themselves apart from the primary care physician or primary care provider through specialized training and education in a health care discipline.

(51) State-mandated health benefit plan--As defined in §21.3502 of this title (relating to Definitions).

(52) Statutory surplus--Admitted assets minus accrued uncovered liabilities.

(53) Subscriber--If conversion or individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO; or if group coverage, the individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

(54) **Subsidiary**--An affiliate controlled by a specified person directly or indirectly through one or more intermediaries.

(55) **Telehealth service**--As defined in Section 57.042, Utilities Code.

(56) **Telemedicine medical service**--As defined in Section 57.042, Utilities Code.

(57) **Total adjusted capital**--An HMO's statutory capital and surplus/total net worth as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed pursuant to the Insurance Code, and such other items, if any, as the RBC instructions provide.

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

(59) **Utilization review**--A system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.

(60) **Voting security**--As defined in Insurance Code §823.007, including any security convertible into or evidencing a right to acquire such security.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500519

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER B. NAME APPLICATION PROCEDURE

28 TAC §11.101

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for

the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary

to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500520

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY

28 TAC §§11.201 - 11.206

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements

of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.205. Documents To Be Available for Qualifying Examinations.

(a) The following documents must be available for review at the HMO's office located within the State of Texas:

(1) administrative: policy and procedure manuals; physician and provider manuals; enrollee materials; organizational charts; key personnel information, e.g., resumes and job descriptions; and other items as requested;

(2) quality improvement: program description and work plan as required by §11.1902 of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs);

(3) utilization management: program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and IRO logs;

(4) complaints and appeals: policies and procedures, examples of letters and examples of complaint and appeal logs. On or after January 1, 2006, each complaint shall be categorized as one or more of the following types of complaint:

- (A) quality of care or services;
- (B) accessibility/availability of services;
- (C) utilization review or management;
- (D) complaint procedures;
- (E) physician and provider contracts;
- (F) group subscriber contracts;
- (G) individual subscriber contracts;
- (H) marketing;
- (I) claims processing; and
- (J) miscellaneous;

(5) health information systems: policies and procedures for accessing enrollee health records and a plan to provide for confidentiality of those records in accordance with applicable law;

(6) network configuration information, as outlined in §11.204(18) of this title (relating to Contents) demonstrating adequacy of the physician, dentist and provider network;

(7) executed agreements, including:

- (A) management services agreements;
- (B) administrative services agreements; and
- (C) delegation agreements;

(8) executed physician and provider contracts: copy of the first page, including the form number, and signature page of individual provider contracts and group provider contracts;

(9) executed subcontracts: copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

(10) current physician manual and current provider manual which shall be provided to each contracting physician and other provider. The manuals shall contain details of the requirements by which the physicians and providers will be governed;

(11) credentialing files: as specified in §11.1902(4) of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs) and §11.2207(d)(4) of this title (relating to Quality Improvement Structure and Program for Single Service HMOs);

(12) a copy of all printed materials to be presented to prospective enrollees, an enrollee handbook, and an evidence of coverage;

(13) the statistical reporting system developed and maintained by the HMO which allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of services, and the accessibility and availability of services;

(14) claims systems: policies and procedures that demonstrate the capacity to pay claims timely and to comply with all applicable statutes and rules;

(15) financial records: including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments and debts; and

(16) any other records demonstrating compliance with applicable statutes and rules, including audits or examination reports by other entities, including governmental authorities or accrediting agencies.

(b) The following documents may be maintained outside the State of Texas if the HMO has received prior approval by the commissioner pursuant to Insurance Code §803.003:

- (1) financial records, including ledgers;
- (2) checkbooks;
- (3) inventory records;
- (4) evidence of expenditures, investments, and debts; and
- (5) the minutes of the HMO organizational meetings which indicate the type and date of each meeting, and the officer or officers who are responsible for the handling of the funds of the applicant; the minutes of meetings of the HMO board of directors; management committee meeting minutes.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500521
Brenda Caldwell
Special Regulatory Counsel
Texas Department of Insurance
Effective date: February 24, 2005
Proposal publication date: November 12, 2004
For further information, please call: (512) 463-6327

◆ ◆ ◆

SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO SUBSEQUENT TO ISSUANCE OF CERTIFICATE OF AUTHORITY

28 TAC §§11.301 - 11.303

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to

require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which,

for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.303. Examination.

(a) The department has authority to conduct examinations of HMOs under Insurance Code §§843.251 and 843.156. Such examinations may be conducted to determine the financial condition ("financial exams"), quality of health care services ("quality of care exams"), or compliance with laws affecting the conduct of business ("market conduct exams" or "complaint exams").

(b) On-site financial, market conduct examinations, complaint or quality of care exams shall be conducted pursuant to Insurance Code Article 1.15 and §7.83 of this title (relating to Appeal of Examination Reports).

(c) The following documents must be available for review at the HMO's office located within the State of Texas:

(1) administrative: policy and procedure manuals; physician and provider manuals; enrollee materials; organizational charts; key personnel information, e.g., resumes and job descriptions; and other items as requested;

(2) quality improvement: program description, work plans, program evaluations, committee and subcommittee meeting minutes;

(3) utilization management: program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(4) complaints and appeals: policies and procedures and templates of letters; and complaint and appeal logs, including documentation and details of actions taken. On or after January 1, 2006, all complaints shall be categorized according to §11.205(a)(4)(A) - (J) of this title (relating to Documents to be Available for Qualifying Examinations); and complaint and appeal files;

(5) satisfaction surveys: enrollee, physician and provider satisfaction surveys, enrollee disenrollment and termination logs;

(6) health information systems: policies and procedures for accessing enrollee health records and a plan to provide for confidentiality of those records;

(7) network configuration information as required by §11.204(18) of this title (relating to Contents) demonstrating adequacy of the physician, dentist and provider network;

(8) executed agreements: including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements.

(9) executed physician and provider contracts: copy of the first page, including form number, and signature page of individual provider contracts and group provider contracts;

(10) executed subcontracts: copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

(11) credentialing: credentialing policies and procedures and credentialing files;

(12) reports: any reports submitted by the HMO to a governmental entity;

(13) claims systems: policies and procedures and systems/processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers and enrollees;

(14) financial records: including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments and debts; and

(15) other: any other records demonstrating compliance with applicable statutes and rules.

(d) Quality of care examinations shall be conducted pursuant to the following protocol:

(1) Entrance conference. The examination team or assigned examiner shall hold an entrance conference with the HMO's key management staff or their designee before beginning the examination.

(2) Interviews. Examination team members or the examiner shall conduct interviews with key management staff or their designated personnel.

(3) Exit conference. Upon completion of the examination, the examination team or examiner shall hold an exit conference with the HMO's key management staff or their designee.

(4) Written report of examination. The examination team or examiner shall prepare a written report of the examination. The department shall provide the HMO with the written report, and if any deficiencies are cited, then the department shall issue a letter outlining the timeframes for the corrective action plan and corrective actions.

(5) Serious deficiencies cited and plan of correction. If the examination team or examiner cites serious deficiencies, the HMO shall provide the examination team or examiner with a signed plan to correct deficiencies within one business day of written notice of deficiencies. The HMO's plan of correction shall allow up to 12 days for correction of the deficiencies in accordance with severity of the deficiencies.

(6) Plan of correction. Except as provided in paragraph (5) of this subsection, if the examination team or examiner cites deficiencies, then the HMO shall provide a signed plan of correction to the department no later than 30 days from receipt of the written examination report. The HMO's plan must provide for correction of these deficiencies no later than 90 days from the receipt of the written examination report.

(7) Verification of correction. The department shall verify the correction of deficiencies by submitted documentation or by on-site examination.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500522

Brenda Caldwell
Special Regulatory Counsel
Texas Department of Insurance
Effective date: February 24, 2005
Proposal publication date: November 12, 2004
For further information, please call: (512) 463-6327

◆ ◆ ◆

SUBCHAPTER F. EVIDENCE OF COVERAGE

28 TAC §§11.502 - 11.506, 11.508, 11.509, 11.512

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and

maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.506. Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate.

Each enrollee residing in this state is entitled to an evidence of coverage under a health care plan. By agreement between the issuer of the evidence of coverage and the enrollee, the evidence of coverage approved under this subchapter and required by this section may be delivered electronically. Each group, individual and conversion contract and group certificate must contain the following provisions.

(1) Name, address, and phone number of the HMO--The toll-free number referred to in Insurance Code Article 21.71, where applicable, must appear on the face page.

(A) The face page of an agreement is the first page that contains any written material.

(B) If the agreements or certificates are in booklet form the first page inside the cover is considered the face page.

(C) The HMO must provide the information regarding the toll-free number referred to in Article 21.71 in accordance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

(2) Benefits--A schedule of all health care services that are available to enrollees under the basic, limited, or single health care service plan, including any copayments or deductibles and a description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The copayment schedule must clearly indicate the benefit to which it applies.

(A) Copayments. An HMO may require copayments to supplement payment for health care services. Each HMO may establish one or more copayment options. A basic service HMO may not impose copayment charges that exceed fifty percent of the total cost of providing any single service to its enrollees, nor in the aggregate

more than twenty percent of the total cost to the HMO of providing all basic health care services. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year. The HMO shall state the copayment in the group, individual or conversion agreement and group certificate.

(B) Deductibles. A deductible shall be for a specific dollar amount of the cost of the basic, limited, or single health care service. An HMO shall charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

(C) Immunizations. An HMO shall not charge a copayment or deductible for immunizations as described in Insurance Code Article 21.53F for a child from birth through the date the child is six years of age, except that a small employer health benefit plan, as defined by Insurance Code Chapter 26, that covers such immunizations may charge a copayment or deductible.

(3) Cancellation and non-renewal--A statement specifying the following grounds for cancellation and non-renewal of coverage and the minimum notice period that will apply.

(A) An HMO may cancel a subscriber in a group and subscriber's enrolled dependents under circumstances described in clauses (i)- (vii) of this subparagraph, so long as the circumstances do not include health status related factors:

(i) For nonpayment of amounts due under the contract, coverage may be cancelled after not less than 30 days written notice, except no written notice will be required for failure to pay premium.

(ii) In the case of fraud or intentional misrepresentation of a material fact, except as described in paragraph (14) of this section, coverage may be cancelled after not less than 15 days written notice.

(iii) In the case of fraud in the use of services or facilities, coverage may be cancelled after not less than 15 days written notice.

(iv) For failure to meet eligibility requirements other than the requirement that the subscriber reside, live, or work in the service area, coverage may be cancelled immediately, subject to continuation of coverage and conversion privilege provisions, if applicable.

(v) In the case of misconduct detrimental to safe plan operations and the delivery of services, coverage may be cancelled immediately.

(vi) For failure of the enrollee and a plan physician to establish a satisfactory patient-physician relationship if it is shown that the HMO has, in good faith, provided the enrollee with the opportunity to select an alternative plan physician, the enrollee is notified in writing at least 30 days in advance that the HMO considers the patient-physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and the enrollee has failed to make such changes, coverage may be cancelled at the end of the 30 days.

(vii) Where the subscriber neither resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, coverage may be cancelled after 30 days written notice. An HMO shall

not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live or work in the service area.

(B) An HMO may cancel a group under circumstances described in clauses (i)- (vi) of this subparagraph:

(i) For nonpayment of premium, all coverage may be cancelled at the end of the grace period as described in paragraph (13) of this section.

(ii) In the case of fraud on the part of the group, coverage may be cancelled after 15 days written notice.

(iii) For employer groups, violation of participation or contribution rules, coverage may be cancelled in accordance with §26.8(h) and §26.303(j) of this title (relating to Guaranteed Issue; Contribution and Participation Requirements and Coverage Requirements).

(iv) For employer groups, in accordance with §26.16 and §26.309 of this title (relating to Refusal To Renew and Application To Reenter Small Employer Market and Refusal To Renew and Application To Reenter Large Employer Market), coverage may be cancelled upon discontinuance of:

(I) each of its small or large employer coverages;

or

(II) a particular type of small or large employer coverage.

(v) Where no enrollee resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees, the HMO may cancel the coverage after 30 days written notice.

(vi) If membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, the HMO may cancel the coverage after 30 days written notice.

(C) In the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees pursuant to this chapter or other law, a group or individual contract holder may cancel the contract after not less than 30 days written notice to the HMO.

(D) An HMO may cancel an individual contract under circumstances described in clauses (i)- (vi) of this subparagraph.

(i) For nonpayment of premiums in accordance with the terms of the contract, including any timeliness provisions, coverage may be cancelled without written notice, subject to paragraph (13) of this section.

(ii) In the case of fraud or intentional material misrepresentation, except as described in paragraph (14) of this section, the HMO may cancel coverage after not less than 15 days written notice.

(iii) In the case of fraud in the use of services or facilities, the HMO may cancel coverage after not less than 15 days written notice.

(iv) Where the subscriber neither resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, coverage may be cancelled after 30 days written notice. An HMO shall not cancel the coverage for a child who is the subject of a medical support order because the child does not reside, live or work in the service area.

(v) In case of termination by discontinuance of a particular type of individual coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, the HMO may cancel coverage after 90 days written notice, in which case the HMO must offer to each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by the HMO in that service area.

(vi) In case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, the HMO may cancel coverage after 180 days written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance at the last coverage not renewed.

(4) Claim payment procedure--A provision that sets forth the procedure for paying claims, including any time frame for payment of claims which must be in accordance with Insurance Code Articles 21.55 and 20A.09Z and the applicable rules.

(5) Complaint and appeal procedures--A description of the HMO's complaint and appeal process available to complainants.

(6) Continuation of coverage--Group agreements must contain a provision providing for mandatory continuation of coverage for enrollees who were continuously covered under a group certificate for three months prior to termination of the group coverage, or newborn or newly adopted children of enrollees with three months prior continuous coverage, that is no less favorable than provided by Insurance Code Article 20A.09(k).

(A) An enrollee shall have the option to continue coverage as provided for by Insurance Code Article 20A.09(k), upon completion of any continuation of coverage provided under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law Number 99-272, 100 stat. 222) and any amendments thereto.

(B) A dependent, upon completion of any continuation of coverage provided under Insurance Code Article 3.51-6 §3B, shall have the privilege to continue coverage for the 6 months prescribed by Insurance Code Article 20A.09(k).

(C) If an HMO offers conversion coverage, it must be offered to the enrollee not less than 30 days prior to the expiration of the COBRA or Article 3.51-6 §3B continuation coverage period.

(D) A basic service HMO shall notify the enrollee not less than 30 days before the end of the six months from the date continuation under Article 20A.09(k) was elected that the enrollee may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under Insurance Code Article 3.77, and shall provide the address and toll-free number of the pool.

(7) Definitions--A provision defining any words in the evidence of coverage which have other than the usual meaning. Definitions must be in alphabetical order.

(8) Effective date--A statement of the effective date requirements of various kinds of enrollees.

(9) Eligibility--A statement of the eligibility requirements for membership, including:

(A) that the subscriber must reside, live or work in the service area and the legal residence of any enrolled dependents must be the same as the subscriber, or the subscriber must reside, live or work

in the service area and the residence of any enrolled dependents must be:

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of such dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the health care of such dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of such dependents;

(iii) in the service area with the subscriber's spouse;

or

(iv) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

(B) the conditions under which dependent enrollees may be added to those originally covered;

(C) any limiting age for subscriber and dependents;

(D) a clear statement regarding the coverage of newborn children:

(i) No evidence of coverage may contain any provision excluding or limiting coverage for a newborn child of the subscriber or the subscriber's spouse.

(ii) Congenital defects must be treated the same as any other illness or injury for which coverage is provided.

(iii) The HMO may require that the subscriber notify the HMO during the initial 31 days after the birth of the child and pay any premium required to continue coverage for the newborn child.

(iv) An HMO shall not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency, or born in a non-network facility to a mother who does not have HMO coverage. The HMO may require that the newborn be transferred to a network facility at the HMO's expense and, if applicable, to a network provider when such transfer is medically appropriate as determined by the newborn's treating physician.

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 31 days following birth. The HMO shall allow an enrollee 31 days after the birth of the child to notify the HMO, either verbally or in writing, of the addition of the newborn as a covered dependent.

(E) a clear statement regarding the coverage of the enrollee's grandchildren up to the age of 25 under the conditions under which such coverage is required by Insurance Code Article 3.70-2, subsection (L) and Article 20A.09H (Children and Grandchildren).

(10) Emergency services--A description of how to obtain services in emergency situations including:

(A) what to do in case of an emergency occurring outside or inside the service area;

(B) a statement of any restrictions or limitations on out-of-area services;

(C) a statement that the HMO will provide for any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists in a hospital emergency facility or comparable facility;

(D) a statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition; and

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to such stabilization shall be provided to enrollees as approved by the HMO, provided that the HMO is required to approve or deny coverage of poststabilization care as requested by a treating physician or provider. An HMO shall approve or deny such treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case shall approval or denial exceed one hour from the time of the request.

(F) For purposes of this paragraph, "comparable facility" includes the following:

(i) any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics which have licensed and/or certified personnel and equipment to provide Advanced Cardiac Life Support (ACLS) consistent with American Heart Association (AHA) and American Trauma Society (ATS) standards of care;

(ii) for purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:

(I) a facility operated by the Texas Department of State Health Services;

(II) a private mental hospital licensed by the Texas Department of State Health Services;

(III) a community center as defined by the Texas Health and Safety Code, §534.001;

(IV) a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;

(V) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or

(VI) a hospital operated by a federal agency.

(11) Entire contract, amendments--A provision stating that the form, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

(12) Exclusions and limitations--A provision setting forth any exclusions and limitations on basic, limited, or single health care services.

(13) Grace period--A provision for a grace period of at least 30 days for the payment of any premium falling due after the first premium during which the coverage remains in effect. A charge may be added to the premium by the HMO for late payment received within the grace period. If payment is not received within the 30 days, coverage may be cancelled after the 30th day and the terminated members may be held liable for the cost of services received during the grace period, if this requirement is disclosed in the agreement.

(14) Incontestability:

(A) All statements made by the subscriber on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew an enrollee's coverage or reduce benefits unless:

(i) it is in a written enrollment application signed by the subscriber; and

(ii) a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.

(B) An individual contract may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application. A group certificate may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application. For small employer coverage, the misrepresentation shall be other than a misrepresentation related to health status.

(C) For a group contract or certificate, the HMO may increase its premium to the appropriate level if the HMO determines that the subscriber made a material misrepresentation of health status on the application. The HMO must provide the contract holder 31 days prior written notice of any premium rate change.

(15) Out-of-network services--Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, upon the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and shall fully reimburse the non-network provider at the usual and customary or an agreed rate.

(A) For purposes of determining whether medically necessary covered services are available through network physicians or providers, the HMO shall offer its entire network, rather than limited provider networks within the HMO delivery network.

(B) The HMO shall not require the enrollee to change his or her primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network.

(C) Each contract must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

(16) Schedule of charges--A statement that discloses the HMO's right to change the rate charged with 60 days written notice pursuant to Insurance Code Article 3.51-10.

(17) Service area--A description and a map of the service area, with key and scale, which shall identify the county, or counties, or portions thereof, to be served indicating primary care physicians, hospitals, and emergency care sites. A ZIP code map and a provider list may be used to meet the requirement.

(18) Termination due to attaining limiting age--A provision that a child's attainment of a limiting age does not operate to terminate the coverage of the child while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent upon the subscriber for support and maintenance.

The HMO may require the subscriber to furnish proof of such incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of such limiting age.

(19) Termination due to student dependent's change in status--Each group agreement and certificate that conditions dependent coverage for a child twenty-five years of age or older on the child's being a full-time student at an educational institution shall contain a provision in accordance with Insurance Code Article 21.24-2.

(20) Conformity with state law--A provision that if the agreement or certificate contains any provision not in conformity with the Act or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Act and other applicable laws.

(21) Conformity with Medicare supplement minimum standards and long-term care minimum standards--Each group, individual and conversion agreement and group certificate must comply with Chapter 3, Subchapter T of this title (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y of this title (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement rules and/or the long-term care rules and the HMO rules, the Medicare supplement rules or long-term care rules shall govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO shall follow both the Medicare supplement rules and/or the long-term care rules and the HMO rules where applicable.

(22) Nonprimary care physician specialist as primary care physician--A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to utilize a nonprimary care physician specialist as a primary care physician as set forth in Insurance Code Article 20A.09(g).

(23) Selected obstetrician or gynecologist--Individual, conversion and group agreements and certificates, except small employer plans as defined by Insurance Code Chapter 26, must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of Insurance Code Article 21.53D. An HMO shall not preclude an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO shall permit an enrollee who selects an obstetrician or gynecologist direct access to the health care services of the selected obstetrician or gynecologist without a referral by the enrollee's primary care physician or prior authorization or precertification from the HMO.

(B) The access to health care services of an obstetrician or gynecologist, includes:

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

(iv) diagnosis, treatment, and referral to a specialist within the HMO's network for any disease or condition within the scope of the selected professional practice of a properly credentialed

obstetrician or gynecologist, including treatment of medical conditions concerning breasts.

(C) An HMO may require an enrollee who selects an obstetrician or gynecologist to select the obstetrician or gynecologist from within the limited provider network to which the enrollee's primary care physician belongs.

(D) An HMO may require a selected obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. However, the HMO shall not impose any penalty, financial or otherwise, upon the obstetrician or gynecologist by the HMO for failure to provide this information if the obstetrician or gynecologist has made a reasonable and good faith effort to provide the information to the primary care physician.

(E) An HMO may limit an enrollee in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. Such limitation shall not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO shall include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in Insurance Code Article 21.53D. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from her primary care physician or primary care provider. Such enrollee shall have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) An enrollee that elects to receive obstetrical or gynecological services from a primary care physician (i.e., a family physician, internal medicine physician, or other qualified physician) shall adhere to the HMO's standard referral protocol when accessing other specialty obstetrical or gynecological services.

(24) Diagnosis of Alzheimer's disease--An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease by a physician licensed in this state pursuant to the Insurance Code Article 3.78 shall satisfy any requirement for demonstrable proof of organic disease.

(25) Drug Formulary--A group agreement and certificate, except small employer plans as defined by Insurance Code Chapter 26, that covers prescription drugs and uses one or more formularies must comply with Insurance Code Article 21.52J and Chapter 21, Subchapter V of this title (relating to Pharmacy Benefits).

(26) Inpatient care by non-primary care physician--If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (e.g., hospital or skilled nursing facility), a provision that upon admission to the inpatient facility a physician other than the primary care physician may direct and oversee the enrollee's care.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500523

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327

◆ ◆ ◆

SUBCHAPTER G. ADVERTISING AND SALES MATERIAL

28 TAC §11.602, §11.603

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the

commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500524

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327

◆ ◆ ◆
SUBCHAPTER I. FINANCIAL REQUIREMENTS

28 TAC §§11.801 - 11.803, 11.806, 11.810

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents

described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04

provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500525

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

28 TAC §§11.901, 11.902, 11.904

The amendments and new section are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care,

maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.901. Required Provisions.

(a) Physician and provider contracts and arrangements shall include provisions:

(1) regarding a hold harmless clause as described in Insurance Code §843.361:

(A) A hold harmless clause is a provision, as required by Insurance Code §843.361, in a physician or health care provider agreement that obligates the physician or provider to look only to the HMO and not its enrollees for payment for covered services (except as described in the evidence of coverage issued to the enrollee).

(B) In accordance with Insurance Code §843.002 relating to an "uncovered expense," if a physician or health care provider agreement contains a hold harmless clause, then the costs of the services will not be considered uncovered health care expenses in determining amounts of deposits necessary for insolvency protection under Insurance Code §843.405.

(C) The following language is an example of an approvable hold-harmless clause: (Physician/Provider) hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency, or breach of this agreement, shall (physician/provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than HMO acting on their behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments made in accordance with the terms of (applicable agreement) between HMO and subscriber/enrollee. (Physician/Provider) further agrees that:

(i) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee; and

(ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (physician/provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than 15 days after the commissioner has received written notice of such proposed changes;

(2) regarding retaliation as described in Insurance Code §843.281;

(3) regarding continuity of treatment, if applicable, as described in Insurance Code §843.309 and §843.362;

(4) regarding written notification to enrollees receiving care from a physician or provider of the HMO's termination of that physician or provider in accordance with Insurance Code §843.308 and §843.309;

(5) regarding written notification of termination to a physician or provider in accordance with Insurance Code §843.306 and §843.307:

(A) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days prior to the effective date of the termination;

(B) not later than 30 days following receipt of the written notification of termination, a physician or provider may request a review by the HMO's advisory review panel;

(C) within 60 days following receipt of the provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the physician or provider;

(6) regarding posting of complaints notice in physician/provider offices as described in Insurance Code §843.283. A representative notice that complies with this requirement may be obtained from the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104;

(7) regarding indemnification of the HMO as described in Insurance Code §843.310;

(8) regarding prompt payment of claims as described in Insurance Code Article 20A.09Z and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J (Payment of Claims to Physicians

and Providers) and Chapter 21, Subchapter T of this title (relating to Submission of Clean Claims) with respect to the payment to the physician or provider for covered services that are rendered to enrollees;

(9) regarding capitation, if applicable, as described in Insurance Code §843.315 and §843.316;

(10) regarding selection of a primary physician or provider, if applicable, as described in Insurance Code §843.315;

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

(A) This information must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider. At a minimum, the information must include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM codes and modifiers;

(I) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider; or

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

(ii) all applicable coding methodologies;

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

(iv) all applicable downcoding policies;

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

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

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

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

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

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

(E) Failure to comply with this paragraph constitutes a violation of Insurance Code Chapters 843 and 20A (Texas Health Maintenance Organization Act).

(F) Upon receipt of a request, the HMO must provide the information required by subparagraphs (A) - (D) of this paragraph to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.

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

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

- (I) the physician's or provider's practice management,
- (II) billing activities,
- (III) other business operations, or
- (IV) communications with a governmental agency involved in the regulation of health care or insurance;

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

(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(H) A physician or provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider shall provide for reasonable advance notice to enrollees being treated by the physician or provider prior to the termination consistent with Insurance Code §843.309.

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

(12) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish x-rays and non-prefabricated orthotics covered by the evidence of coverage; and

(13) regarding electronic health care transactions as set forth in §21.3701 of this title (relating to Electronic Health Care Transactions) if the contract requires electronic submission of any information described by that section.

(b) An HMO may require a contracting physician or provider to retain in the contracting physician or provider's records updated information concerning a patient's other health benefit plan coverage.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500526

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER K. REQUIRED FORMS

28 TAC §11.1001

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality

assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500527

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER N. HMO SOLVENCY SURVEILLANCE COMMITTEE PLAN OF OPERATION

28 TAC §§11.1301 - 11.1306

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other

business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500528

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER O. ADMINISTRATIVE PROCEDURES

28 TAC §§11.1401 - 11.1404

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K,

21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4,

provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500529

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER P. PROHIBITED PRACTICES

28 TAC §11.1500

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have

adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500530



SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §§11.1600 - 11.1602, 11.1604 - 11.1607

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and

maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

(a) An HMO shall provide an accurate written description of health care plan terms and conditions to allow any prospective contract holder or enrollee or current contract holder or enrollee to make comparisons and informed decisions before selecting among health care plans. By agreement, the HMO may deliver the required description of health care plan terms required by this section electronically.

(b) The written or electronic plan description must be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements), by category, and must include a clear, complete and accurate description of these items in the following order:

- (1) a statement that the entity providing the coverage is an HMO;
- (2) a toll-free number, unless exempted by statute or rule, and address for obtaining additional information, including provider information;
- (3) all covered services and benefits, including a description of the options (if any) for prescription drug coverage, both generic and brand name;
- (4) emergency care services and benefits, including coverage for out-of-area emergency care services and information on access to after-hours care;
- (5) out-of-area services and benefits (if any);
- (6) an explanation of enrollee financial responsibility for payment of premiums, copayments, deductibles, and any other out-of-pocket expenses for noncovered or out-of-plan services, and an explanation that network physicians and providers have agreed to look only

to the HMO and not to its enrollees for payment of covered services, except as set forth in this description of the plan;

(7) any limitations or exclusions, including the existence of any drug formulary limitations;

(8) any prior authorization requirements, including limitations or restrictions thereon, and a summary of procedures to obtain approval for, referrals to providers other than primary care physicians or dentists, and other review requirements, including preauthorization review, concurrent review, post service review, and post payment review, and the consequences resulting from the failure to obtain any required authorizations;

(9) provision for continuity of treatment in the event of the termination of a primary care physician or dentist;

(10) a summary of the complaint and appeal procedures of the HMO, a statement of the availability of the independent review process, and a statement that the HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO;

(11) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, updated on at least a quarterly basis. The list shall include the information necessary to fully inform prospective or current enrollees about the network, including names and locations of physicians and providers, a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network, and a disclosure of which physicians and providers will not accept new enrollees or participate in closed provider networks serving only certain enrollees.

(A) If an HMO limits enrollees' access to a limited provider network, it shall provide to prospective and current group contract holders and enrollees a notice in substantially the following form: "Choosing Your Physician--Now that you have chosen XYZ Health Plan, your next choice will be deciding who will provide the majority of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick and when you need preventive care such as immunizations. Your PCP is also part of a "network" or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer."

(B) If an HMO does not limit an enrollee's selection of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or provider belongs, it shall provide to current or prospective enrollees a notice in compliance with Insurance Code Article 21.53D in substantially the following form: "ATTENTION FEMALE ENROLLEES: You have the right to select an OB-GYN to whom you have access without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select

an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

(C) An HMO shall clearly differentiate limited provider networks and open networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. An HMO shall include an index of the alphabetical listing of all physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and shall indicate the limited provider network(s) to which the physician or provider belongs, and the page number where the physician or provider's name can be found.

(D) An HMO shall provide notice to enrollees informing them to contact the HMO upon receipt of a bill for covered services from any physician or provider. The notice shall inform enrollees of the method(s) for contacting the HMO for this purpose.

(E) An HMO that maintains an internet site shall include on its internet site the information as required in subparagraphs (A) - (D) of this paragraph.

(12) the service area.

(c) No HMO, or representatives thereof, may cause or knowingly permit the use or distribution of enrollee information which is untrue or misleading.

(d) An HMO may utilize its handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure as the written or electronic description prescribed by the commissioner and contains all the information required under subsection (b) of this section.

(e) If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (e.g., hospital or skilled nursing facility), the plan description must disclose that upon admission to the inpatient facility, a physician other than the primary care physician may direct and oversee the enrollee's care.

(f) An HMO that maintains an internet site shall list the information as required by subsection (b)(11) of this section and Insurance Code §843.2015 on its internet site. Such information shall be easily accessible from the home page of the site.

§11.1601. Enrollee Identification Cards.

(a) If an HMO issues identification (ID) cards to enrollees, the HMO shall issue the ID cards within 30 calendar days of receiving notice of the enrollee's selection of a primary care physician. The enrollee ID card will include, at a minimum, all necessary information to allow an enrollee to access all services under the certificate or evidence of coverage which require presentation of the card.

(b) All ID cards an HMO issues shall comply with the requirements of §21.2820 of this title (relating to Identification Cards).

(c) If an evidence of coverage provides benefits for prescription drugs, an HMO shall issue an ID card in compliance with §§21.3002 - 21.3004 of this title (relating to Definitions; Pharmacy Identification Cards, and Issuance of Standard Identification Cards).

(d) All ID cards issued by an HMO shall comply with the requirements of Business and Commerce Code Section 35.58, which restricts the display of social security numbers on ID cards.

§11.1605. Pharmaceutical Services.

(a) Should an HMO provide prescription drug coverage, such coverage shall be subject to copayments for both generic drugs and

name brand drugs. If the negotiated or usual or customary cost of the drug is less than the copayment, the enrollee shall pay the lower cost. The copayments may be the same, or if different, shall be applied as follows:

(1) if the prescription is for a generic drug, the enrollee shall pay no more than the generic copayment;

(2) if the prescription is for a name brand drug, the enrollee shall pay no more than the name brand copayment if:

(A) the prescription is written "Dispense as written"; or

(B) there is no generic equivalent for the prescribed drug;

(3) if the prescription is written "product selection permitted" and the enrollee elects to receive a name brand drug when a generic equivalent is available, the enrollee shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name brand drug.

(4) if the enrollee's prescription benefit requires the use of generic equivalent drugs ("required generic") and the enrollee receives a name brand drug when a generic equivalent is available, the enrollee shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name brand drug, even when the prescription is written "dispense as written."

(b) Pharmacy services, if offered, shall be available and accessible within the service area for the enrolled population through pharmacies licensed by the Texas State Board of Pharmacy. The HMO shall offer such pharmacy services directly or through contracts.

(c) An HMO that provides coverage for prescription drugs under an individual or group health benefit plan shall comply with the requirements of Insurance Code Article 21.53M, and §§21.3010 and §21.3011 of this title (relating to Definitions; Coverage of Off-Label Drugs and Minimum Standards of Coverage for Off-Label Drug Use).

(d) An HMO that provides coverage for prescription drugs or devices under an individual or group state-mandated health benefit plan shall comply with the requirements of Insurance Code Article 21.52L (Health Benefit Plan Coverage for Prescription Contraceptive Drugs and Devices and Related Services).

(e) An HMO that provides coverage for prescription drugs under a group state-mandated health benefit plan and that utilizes one or more drug formularies to specify which prescription drugs the plan will cover shall comply with the requirements of Insurance Code Article 21.52J and §§21.3020 - 21.3023 of this title (relating to Definitions; Prescription Drug Formulary, Required Disclosure of Drug Formulary, Continuation of Benefits, and Nonformulary Prescription Drugs; Adverse Determination).

§11.1607. Accessibility and Availability Requirements.

(a) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network which is adequate and complies with Insurance Code §843.082.

(b) There shall be a sufficient number of primary care physicians and specialists with hospital admitting privileges to participating facilities who are available and accessible 24 hours per day, seven days per week, within the HMO's service area to meet the health care needs of the HMO's enrollees.

(c) An HMO shall make general, special, and psychiatric hospital care available and accessible 24 hours per day, seven days per week, within the HMO's service area.

(d) If an HMO limits enrollees' access to a limited provider network, it must ensure that such limited provider network complies with the provisions of this section.

(e) An HMO shall make emergency care available and accessible 24 hours per day, seven days per week, without restrictions as to where the services are rendered.

(f) All covered services that are offered by the HMO shall be sufficient in number and location to be readily available and accessible within the service area to all enrollees.

(g) HMOs must arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis upon request and consistent with guidelines set out in paragraphs (1) - (3) of this subsection:

(1) Urgent care shall be available:

(A) within 24 hours for medical and dental conditions;

and

(B) within 24 hours for behavioral health conditions.

(2) Routine care shall be available:

(A) within three weeks for medical conditions;

(B) within eight weeks for dental conditions; and

(C) within two weeks for behavioral health conditions.

(3) Preventive health services shall be available:

(A) within two months for a child;

(B) within three months for an adult; and

(C) within four months for dental services.

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) 30 miles for primary care and general hospital care; and

(2) 75 miles for specialty care.

(i) If any covered health care service or a participating physician and provider is not available to an enrollee within the mileage radii specified in subsection (h)(1) and (2) of this section because physicians and providers are not located within such mileage radii, or if the HMO is unable to obtain contracts after good faith attempts, or physicians and providers meeting the minimum quality of care and credentialing requirements of the HMO are not located within the mileage radii, the HMO shall submit an access plan to the department for approval, at least 30 days before implementation in accordance with the filing requirements in §11.301 of this title (relating to Filing Requirements). The access plan shall include the following:

(1) the geographic area identified by county, city, ZIP code, mileage, or other identifying data in which services and/or physicians and providers are not available;

(2) for each geographic area identified as not having covered health care services and/or physicians or providers available, the reason or reasons that covered health care services and/or physicians and providers cannot be made available;

(3) a map, with key and scale, which identifies the areas in which such covered health care services and/or physicians and providers are not available;

(4) the HMO's plan for making covered health care services and/or physicians and providers available to enrollees in each geographic area identified;

(5) the names and addresses of the participating physicians and providers and a listing of the covered health care services to be provided through the HMO delivery network to meet the medical needs of the enrollees covered under the HMO's plan required under paragraph (4) of this subsection;

(6) the names and address of other physicians and providers and a listing of the specialties for any other health care services or physicians and providers to be made available in the geographic area in addition to those physicians and providers participating in the HMO delivery network listed under paragraph (5) of this subsection;

(7) the procedures to be followed by the HMO to assure that primary care physicians, general hospitals, specialists, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, or single or limited health care service providers and all other mandated health care services are made available and accessible to enrollees in the geographic areas identified as being areas in which such covered health care services and/or physicians and providers are not available and accessible, and any plans of the HMO for attempting to develop an HMO delivery network through which covered health care services are available and accessible to enrollees in these geographic areas in the future; and

(8) any other information which is necessary to assess the HMO's plan.

(j) The HMO may make arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level which is available within the HMO service area such as, but not limited to, transplants, treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive such services, unless the HMO provides the enrollee with a written explanation of the benefits and detriments of in-area and out-of-area options.

(k) The HMO shall not be required to expand services outside its service area to accommodate enrollees who live outside the service area, but work within the service area.

(l) In accordance with Insurance Code Article 21.53F (Telemedicine), each evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or a telemedicine medical service.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500531

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS

28 TAC §§11.1702 - 11.1704

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7

the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500532

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID

28 TAC §§11.1801 - 11.1806

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate

of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of

Insurance under the Insurance Code and other laws of this state.

§11.1806. Additional Information That May be Requested From an MCO Participating in Medicaid.

(a) Whenever requested by the department, the MCO shall file a complete set of financial exhibits pertaining to the state Medicaid program, in the format of the Managed Care Financial Statistical Report, as may be modified or amended by the Texas Health and Human Services Commission. When a request is received, the MCO shall then file, on two separate occasions, an original Managed Care Financial Statistical Report reflecting the state Medicaid program operations for each contract year in the same format as the monthly Managed Care Financial Statistical Report. These reports shall be in accordance with the instructions promulgated by the Health and Human Services Commission.

(b) For any new or modified request to the Texas Health and Human Services Commission for participation in the Medicaid managed care program, all financial projections, including enrollment projections, from the effective or renewal date of a Medicaid contract that are submitted to the Texas Health and Human Services Commission are also required to be submitted to the Texas Department of Insurance. The MCO shall submit the same financial projections, including a cash flow statement, submitted to the Texas Health and Human Services Commission with the request to participate in the Medicaid program. This information shall be submitted with the certificate of authority if the MCO is not already a licensed MCO. If the MCO is a licensed operation, then the financial projections must be sent with the next financial statement due to the department.

(c) The MCO shall notify the department of any similar financial or statistical reports required by other contracting state agencies and shall submit copies of these reports, when requested by the department.

(d) Information submitted pursuant to this section shall be sent to the Texas Department of Insurance, Financial Analysis & Examinations, Mail Code 303-1A, P.O. Box 149104, Austin, Texas 78714-9104.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500533

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER T. QUALITY OF CARE

28 TAC §11.1901, §11.1902

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper

administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized

form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.1902. Quality Improvement Program for Basic and Limited Services HMOs.

The QI program for basic and limited services HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program shall include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program shall include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status. The work plan shall include:

(A) Objective and measurable goals; planned activities to accomplish the goals; time frames for implementation; responsible individuals; and evaluation methodology.

(B) The work plan shall address each program area, including:

(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;

(ii) Continuity of health care and related services;

(iii) Clinical studies;

(iv) The adoption and periodic updating of clinical practice guidelines or clinical care standards; the QI program shall assure the practice guidelines:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services;

(v) Enrollee, physician, and individual provider satisfaction;

(vi) The complaint and appeals process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians, and providers from effectively making complaints against the HMO;

(vii) Preventive health care through health promotion and outreach activities;

(viii) Claims payment processes;

(ix) Contract monitoring, including delegation oversight and compliance with filing requirements;

(x) Utilization review processes;

(xi) Credentialing;

(xii) Member services; and

(xiii) Pharmacy services, including drug utilization.

(3) Evaluation. The QI program shall include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers, which includes the following elements, as applicable:

(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.

(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.

(i) The HMO shall credential all physicians and providers, including advanced practice nurses, and physician assistants, if they are listed in the provider directory. An HMO shall credential each physician or individual provider who is a member of a contracting group, such as an independent physician association or medical group.

(ii) Policies and procedures must include the following physicians' and providers' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) An HMO is not required to credential:

(I) hospital-based physicians or individual providers, including advanced practice nurses and physician assistants unless listed in the provider directory;

(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;

(III) students, residents, or fellows;

(IV) pharmacists; or

(V) opticians.

(iv) An HMO must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the physician or provider.

(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee's decision.

(vi) An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to Insurance Code §§843.306 - 843.309.

(vii) The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:

(I) Medicare and Medicaid sanctions: the HMO must determine the publication schedule or release dates applicable to its physician and provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;

(II) Information from state licensing boards regarding sanctions or licensure limitations; and

(III) Complaints.

(viii) The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients.

(ix) The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician's or provider's affiliation is suspended or terminated due to quality of care concerns.

(C) Initial credentialing process for physicians and individual providers shall include the following:

(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients from the HMO. This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.

(ii) The HMO shall verify the following from primary sources and shall include evidence of verification in the credentialing files:

(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.

(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the physician's or individual provider's schools and facilities,

evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the HMO must use the most recent available source.

(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them by any one of the following means:

- (-a-) copy of the DEA or DPS certificate;
- (-b-) visual inspection of the original certificate;
- (-c-) confirmation with DEA or DPS;
- (-d-) entry in the National Technical Information Service database; or
- (-e-) entry in the American Medical Association Physician MasterFile.

(iii) The HMO shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the physician's or individual provider's credentialing file the following:

(I) Past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain from the professional liability carrier or the National Practitioner Data Bank;

(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain from one of the following:

- (-a-) National Practitioner Data Bank;
- (-b-) Cumulative Sanctions Report available over the internet;
- (-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting HMOs;
- (-d-) state Medicaid agency or intermediary and the Medicare intermediary;
- (-e-) Federation of State Medical Boards;
- (-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General; or
- (-g-) entry in the American Medical Association Physician MasterFile.

(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual primary care provider, obstetrician-gynecologist, primary care dentist, and high-volume behavioral health physician or individual behavioral health provider as part of the initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume behavioral health physicians or individual behavioral health providers. If physicians or individual providers are part of a group practice that shares the same office, the HMO may perform one visit to the site for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment available to the department for review. The HMO shall have a process to track the relocation of and the opening of additional office sites for primary care physicians and individual primary care providers, obstetrician-gynecologists, primary

care dentists, and high-volume behavioral health physicians or individual behavioral health providers as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO shall determine whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing.

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current illegal drug use;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include the following processes:

(I) Reverification of the following from the primary sources:

(-a-) Licensure and information on sanctions or limitations on licensure;

(-b-) Board certification:

(-1-) if the physician or individual provider was due to be recertified; or

(-2-) if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recertified; and

(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:

(-1-) copy of the DEA or DPS certificate;

(-2-) visual inspection of the original certificate;

(-3-) confirmation with DEA or DPS;

(-4-) entry in the National Technical Information Service database; or

(-5-) entry in the American Medical Association Physician MasterFile.

(II) Review of updated history of professional liability claims in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for institutional providers shall include the following:

(i) Evidence of state licensure;

(ii) Evidence of Medicare certification;

(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from the Texas Department of Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are appropriate for different types of institutional providers. The HMO's written policies and procedures must state which national accrediting bodies it accepts; and

(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.

(F) The HMO procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (iv) of this paragraph.

(G) Under Insurance Code Article 20A.39, the standards adopted in this paragraph must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA) to the extent that those standards do not conflict with other laws of the state. Therefore, if the NCQA standards change and there is a difference between the standards specified in this paragraph and the NCQA standards, the NCQA standards shall prevail to the extent that those standards do not conflict with the other laws of this state.

(5) Site visits for cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing.

(A) If the HMO delegates credentialing functions to other entities, it shall have:

- (i) a process for developing delegation criteria and for performing pre-delegation and annual audits;
- (ii) a delegation agreement;
- (iii) a monitoring plan; and
- (iv) a procedure for termination of the delegation agreement for non-performance.

(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.

(C) The HMO shall maintain:

- (i) documentation of pre-delegation and annual audits;
- (ii) executed delegation agreements;
- (iii) semi-annual reports received from the delegated entities;
- (iv) evidence of evaluation of the reports;
- (v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and
- (vi) documentation of ongoing monitoring and shall make it available to the department for review.

(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.

(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500534

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

28 TAC §§11.2101 - 11.2103

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K,

21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4,

provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500535

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER W. SINGLE SERVICE HMOS

28 TAC §§11.2200, 11.2201, 11.2203, 11.2204, 11.2207, 11.2208

The amendments and new sections are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules

to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§11.2207. Quality Improvement Structure and Program for Single Service HMOs.

(a) A single service HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a QI committee (QIC) that shall include practicing physicians, individual providers and at least one enrollee from throughout the HMO's service area. For purposes of this section, the enrollee appointed to the committee may not be an employee of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet no less than annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC shall evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual providers, and enrollees from the service area.

(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services .

(B) All committees shall meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.

(d) The QI program for single service HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program shall include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program shall include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status, as applicable. The work plan shall include:

(A) Objective and measurable goals; planned activities to accomplish the goals; time frames for implementation; responsible individuals; and evaluation methodology.

(B) The work plan shall address each program area, including:

(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;

(ii) Continuity of health care and related services, as applicable;

(iii) Clinical studies;

(iv) The adoption and use of current professionally-recognized clinical practice guidelines, or, in the absence of current professionally-recognized clinical practice guidelines for

particular practice areas or conditions, those developed by the health plan that:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services.

(v) Enrollee, physician, and individual provider satisfaction;

(vi) The complaint and appeal process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians and providers from effectively making complaints against the HMO;

(vii) Preventive health care through health promotion and outreach activities:

(viii) Claims payment processes, as applicable;

(ix) Contract monitoring, including delegation oversight and compliance with filing requirements;

(x) Utilization review processes, as applicable;

(xi) Credentialing;

(xii) Member services; and;

(xiii) Pharmacy services, including drug utilization.

(3) Evaluation. The QI program shall include an annual report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers, which includes the following elements, as applicable:

(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.

(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.

(i) The HMO shall credential all physicians and providers including advanced practice nurses and physician assistants, if they are listed in the provider directory. An HMO shall credential each physician and individual provider who is a member of a contracting group, such as an independent practice association or medical group.

(ii) Policies and procedures must include the following physicians' and providers' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) An HMO is not required to credential:

(I) hospital-based physicians or individual providers, including advanced practice nurses and physician assistants unless listed in the provider directory;

(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;

(III) students, residents, or fellows;

(IV) pharmacists; or

(V) opticians.

(iv) An HMO must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the physician or provider.

(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee's decision.

(vi) An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to Insurance Code §§843.306 - 843.309.

(vii) The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:

(I) Medicare and Medicaid sanctions: the HMO must determine the publication schedule or release dates applicable to its physician and provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;

(II) Information from state licensing boards regarding sanctions or licensure limitations; and

(III) Complaints.

(viii) The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients.

(ix) The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician's or provider's affiliation is suspended or terminated due to quality of care concerns.

(C) Initial credentialing process for physicians and individual providers shall include the following:

(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients

from the HMO. This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.

(ii) The HMO shall verify the following from primary sources and shall include evidence of verification in the credentialing files:

(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.

(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the physician's or individual provider's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the HMO must use the most recent available source.

(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them by any one of the following means:

- (-a) copy of the DEA or DPS certificate;
- (-b) visual inspection of the original certificate;
- (-c) confirmation with DEA or DPS;
- (-d) entry in the National Technical Information Service database; or
- (-e) entry in the American Medical Association Physician MasterFile.

(iii) The HMO shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the physician's or individual provider's credentialing file the following:

(I) Past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain from the professional liability carrier or the National Practitioner Data Bank;

(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain from one of the following:

- (-a) National Practitioner Data Bank;
- (-b) Cumulative Sanctions Report available over the internet;
- (-c) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting HMOs;

(-d-) state Medicaid agency or intermediary and the Medicare intermediary;

(-e-) Federation of State Medical Boards;

(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General;

(-g-) entry in the American Medical Association Physician MasterFile.

(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual provider, obstetrician-gynecologist, primary care dentist, and high-volume behavioral health physician or individual provider as part of the initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume behavioral health physicians and individual providers. If physicians or individual providers are part of a group practice that shares the same office, the HMO may perform one visit to the site for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment available to the department for review. The HMO shall have a process to track the opening of new physician or individual provider offices. The HMO shall perform a site visit of each new office site of primary care physicians and individual providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual providers as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO shall determine whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing.

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current illegal drug use;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include the following processes:

(I) Reverification of the following from the primary sources:

(-a-) Licensure and information on sanctions or limitations on licensure;

(-b-) Board certification:

(-1-) if the physician or individual provider was due to be recertified; or

(-2-) if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recertified; and

(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:

(-1-) copy of the DEA or DPS certificate;

(-2-) visual inspection of the original certificate;

(-3-) confirmation with DEA or DPS;

(-4-) entry in the National Technical Information Service database; or

(-5-) entry in the American Medical Association Physician MasterFile.

(II) Review of updated history of professional liability claims, and sanction and restriction information from Medicare and Medicaid in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for institutional providers shall include the following:

(i) Evidence of state licensure;

(ii) Evidence of Medicare certification;

(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from Texas Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are appropriate for different types of institutional providers. The HMO's written policies and procedures must state which national accrediting bodies it accepts;

(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.

(F) The HMO's procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (iv) of this paragraph.

(G) Under Insurance Code Article 20A.39, the standards adopted in this paragraph must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA) to the extent that those standards do not conflict with other laws of the state. Therefore, if the NCQA standards change and there

is a difference between the standards specified in this paragraph and the NCQA standards, the NCQA standards shall prevail to the extent that those standards do not conflict with the other laws of this state.

(5) Site Visits for Cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing.

(A) If the HMO delegates credentialing functions to other entities, it shall have:

- (i) a process for developing delegation criteria and for performing pre-delegation and annual audits;
- (ii) a delegation agreement;
- (iii) a monitoring plan; and
- (iv) a procedure for termination of the delegation agreement for non-performance.

(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.

(C) The HMO shall maintain:

- (i) documentation of pre-delegation and annual audits;
- (ii) executed delegation agreements;
- (iii) semi-annual reports received from the delegated entities;
- (iv) evidence of evaluation of the reports;
- (v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and
- (vi) documentation of ongoing monitoring and shall make it available to the department for review.

(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.

(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.

§11.2208. *Single Health Care Services Accessibility and Availability.*

(a) A single health care service HMO that chooses to offer to an enrolled population a particular service shall comply with §11.1607(a) and (e) - (j) of this title (relating to Accessibility and Availability Requirements). Any single health care service shall be offered directly by the HMO or by contract.

(b) A sufficient number of participating single health care physicians or dentists or other individual providers with appropriate hospital or inpatient facility admitting privileges shall be available and accessible 24 hours per day, seven days per week, within the HMO's service area, to ensure availability and accessibility of care, including inpatient admissions and care, as appropriate.

(c) If a service offered by a single health care service HMO requires inpatient status for the management of a single health care condition the HMO shall provide for the appropriate inpatient facility according to the need by contracting with one or more general, or special hospitals; or home and community support services agencies for outpatient services.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500536
Brenda Caldwell
Special Regulatory Counsel
Texas Department of Insurance
Effective date: February 24, 2005
Proposal publication date: November 12, 2004
For further information, please call: (512) 463-6327



SUBCHAPTER X. PROVIDER SPONSORED ORGANIZATIONS

28 TAC §§11.2303, 11.2311, 11.2314

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section

843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500537

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER Y. LIMITED SERVICE HMOS

28 TAC §§11.2402, 11.2405, 11.2406

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the

commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500538

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER Z. POINT-OF-SERVICE RIDERS

28 TAC §§11.2501 - 11.2503

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper

administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized

form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500539

Brenda Caldwell

Special Regulatory Counsel

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



SUBCHAPTER AA. DELEGATED ENTITIES

28 TAC §11.2601, §11.2602

The amendments are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum

physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500540

Brenda Caldwell
Special Regulatory Counsel
Texas Department of Insurance
Effective date: February 24, 2005
Proposal publication date: November 12, 2004
For further information, please call: (512) 463-6327



CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

The Commissioner of Insurance adopts the repeal of Subchapter L, §11.1101 and §11.1102, concerning standard language for mandatory and other provisions; Subchapter Q, §11.1608, concerning other requirements; and Subchapter U, §§11.2001 - 11.2006, concerning services. The repeal of these sections is adopted without changes to the proposal published in the November 12, 2004, issue of the *Texas Register* (29 TexReg 10419).

The repeal of Subchapters L and U is necessary to streamline and improve the regulatory efficiency of Chapter 11. The provisions of Subchapters L and U have either been transferred to other subchapters and published elsewhere in this issue of the *Texas Register*, or deleted as unnecessary. The repeal of §11.1608 is necessary because many of its notice provisions are now included in adopted §11.1600(b)(11), published elsewhere in this issue of the *Texas Register*.

The purpose and objective of the repeal is to allow for the streamlining and adoption of amendments to Chapter 11. The repealed sections have either been incorporated into other provisions in Chapter 11 or deleted as unnecessary.

No comments were received.

SUBCHAPTER L. STANDARD LANGUAGE FOR MANDATORY AND OTHER PROVISIONS

28 TAC §11.1101, §11.1102

The repeal of the sections is adopted pursuant to the Insurance Code §§843.102, 843.151, and 36.001. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides the commissioner may adopt reasonable rules as necessary and proper to fully implement Insurance Code Chapters 843 and 20A, as well as the requirements of federal law and regulations. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Subchapter L. Standard Language for Mandatory and Other Provisions

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500543

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: February 24, 2005
Proposal publication date: November 12, 2004
For further information, please call: (512) 463-6327



SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §11.1608

The repeal of the section is adopted pursuant to the Insurance Code §§843.102, 843.151, and 36.001. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides the commissioner may adopt reasonable rules as necessary and proper to fully implement Insurance Code Chapters 843 and 20A, as well as the requirements of federal law and regulations. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500542

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: February 24, 2005
Proposal publication date: November 12, 2004
For further information, please call: (512) 463-6327



SUBCHAPTER U. SERVICES

28 TAC §§11.2001 - 11.2006

The repeal of the sections is adopted pursuant to the Insurance Code §§843.102, 843.151, and 36.001. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides the commissioner may adopt reasonable rules as necessary and proper to fully implement Insurance Code Chapters 843 and 20A, as well as the requirements of federal law and regulations. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2005.

TRD-200500541

Gene C. Jarmon

General Counsel and Chief Clerk

Texas Department of Insurance

Effective date: February 24, 2005

Proposal publication date: November 12, 2004

For further information, please call: (512) 463-6327



TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 17. TEXAS STATE SOIL AND WATER CONSERVATION BOARD

CHAPTER 518. GENERAL PROCEDURES SUBCHAPTER B. HISTORICALLY UNDERUTILIZED BUSINESS PROGRAM

31 TAC §518.5

The Texas State Soil and Water Conservation Board (State Board) adopts new 31 TAC §518.5 concerning the Historically Underutilized Business (HUB) Certification Program. Adoption is without change from the proposed text as published in the December 17, 2004 issue of the *Texas Register* (29 TexReg 11561). The text of the rule will not be republished.

This new rule adopts by reference the rules of the Texas Building and Procurement Commission in 1 TAC §§111.11-111.28, as amended, and is adopted to guide this agency in the implementation of a HUB program.

No comments were received regarding the adoption of this rule.

The new rule is adopted under §201.020, Agriculture Code, which authorizes the State Board to adopt rules that are necessary for the performance of its functions under the Agriculture Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 3, 2005.

TRD-200500495

Mel Davis

Special Projects Coordinator

Texas State Soil and Water Conservation Board

Effective date: February 23, 2005

Proposal publication date: December 17, 2004

For further information, please call: (254) 773-2250



TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 3. TEXAS YOUTH COMMISSION

CHAPTER 91. PROGRAM SERVICES SUBCHAPTER D. HEALTH CARE SERVICES

37 TAC §91.94

The Texas Youth Commission (the commission) adopts new §91.94, Automated External Defibrillators with changes to the proposed text as published in the December 10, 2004, issue of the *Texas Register* (29 TexReg 11461). Changes to the proposed text were made in response to the public comments listed below.

The justification for the new rule is to provide for the emergency medical care of commission staff and youth.

The new rule will establish guidelines for the operation and training requirements associated with the use of an Automated External Defibrillator to aid in an emergency response to a sudden cardiac arrest which occurs at a commission facility, a District office, or the Central/Annex office.

The commission received comments from the American Red Cross (ARC) regarding the proposed new rule. The comments are summarized below, followed by the commission's response.

Comment: Regarding subsection (f)(1), a recommendation was made to Call 9-1-1 or the local emergency number, and include notification that an AED is available.

Response: The commission has operational procedures for the commission's facilities regarding life-threatening emergencies. In the event of a life-threatening emergency, the individual who discovers or is first notified of the emergency will call for help via radio or telephone to the gatehouse/control center staff and state "CODE BLUE/Call 911" and state the location and nature of the 911 emergency. The gatehouse/control center staff hearing the "CODE BLUE/Call 911" will immediately call for an ambulance and include notification that an AED is available for use. Control center staff will immediately call "CODE BLUE" via the radio and will then call the infirmary, security and the superintendent or administrator on duty. The protocol for Central, District and Annex offices is to directly call 911. The commission has determined not to make the recommended change, based on current practice.

Comment: Regarding subsection (f)(2), a recommendation was made to delete the word "begin" and insert the word "early" to be consistent with (f)(3).

Response: The commission does not agree with the recommendation to insert the word "early" to subsection (f)(2). If an individual is in sudden cardiac arrest, CPR should begin immediately rather than early. The commission made no changes to the rule in response to the recommendation.

Comment: Regarding subsection (f)(4), the comment expressed that Advanced Cardiac Life Support is a specific course taught by the American Heart Association (AHA). The recommendation is to name the fundamentals, which may be covered in similar courses.

Response: The commission agrees using the Advance Cardiac Life Support language is too specific, in that it refers to a course taught by the AHA, which was not the intent of the Cardiac Chain of Survival procedure. The commission's intention was to include language that reflected AHA or similar courses in how to prepare an individual to perform advanced medical care; therefore, the commission amends the proposed subsection (f)(4) to read *facilitate access to advanced medical care*.

Comment: Regarding subsection (f)(4), the comment expressed the preferred terminology for "has no pulse" is "shows no signs of circulation". The recommendation is to change the sentence to read, "The AED is to be used only if the person is unresponsive and shows no sign of circulation".

Response: The commission does not agree with the recommendation. The lay terminology for "shows no signs of circulation" is one that "has no pulse". The commission made no changes to the rule in response to the recommendation.

Comment: Regarding subsection (g)(2), the comment recommended that the commission consider equipping the AEDs with pediatric pads.

Response: The commission's youth population averages 17 years old (with ten (10) being the youngest). The commission facilities receive a small percentage of visitors who are under the age of eight. The commission believes these factors do not warrant the inclusion of pediatric pads on TYC residential facilities and administrative offices. No amendments were made to the rule in response to the comment.

Comments: Regarding subsection (h)(1), the comment expressed a concern that the first sentence was unclear as to its purpose and the second sentence is redundant with the first sentence regarding TYC direct care staff training requirements.

Response: The commission agrees with ARC comment regarding the duplication of training requirements for all TYC direct care staff in both sentences. The commission has made an amendment to subsection (h)(1) to read, "AED training is incorporated into the ARC training. All TYC direct care staff are required to be trained annually by a qualified CPR/First Aid/AED TYC trainer or a qualified contracted trainer".

Comment: Regarding subsection (h)(2), the comment expressed that non-direct care staff should not be expected to be users of the AEDs, and watching a training video without a practical skill component is not considered to be a sufficient "training" experience. The ARC recommends the alternative language "All TYC non-direct care staff working in TYC facilities that house youth, designated District offices, and Central office/Annex are required to watch the AED training video at least once annually. The ARC encourages all staff to learn about the Chain-of-Survival and the importance of early recognition of sudden cardiac arrest and immediate notification of emergency medical services.

Response: The commission's General Counsel, with consultation from the commission's Medical Director, has determined the video training for all non-direct care staff is sufficient training for the usage of the AED. The risk of misusing the AED equipment is far less than the potential harm caused by not using the AED in a sudden cardiac arrest situation. The commission made no changes in response to the recommendation.

Comment: Regarding subsection (i)(4)(B), a recommendation was made that scissors should be blunt-tipped in order to prevent additional injury.

Response: The commission agrees with the recommendation. Therefore, an amendment has been made in subsection (i)(4)(B) to read "trauma shears or blunt-tipped (safety) scissors;"

Comment: Regarding (i)(4)(F), the comment noted that "Pocket Mask" is a specific name brand, and the correct terminology is a CPR breathing barrier or a resuscitation mask.

Response: The commission did not intend to limit the mask to a single brand. To broaden the type of breathing barriers, the commission amends the proposed subsection to read "CPR breathing barrier or resuscitation mask;"

Comment: Regarding subsection (i)(4)(G), the comment expressed concern that some individuals may have latex allergies, therefore, the ARC recommends having non-latex gloves available. Also, multiple pairs of gloves should be available for the responder(s) to use.

Response: The commission does not agree that non-latex and latex gloves should be stored together with the AED equipment. The commission has determined that the risk of providing multiple types of gloves (non-latex and latex) could cause confusion and potentially delay an already-crisis situation. The commission made no changes in response to the recommendation.

Comment: In addition to the items listed under subsection (i), ARC is recommending to have a spare battery for the AED available. The recommendation is to insert a new subparagraph (H) to subsection (i)(4) with the following language "spare battery for the AED".

Response: The commission has determined that a spare battery is not necessary, in that, the AED has a rechargeable battery with a four-year life span. Therefore, the commission made no changes in response to the recommendation.

The new rule is adopted under the Human Resources Code, §61.045, which provides the commission with the authority to adopt rules that provide for the welfare of the youth in its care.

The adopted rule implements the Human Resources Code, §61.034.

§91.94. Automated External Defibrillators.

(a) Purpose. The purpose of this policy is to establish procedures and guidelines for the operation, storage, and maintenance, and training requirements associated with the use of Automated External Defibrillators (AEDs). It is Texas Youth Commissions (TYC's) objective to provide immediate emergency response to a sudden cardiac arrest that occurs at a TYC-operated facility, designated TYC district offices, and Central Office/Annex.

(b) Applicability.

(1) This rule applies to employees at TYC-operated facilities, designated district offices, and Central Office/Annex.

(2) The use of AEDs applies to TYC youth, staff, volunteers, visitors, and contractors.

(c) Explanation of Terms Used.

(1) Automated External Defibrillator (AED)--a United States Food and Drug Administration (FDA) approved electronic device, about the size of a laptop computer, which is programmed to analyze the heart's rhythm for any abnormalities and, if necessary, directs the rescuer to deliver an electrical shock (defibrillation) to assist the heart in reestablishing a normal rhythm.

(2) Cardiac Arrest--a malfunction in the heart's electrical system (ventricular fibrillation or rapid ventricular tachycardia) that may cause the heart to stop suddenly.

(3) Myocardial Infarction--death of heart muscle tissue caused by lack of blood supply to the heart due to plaque or blood clot.

(d) The TYC Medical Director authorizes the acquisition of AEDs at TYC-operated facilities, designated District offices, and Central Office/Annex.

(e) Upon acquiring an AED, the chief local administrator or designee shall notify the local EMS provider of the existence, location, and type of AED.

(f) Cardiac Chain of Survival. Cardiac chain of survival is the current treatment for sudden cardiac arrest that includes the following four steps:

- (1) Call 911 or facility gatehouse/control center and include notification that an AED will be used;
- (2) begin Cardiopulmonary Resuscitation (CPR);
- (3) provide early defibrillation; and
- (4) facilitate access to advanced medical care.

(g) Restrictions for Use.

(1) The AED is to be used only if the person is unresponsive and has no pulse.

(2) The AED is to be used only on persons over the age of eight (8) years old.

(3) The AED will provide voice prompts giving further instructions if it cannot read the cardiac rhythm due to improper electrode placement, motion of the person, low battery, or electromagnetic interference, etc.

(4) The AED voice prompt will not instruct the user to shock the person if the person's cardiac rhythm does not warrant a shock or if the person's cardiac rhythm suddenly changes and shock is no longer indicated.

(5) The AED voice prompts will not advise the user to shock the person if the person is experiencing a myocardial infarction.

(h) AED Training.

(1) AED training is incorporated into the American Red Cross CPR/First Aid training required for all TYC direct care staff. All TYC direct care staff are required to be trained annually by a qualified CPR/First Aid/AED TYC trainer or a qualified contracted trainer.

(2) All TYC non-direct care staff working in TYC facilities that house youth, designated district offices, and Central Office/Annex are required to watch the AED training video at least once annually, and the training will be documented and maintained by the local training officer.

(3) The AED training program is approved by the TYC Medical Director and the Texas Department of Health in accordance with the Health & Safety Code, Chapter 779.

(i) General Requirements.

(1) At no time shall a TYC youth be accessible to the AED.

(2) Each TYC-operated facility that houses youth, designated TYC district offices, and Central Office/Annex will have an AED on-site. Al Price State Juvenile Correctional Facility, Ron Jackson State Juvenile Correctional Complex, and McLennan County State Juvenile Correctional Facility will have two AEDs on-site (one for each unit and one for the medical dorm).

(3) The AED should be stored in a protective case at all times. The storage area is free from water, dirt, extreme cold (less than 32 degrees F), and extreme heat (over 100 degrees F).

(4) The following equipment should be stored with each AED:

- (A) carrying case;

(B) trauma shears or blunt-tipped (safety) scissors;

(C) defibrillation pads (2 sets; each facility/district office will keep on hand an additional set of AED replacement pads);

(D) razor;

(E) towel;

(F) CPR breathing barrier or resuscitation mask; and

(G) latex disposable gloves.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2005.

TRD-200500444

Dwight Harris

Executive Director

Texas Youth Commission

Effective date: February 21, 2005

Proposal publication date: December 10, 2004

For further information, please call: (512) 424-6301

◆ ◆ ◆

TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 12. TEXAS BOARD OF OCCUPATIONAL THERAPY EXAMINERS

CHAPTER 372. PROVISION OF SERVICES

40 TAC §372.1

The Texas Board of Occupational Therapy Examiners adopts amendments to §372.1, concerning Provision of Services without changes to the proposed text as published in the November 26, 2004, issue of *Texas Register* (29 TexReg 10904) and will not be republished.

The section was amended to add clarification of the rules.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Occupational Therapy Practice Act, Title 3, Subchapter H, Chapter 456, Occupations Code, which provides the Texas Board of Occupational Therapy Examiners with the authority to adopt rules consistent with this Act to carry out its duties in administering this Act.

Title 3, Subchapter H, Chapter 454 of the Occupations Code is affected by this amended section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500553

John Maline
Executive Director
Texas Board of Occupational Therapy Examiners
Effective date: February 27, 2005
Proposal publication date: November 26, 2004
For further information, please call: (512) 305-6900



CHAPTER 373. SUPERVISION

40 TAC §373.3

The Texas Board of Occupational Therapy Examiners adopts amendments to §373.3, concerning Supervision of a Licensed Occupational Therapy Assistant with changes to the proposed text as published in the November 26, 2004, issue of *Texas Register* (29 TexReg 10904).

The section was amended to add clarification of the rules.

No comments were received regarding adoption of the amendment.

The amendment is proposed under the Occupational Therapy Practice Act, Title 3, Subchapter H, Chapter 456, Occupations Code, which provides the Texas Board of Occupational Therapy Examiners with the authority to adopt rules consistent with this Act to carry out its duties in administering this Act.

Title 3, Subchapter H, Chapter 454 of the Occupations Code is affected by this amended section.

§373.3. *Supervision of a Licensed Occupational Therapy Assistant.*

(a) Supervision of a full time employed COTA or LOTA by the OTR or LOT includes:

(1) A minimum of six hours a month of frequent communication between the supervising OTR(s) or LOT(s) and the COTA or LOTA by telephone, written report, email, conference etc., including review of progress of patient's/client's assigned, plus

(2) A minimum of two hours of supervision a month of face-to-face, real time interaction with the OTR(s) or LOT(s) observing the COTA or LOTA providing services with patients/clients.

(b) Licensees working part-time or less than a full month within a given month may pro-rate these hours, but shall document no less than four hours of supervision per month, one hour of which includes face-to-face, real time interaction by the OTR(s) and LOT(s) observing the COTA or LOTA providing services with patients/clients. Those months where the licensee does not work, he or she shall write N/A in the COTA Supervision Log for that month.

(c) COTAs or LOTAs with more than one employer must have a supervisor at each job whose name is on file with the board and must receive supervision by an OTR or LOT, as outlined for part-time employment in this section.

(d) The COTA or LOTA must include the name of the supervising OTR or LOT in each patient's treatment note.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 7, 2005.

TRD-200500554

John Maline
Executive Director

Texas Board of Occupational Therapy Examiners
Effective date: February 27, 2005

Proposal publication date: November 26, 2004

For further information, please call: (512) 305-6900



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: 1 TAC §373.209(d)(5)

Type of Heir	Family Members, If Living in the Heir's Household
Adult 18 years of age or older, or individual younger than 18 years of age and legally emancipated	Heir Heir's spouse Heir's biological or legally adopted minor children or stepchildren under age 18
Individual younger than 18 years of age and not legally emancipated	Heir Heir's parent (s) Heir's stepparent Heir's minor siblings residing in the household, including half-, step-, and legally adopted siblings under age 18

Figure: 22 TAC §661.99(6)

Citation	Violation	Sanction on a First Offense
§1071.251(b)	Engaging in the practice of professional land surveying without registration	Injunction/1500
§1071.251(c)	Offering to practice professional land surveying without registration	Injunction/1500
§1071.251(d)	Using a title or advertising a title or description that tends to convey the impression that a non registered/licensed person is a professional land surveyor	Injunction/1500
§1071.261(a)	Failure to display the certificate or license at a person's place of business or practice	Reprimand/100
§1071.263(a)	The practice of professional surveying while license has been placed on Inactive Status	Revocation/1500
§1071.351(b)	Failure to secure an impression seal (§661.46)	Reprimand/100
§1071.351(d)	Application of name, seal or certification to surveying work that is not prepared by registrant/licensee or full time employee supervised by registrant/licensee	Revocation/1500
§1071.351(e)	Allowing a non registrant/licensee to exert control over surveying work	Revocation/1500
§1071.352(a)	Offering surveying services with no RPLS employed full-time where the services are offered	Injunction/1500 Reprimand/1500
§1071.352(b)	Failure of group practice to properly identify the registrant responsible for the practice	Injunction/1500 Reprimand/1500
§1071.353	Failure to file notice of assumed name	Reprimand/100
§1071.359(a)	Failure to sign and notate "Licensed State Land Surveyor"(LSLS) on all LSLS official field notes	Reprimand/100
§1071.359(b)	Failure to conform LSLS field notes and plats to specifications contained in Section 21 of the Natural Resources Code	Reprimand/100
§1071.360(1) and (2)	Failure of the LSLS to notify person who has undisclosed public land enclosed and/or forward a report of undisclosed public land and the acreage to the commissioner	Reprimand/100
§1071.361(a)	Failure to allow LSLS access to County Surveyor's records	Reprimand/1500
§1071.361(c)	Failure to comply with any regulations prescribed by the county surveyor or the commissioners court for protecting and preserving the records	Reprimand/1500
§1071.401(a)(1)	Fraud or deceit in obtaining a certificate or license	Revocation/1500
§1071.401(a)(2)	Gross negligence, incompetence, or misconduct in the practice of surveying	Revocation/1500
§1071.401(a)(3)	Violation of the Act or Board Rule	Revocation/1500
§1071.401(b)	LSLS directly or indirectly interested in the purchase or acquisition of title to public land	Revocation/1500

Citation	Violation	Sanction on a First Offense
§1071.504(1)	Engaging or offering land surveying services without being registered/licensed	Injunction/1500
§1071.504(2)	Presents or attempts to use another person's certificate, license or seal	Revocation/1500 Injunction/1500
§1071.504(3)	Giving false or forged evidence to obtain or assist another in obtaining a registration/license	Revocation/1500
§661.45(f)	Actions to compromise the examination	Disqualification/1500
§661.45(g)	Deception and/or cheating on an examination	Disqualification/1500
§661.46	Failure to secure an impression seal and submit impression to the Board	Reprimand/100
§661.60	Failure to respond to Board inquiries/orders	Reprimand/1500
§661.95	Failure to attend hearing	Default Judgment
§661.121	Firms failure to employ a full-time RPLS	Injunction/1500
§663.1(c)	Failure to notify the Board of any change of mailing address as it occurs	Reprimand/100
§663.1(d)	Failure to notify consumers of the name, mailing address, and phone number of the Board	Reprimand/100
§663.3(1)	Failure to accurately and truthfully represent ones capabilities and qualifications	Reprimand/100
§663.3(2)	Performing services for which he/she is not qualified	Reprimand/100
§663.3(3)	Evading statutory responsibility to client or employer	Reprimand/100
§663.4(1)	Performing surveying services if there exists any financial or other interest that may be in conflict with the obligation to render a faithful discharge of such services	Reprimand/1500
§663.4(4)	Failure to withdraw from employment at any time during such employment or engagement when it becomes apparent that it is not possible to faithfully discharge the duty and performance of services owned the client or employer	Reprimand/1500
§663.4(5)	Accepting remuneration from any party other than his/her client or employer for a particular project nor have any other direct or indirect financial interest in other services or phase of service to be provided for such project	Reprimand/1500
§663.4(6)	Failure to keep inviolate the confidences of his/her client or employer	Reprimand/1500
§663.5	Failure to perform work with integrity, truthfulness and accuracy Misleading the public	Reprimand/1500
§663.5(1)	Allowing a person who is not registered or licensed to exert control over professional work	Reprimand/1500
§663.5(2)	Indulging in publicity that is false, misleading or deceptive	Reprimand/100

Citation	Violation	Sanction on a First Offense
§663.5(3)	Misrepresenting the amount or extent of prior education or experience to any employer, client, or the board	Reprimand/100
§663.5(5)	Representing themselves as being engaged in a partnership or association when no partnership or association exists	Reprimand/100
§663.5(6)	Recommend to a client services of another for the purpose of collecting a fee for himself, without the knowledge and consent of client	Reprimand/100
§663.6(1)	Failure to make known to the board any unauthorized practice of which the registrant has personal knowledge	Reprimand/100
§663.6(2)	Failure to divulge any information, of which the registrant has personal knowledge, related to any unauthorized practice to the board upon request	Reprimand/100
§663.6(3)	Delegate responsibility to, nor aid or abet, an unauthorized person to practice or offer to practice	Reprimand/1500
§663.8(1)	Failure to abide by and conform to the registration and licensing laws of the state	Reprimand/1500
§663.8(2)	Failure to abide by and conform to the provisions of the state code and all local codes and ordinances	Reprimand/1500
§663.8(4)	Signing or impressing ones seal or stamp upon documents not prepared by him/her or knowingly permit ones seal or stamp to be used by any other person	Reprimand/1500
§663.8(5)	Submitting a request or a competitive bid to perform professional surveying services for a governmental entity or political subdivision of the State of Texas unless specifically authorized by state law	Reprimand/100
§663.9(a)	Offering or promising to pay any commission, contribution, gift, favor, gratuity, or reward as an inducement to secure any specific work without full disclosure to all interested parties	Reprimand/100
§663.9(b)	Making, publishing or cause to be made or published any representation or statement concerning ones professional qualifications or those of his/her partners or associates that is misleading	Reprimand/100
§663.9(c)	Failure to have personal knowledge of documents, plats, maps or reports that bear the surveyor's seal or signature	Reprimand/1500
§663.10(1)	Violating any provision of the Act or Rules	Reprimand/100

Citation	Violation	Sanction on a First Offense
§663.10(2)	Circumventing or attempting to circumvent any provision of the Act or Rules	Reprimand/1500
§663.10(3)	Participate in any plan, scheme or arrangement attempting to or having as its purpose the evasion of any provision of the Act or Rules	Reprimand/1500
§663.10(4)	Failure to exercise reasonable care or diligence to prevent his/her partners, associates or employees from engaging in conduct which, if done by him/her, would violate any of the provisions of the Act or Rules	Reprimand/1500
§663.10(5)	Engaging in any conduct that discredits or attempts to discredit the profession of surveying	Reprimand/100
§663.10(6)	Permit or allow ones professional identification, seal, form, business name or service to be used or made use of to make it possible to create the opportunity for the unauthorized practice of professional surveying by any person, firm or corporation	Reprimand/1500
§663.10(7)	Allowing an omission or making an assertion or representation that is fraudulent, deceitful or misleading or tends to create a misleading impression	Reprimand/1500
§663.10(8)	Aid or abet any unlicensed person in connection with the authorized practice of professional surveying or any firm or corporation in the practice of professional surveying unless carried on in accordance with the Act	Reprimand/1500
§663.11	Failure to set or leave as found markers to represent or reference boundary corners, angle points and points of curvature or tangency. Failure to show and describe the locations of such markers on the plat	Reprimand/1500
§663.11(1)	Failure to reference and describe the survey markers as shown on the plat	Reprimand/1500
§663.11(2)	Failure to seal and sign the plat	Reprimand/1500
§663.15(a)	Failure to achieve a positional tolerance of 1:10,000 + 0.10 feet within the corporate city limits	Reprimand/1500
§663.15(b)	Failure to achieve a positional tolerance of 1:7,500 +0.10 feet within the extraterritorial jurisdiction (ETJ) of any city	Reprimand/1500
§663.15(c)	Failure to achieve a positional tolerance of 1:5,000 + 0.10 feet in rural areas outside ETJ	Reprimand/1500
§663.15(d)	Failure to report areas to the least significant number compatible with the precision of closure	Reprimand/100

Citation	Violation	Sanction on a First Offense
§663.15(e)	Failure to use equipment and methods of practice capable of attaining the tolerances specified	Reprimand/1500
§663.16(a)	Failure to delineate a property or boundary line as an integral portion of a survey. Failure to respect junior/senior property rights, footsteps of the original surveyor, intent of the parties involved, the proper application of the rules of dignity or the priority of calls, and applicable statutory and case law of Texas	Reprimand/1500
§663.16(b)	Failure to rely upon appropriate deeds and/or other documents including those for adjoining parcels, for the location of the boundaries of the subject parcel(s)	Reprimand/1500
§663.16(c)	Failure to assume the responsibility for such research of adequate thoroughness to support the determination of the location of intended boundaries of the land parcel surveyed	Reprimand/1500
§663.16(d)	Failure to connect all boundaries to identifiable physical monuments related to corners of record dignity. In the absence of such monumentation, failure to report the surveyor's opinion of the boundary location by other appropriate physical evidence	Reprimand/1500
§663.17(a)	Failure to set monuments at sufficient depths to retain a stable and distinctive location or be of sufficient size to withstand the deteriorating forces of nature or be of such material that in the surveyor's judgment will best achieve this goal	Reprimand/1500
§663.17(b)	Failure to set, or leave as found, sufficient, stable and reasonably permanent survey markers to represent or reference the property or boundary corners, angle points, and points of curvature or tangency. Failure to show and describe survey markers with sufficient evidence of the location of such markers on the surveyors' plat	Reprimand/1500
§663.17(b)(1)	Failure to reference a description of survey markers shown on the plat, when written reports are filed in compliance with §663.17(b)	Reprimand/1500
§663.17(b)(2)	Failure to apply seal and signature to written reports when filed in compliance with §663.17(b)	Reprimand/100
§663.17(d)	Failure to mark, in a way that is traceable, all monuments; when practical	Reprimand/100
§663.18(a)	Failure to apply surveyor's seal to all documents representing professional surveying	Reprimand/100

Citation	Violation	Sanction on a First Offense
§663.18(c)	When preparing preliminary documents, failure to identify the purpose of the document, the surveyor of record and the surveyor's registration number, and the release date. Failure to note the following statement in the signature space: "Preliminary, this document shall not be recorded for any purpose"	Reprimand/1500
§663.19(1)	Failure to delineate the relationship between record monuments and the location of boundaries surveyed. Failure to show such relationship on the survey plat, if a plat is prepared, and/or separate report and failure to recite such in the description with the appropriate record referenced thereon and therein	Reprimand/1500
§663.19(2)	Failure to provide a definite and unambiguous identification of the location of boundaries and describe all pertinent monuments found or placed for descriptions prepared for defining boundaries	Reprimand/1500
§663.19(3)	Failure to prepare the plat to a convenient scale and provide a definite and unambiguous representation of the location of the surveyed land according to its record description	Reprimand/1500
§663.19(3)(A) and (B)	Where material discrepancies are found between the record and conditions discovered, failure to apprise the client with a specific reference to discrepancy on the plat or a report of survey or other written notice	Reprimand/1500
§663.19(4)	Failure to reference courses by notation upon the survey plat to an identifiable line for directional control	Reprimand/1500
§663.19(5)	Failure to note the firm name, surveyor's name, address, and phone number of the land surveyor responsible for the land survey, his/her official seal, his/her original signature and date surveyed on the plat	Reprimand/1500
§663.19(6)	Failure to note, upon the survey plat, which boundary monuments were found or placed by the surveyor and failure to note controlling monuments to which the survey may be referenced	Reprimand/1500
§663.19(7)	Failure to cite a reference on the plat to the record instrument that defines the location of adjoining boundaries	Reprimand/1500
§663.19(9)	If any report consists of more than one part, failure to note the existence of the other part or parts	Reprimand/1500

Citation	Violation	Sanction on a First Offense
§663.20(a)(1)	Failure of the registrant to notify the Board in writing within 90 days of any felony or misdemeanor conviction	Reprimand/1500
§663.20(a)(2)	Failure of an applicant to state if he/she has ever been convicted of a felony or misdemeanor	Application Rejected Revocation
§663.20(a)(3)	Failure of the registrant/applicant to provide a summary of the conviction in sufficient detail to allow the Board to determine if it is applicable to the practice of land surveying	Application Rejected Revocation
§663.21(1)	Falsifying the recipient or purpose of a metes and bounds description when preparing a description for a Political Subdivision	Reprimand/1500
§663.21(2)	Preparing a description for a Political Subdivision that is ambiguous and non-locatable on the ground by ordinary surveying procedures	Reprimand/1500
§663.21(3)	Failure to place and describe record monuments or physical monuments called for in the description prepared for a Political Subdivision	Reprimand/1500
§663.21(4)	Failure to perform an on the ground survey for any course and distance recited in the description when such is not referenced in a recited record	Reprimand/1500
§663.21(5)	Failure to place the required notation on descriptions prepared for Political Subdivisions	Reprimand/1500

IN

ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Automobile Theft Prevention Authority

Request for Applications Under the Automobile Theft Prevention Authority Fund

Notice of Invitation for Applications:

The Automobile Theft Prevention Authority is soliciting applications for grants to be awarded for projects under the Automobile Theft Prevention Authority (ATPA) Fund. This grant cycle will be one year in duration, and will begin on September 1, 2005. One or more of the following types of projects may be awarded, depending on the availability of funds:

Law Enforcement/Detection/Apprehension Projects, to establish motor vehicle theft enforcement teams and other detection/apprehension programs. Priority funding may be provided to state, county, precinct commissioner, general or home rule cities for enforcement programs in particular areas of the state where the problem is assessed as significant. Enforcement efforts covering multiple jurisdictional boundaries may receive priority for funding.

Prosecution/Adjudication/Conviction Projects, to provide for prosecutorial and judicial programs designed to assist with the prosecution of persons charged with motor vehicle theft offenses.

Prevention, Anti-Theft Devices and Automobile Registration Projects, to test experimental equipment which is considered to be designed for auto theft deterrence and registration of vehicles in the Texas Help End Auto Theft (H.E.A.T.) Program.

Reduction of the Sale of Stolen Vehicles or Parts Projects, to provide vehicle identification number labeling, including component part labeling and etching methods designed to deter the sale of stolen vehicles or parts.

Public Awareness and Crime Prevention/Education/Information Projects, to provide education and specialized training to law enforcement officers in auto theft prevention procedures, provide information linkages between state law enforcement agencies on auto theft crimes, and develop a public information and education program on theft prevention measures.

Eligible Applicants: State agencies, local general-purpose units of government, independent school districts, nonprofit, and for profit organizations are eligible to apply for grants for automobile theft prevention assistance projects. Nonprofit and profit organizations shall be required to provide with their grant applications sufficient documentation to evaluate the credibility and the community support of the organization and the viability of the organization's existing activities in the context of providing automobile theft prevention assistance.

Grant Offering:

The Texas Automobile Theft Prevention Authority will not consider grant application requests for Equipment Only for Fiscal Year 2006 funds.

Contact Person:

Detailed specifications, including selection process and schedule for applications workshops will be made available through ATPA. Copies of the Grant Administrative Guide and the application can be found at www.txwatchyourcar.com

Contact Susan Sampson, Director,

Texas Automobile Theft Prevention Authority,

4000 Jackson Avenue, Austin, Texas 78731, (512) 374-5101.

Application Workshops:

A mandatory workshop for all applicants that wish to apply for the Texas Automobile Theft Prevention Grant funds with at least one (1) representative will be held on: **March 22, 2005, Tuesday, Austin, Texas, 10:00 a.m.- 3:00 p.m., Doubletree Hotel, 6505 North IH-35, Austin, Texas, (512) 454- 3737.**

Application Deadline and Submission Requirements:

The Authority must receive applications by 5 p.m., May 6, 2005 or postmarked by May 6, 2005. Each Application must:

1. Include all signed certifications and signature pages.
2. Application must be mailed or delivered to: Texas Automobile Theft Prevention Authority, 4000 Jackson Avenue Austin, Texas 78731
3. Submit **one (1) original** and **four (4)** copies of the proposal.
4. Facsimile transmissions will not be accepted.

If mailed, applications must be marked "Personal and Confidential" and addressed to the contact person listed above. If delivered, please leave application with the contact person (or designee) at the address listed.

Selection Process:

Applications will be selected according to rules §57.2, §57.4, §57.7, and §57.14, as published in Title 43 Chapter 57, Texas Administrative Code. Grant award decisions by ATPA are final and not subject to judicial review. Grants will be awarded on or before September 1, 2005.

TRD-200500555

Susan Sampson

Director

Automobile Theft Prevention Authority

Filed: February 7, 2005

Coastal Coordination Council

Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program

On January 10, 1997, the State of Texas received federal approval of the Coastal Management Program (CMP) (62 Federal Register pp. 1439-1440). Under federal law, federal agency activities and actions affecting the Texas coastal zone must be consistent with the CMP goals and policies identified in 31 TAC Chapter 501. Requests for federal

consistency review were deemed administratively complete for the following project(s) during the period of January 28, 2005, through February 3, 2005. As required by federal law, the public is given an opportunity to comment on the consistency of proposed activities in the coastal zone undertaken or authorized by federal agencies. Pursuant to 31 TAC §§506.25, 506.32, and 506.41, the public comment period for these activities extends 30 days from the date published on the Coastal Coordination Council web site. The notice was published on the web site on February 9, 2005. The public comment period for these projects will close at 5:00 p.m. on March 11, 2005.

FEDERAL AGENCY ACTIONS:

Applicant: Schlitterbahn Beach Water Park Location: The project is located in the south Laguna Madre adjacent to the south end of the Isla Blanca County Park in South Padre Island, Cameron County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Port Isabel, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 14; Easting: 683661; Northing: 2884430. Project Description: The applicant proposes to install three 6-inch PVC seawater intake pipelines, one 6-inch discharge line, and a 3-pile cluster of pilings. The three intake lines would extend perpendicular from the shoreline from an existing pumping facility, 320 feet into USACE jurisdictional waters, and attach to a cluster of pilings designed to secure the intake manifold. The discharge line would extend perpendicular from the shoreline, approximately 30 feet into USACE jurisdictional waters to a depth of 19" below Mean Sea Level. The discharge line would terminate with an upturned PVC elbow and a section of screen-covered PVC extending 6" above the substrate surface to prevent bottom scouring. The 320-foot intake lines would be installed using a water-jet trenching method to a depth of 24" below the substrate using the Texas Commission on Environmental Quality's Best Management Practice guidelines. The intake lines would traverse and impact approximately 175 square feet of sea grasses consisting of *Syringodium filiforme* and *Halodule wrightii*. The three intake lines would be installed for redundancy and no more than one would be in use at any time. The purpose of the intake and discharge lines would be to supply natural seawater to two live organism enclosures (aquaria) that would be maintained in a semi-closed system. Seawater would remain in the system and would be replenished periodically after evaporation or loss, and emergency or routine discharge. The applicant has minimized or avoided sea grasses to the extent possible within their pipeline easement. To mitigate adverse impacts to sea grasses, the applicant proposes to replant the affected area with 4" diameter plugs of sea grass collected from the pipeline corridor prior to installing the pipeline at a density of one plug per foot. Monitoring of the replanting efforts would occur monthly for one year and quarterly for two years for a total of three years of monitoring. A detailed mitigation plan is available upon request. CCC Project No.: 05-0118-F1 Type of Application: U.S.A.C.E. permit application #23501 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: Brown Navigation District Location: The project is located at Oil Dock No. 5, Port of Brownsville, Cameron County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Rockport, Texas. Approximate UTM Coordinates: Zone 14; Easting: 661552; Northing: 2872045. Project Description: The applicant proposes to amend permit 17850(02) to add an additional multiple pile breasting structure onto the east side of an existing breasting structure. The new structure will have a footprint of approximately 305 square feet. CCC Project No.: 05-0121-F1 Type of Application: U.S.A.C.E. permit application #17850(03) is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403).

Applicant: ExxonMobil Refining and Supply Company Location: The project site is located in Mitchell Bay, adjacent to the Houston Ship Channel, at the existing ExxonMobil Baytown Refinery dock facility, at 5000 Bayway Drive, in Baytown, Harris County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: La Porte, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 15; Easting: 304373; Northing: 3290191. Project Description: The applicant is requesting authorization to repair and upgrade the existing dock facilities located on the site. The proposed upgrades are necessary to improve safety and to enable Dock No. 5 to receive fully loaded Aframax class ships. At Dock No. 1, the applicant proposes to replace two dolphins with two 60-inch monopole mooring dolphins and reconnect existing walkways. At Dock No. 4, the applicant will construct two extensions with support structures and drawbridge walkways. This activity will involve the placement of 8 new piles. Repairs and upgrades to Dock No. 5 will include two new breasting dolphins and the replacement of H-type fenders with rubber fenders. The existing fenders will be removed using a vibration method. At Dock No. 7, the applicant will construct four new extensions with support structures and drawbridge walkways. This activity will require the installation of 16 new piles. No wetlands or vegetated shallows will be impacted as a result of the proposed activity. CCC Project No.: 05-0122-F1 Type of Application: U.S.A.C.E. permit application #23635 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403).

Applicant: BL Real Estate Holding Company LP Location: The project is located at the end of Caribbean Drive on a peninsula of land located adjacent to the Laguna Madre in Corpus Christi, Nueces County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Oso Creek, NE, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 14; Easting: 668900; Northing: 3057150. Project Description: The applicant proposes to amend permit 12004(06) to add an additional placement area (PA) to hold dredge material removed from the Bluff Landing Marina located at 4242 Laguna Shores Drive in Corpus Christi, Texas. Permit 12004 was issued on May 4, 1978, and authorized the construction of the marina. Amendments (01) through (04) authorized extensions of time. The most recent amendment (06) was issued on August 10, 2001, and authorized an extension of time to complete dredging of the marina, construct covered boat slips and to repair existing structures at the marina. The additional proposed PA would be located on uplands adjacent to the Laguna Madre, and would measure approximately 120 feet wide and 645 feet in length. An earthen berm and silt-screen fence would be constructed around the PA. In the near future, the applicant proposes to construct a condominium project on the proposed PA. CCC Project No.: 05-0123-F1 Type of Application: U.S.A.C.E. permit application #12004(07) is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403).

Applicant: United States Coast Guard Location: Goose Creek, mile 2.3(3.7 km) in Baytown, Harris County. Project Description: The purpose of the proposed project is to replace and existing railroad structure that is not considered adequate to safely maintain rail traffic. CCC Project No.: 05-0125-F1 Type of Application: U.S. Coast Guard Public Notice (01-05) is being evaluated as a Section 9 Bridge Permit under the General Bridge Act of 1946 (33 U.S.C.A. §525).

Applicant: Erosion Control Systems Location: The project is located at 2 and 3 Rains Way, Houston, in Buffalo Bayou, Harris County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Houston Heights, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 15; Easting: 265588; Northing: 3294279. Project Description: The applicant proposes to install shoreline protection along the bayou in order to prevent future erosion and bank failure that is currently taking place at the project site. This activity consists of the placement of riprap, as well as dredging, along portions of the

project. The applicant will place 98 cubic yards of riprap, along 132 linear feet, below the ordinary high water mark of the bayou. In addition, the applicant will mechanically excavate 550 cubic yards of material, along 248 linear feet, below the ordinary high water mark of the bayou. The excavated material will be placed on adjacent uplands and then hauled off to an existing sand and gravel operation. CCC Project No.: 05-0127-F1 Type of Application: U.S.A.C.E. permit application #23589 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: James A Whitson Location: The project is located in State Tract (ST) 125 in Galveston Bay, Chambers County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Morgans Point, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 15; Easting: 309027.443; Northing: 3279866.337. Project Description: The applicant proposes to install, operate, and maintain structures and equipment necessary for oil and gas drilling and production activities for the ST-125 Well No. 1. This activity consists of the permanent placement of a 30-foot by 7-foot well platform and a 70-foot by 70-foot production platform, with a flowline jetted or trenched between the two. During drilling operations the applicant will place 2,667 cubic yards of shell, gravel, or crushed rock for the marine barge pad. A survey was conducted and no shell reefs or oysters were found within the proposed work area. CCC Project No.: 05-0128-F1 Type of Application: U.S.A.C.E. permit application #23638 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Texas Railroad Commission under §401 of the Clean Water Act.

Pursuant to §306(d)(14) of the Coastal Zone Management Act of 1972 (16 U.S.C.A. §§1451-1464), as amended, interested parties are invited to submit comments on whether a proposed action is or is not consistent with the Texas Coastal Management Program goals and policies and whether the action should be referred to the Coastal Coordination Council for review.

Further information on the applications listed above may be obtained from Ms. Tammy Brooks, Program Specialist, Coastal Coordination Council, P.O. Box 12873, Austin, Texas 78711-2873, or tammy.brooks@glo.state.tx.us. Comments should be sent to Ms. Brooks at the above address or by fax at (512) 475-0680.

TRD-200500574
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: February 8, 2005

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 Sections 303.003 and 303.009, Tex. Fin. Code.

The weekly ceiling as prescribed by Sections 303.003 and 303.009 for the period of 02/14/05 - 02/20/05 is 18% for Consumer¹/Agricultural/Commercial²/credit thru \$250,000.

The weekly ceiling as prescribed by Sections 303.003 and 303.009 for the period of 02/14/05-- 02/20/05 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-200500573
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: February 8, 2005

Texas Education Agency

Notice of Texas Education Agency Security Environment (TEASE) Access Required for Even Start Family Literacy Program eGrant Application

Even Start Family Literacy. The grant application for Even Start Family Literacy will only be available in the Texas Education Agency (TEA) eGrants system, with an expected publication date of April 1, 2005. All external customers and users anticipating a need to access the eGrants system to submit a competitive application under Even Start Family Literacy, or those who anticipate being part of a shared services arrangement, must have a username and password for the Texas Education Agency Secure Environment (TEASE) in order to access the eGrants system. Participants are encouraged to request TEASE access no later than March 11, 2005, in order to obtain a TEASE username and password in a timely manner.

Any users who have previously applied for an eGrants TEASE username and password do not need to reapply. However, users are encouraged to review the role previously requested for their eGrants username and password to ensure it is appropriate. If the role is not correct, users will need to submit a new eGrants/expenditure report (ER) TEASE access request form indicating the change in role. If a username and password were assigned to an individual who should no longer have access, please complete the eGrants/ER TEASE access form to delete system access for that individual.

A TEASE username and password are required for each user of eGrants, including authorized officials such as superintendents and executive directors who submit grant applications, employees or contractors who will assist in writing/completing applications in eGrants, grant personnel who will be completing project progress reports in eGrants, and business office personnel who will be entering and/or certifying and submitting expenditure reports and requesting payment for various eGrants. For each user, a single TEASE username and password is valid for all grant expenditure reporting and all eGrants applications and is not limited to any one specific grant. Privileges listed under a role apply to all grants, progress/results reports, and expenditure reports.

To request a username and password, go to http://www.tea.state.tx.us/forms/tease/egrants_ext.htm. Information on how to apply for eGrants and ER access can be found at <http://www.tea.state.tx.us/opge/egrant/>.

Training Available on Texas Education Telecommunication Network (TETN). TEA is offering training via TETN (TETN Event #10782) on Friday, April 8, 2005, from 1:00 p.m. to 4:00 p.m.. This training will cover the Even Start Family Literacy grant application and will provide the opportunity for questions and answers. As space is limited, individuals planning to attend the event must reserve seating with their regional education service center.

TRD-200500590

Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: February 9, 2005

Texas Commission on Environmental Quality

Enforcement Orders

An agreed order was entered regarding Camilla Coves Lot Owners Association, Inc. dba Camilla Coves Water System, Docket No. 2003-1218-PWS-E on 01/28/2005 assessing \$3,570 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Harvey Wilson, Enforcement Coordinator at 512/239-0321, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Dallas Trading Enterprises, Inc. dba Kuick Check, Docket No. 2003-0848-PST-E on 01/28/2005 assessing \$2,400 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Sarah Utley, Staff Attorney at 210/490-3096, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Maxey Road Water Supply Corporation, Docket No. 2003-1421-MWD-E on 01/28/2005 assessing \$8,450 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting John Schildwachter, Enforcement Coordinator at 512/239-2355, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of DeKalb, Docket No. 2003-0333-MWD-E on 01/28/2005 assessing \$3,300 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Carolyn Lind, Enforcement Coordinator at 903/535-5145, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Slaton, Docket No. 2003-1267-MWD-E on 01/28/2005 assessing \$8,800 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Terry Murphy, Enforcement Coordinator at 512/239-5025, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding High Country Ventures, Inc. dba chevron Truck Stop, Docket No. 2003-1483-PST-E on 01/28/2005 assessing \$17,850 in administrative penalties with \$17,250 deferred.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, Enforcement Coordinator at 817/588-5890, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Tahir Iqbal Kahn dba Dollar Saver, Docket No. 2003-1143-PST-E on 01/28/2005 assessing \$9,000 in administrative penalties with \$1,800 deferred.

Information concerning any aspect of this order may be obtained by contacting Trina Grieco, Enforcement Coordinator at 713/767-3607,

Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Scot Industries, Inc., Docket No. 2003-0416-IHW-E on 01/28/2005 assessing \$13,770 in administrative penalties with \$2,754 deferred.

Information concerning any aspect of this order may be obtained by contacting Carolyn Lind, Enforcement Coordinator at 903/535-5145, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Atofina Petrochemicals USA, Inc., Docket No. 2003-0089-AIR-E on 01/28/2005 assessing \$28,200 in administrative penalties with \$5,640 deferred.

Information concerning any aspect of this order may be obtained by contacting Trina Grieco, Enforcement Coordinator at 713/767-3607, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Travis County, Docket No. 2003-1501-MSW-E on 01/28/2005 assessing \$2,000 in administrative penalties with \$400 deferred.

Information concerning any aspect of this order may be obtained by contacting Joseph Daley, Enforcement Coordinator at 512/239-3308, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Quick Deal Enterprises, Inc. dba JR's Minutemaid, Docket No. 2003-0987-PST-E on 01/28/2005 assessing \$3,450 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting David Speaker, Staff Attorney at 512/239-2548, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Bailey, Docket No. 2003-1367-MWD-E on 01/28/2005 assessing \$30,400 in administrative penalties with \$29,800 deferred.

Information concerning any aspect of this order may be obtained by contacting Carolyn Lind, Enforcement Coordinator at 903/535-5145, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding H. Muehlstein & Co., Inc., Docket No. 2003-1373-IWD-E on 01/28/2005 assessing \$8,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Carolyn Lind, Enforcement Coordinator at 903/535-5145, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Deco Surfaces, Inc., Docket No. 2004-0121-AIR-E on 01/28/2005 assessing \$2,200 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting David Speaker, Staff Attorney at 512/239-2548, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Sitton Oil and Marine Company, Inc. and Neil Momin, Docket No. 2004-0168-PST-E on 01/28/2005 assessing \$770 in administrative penalties with \$154 deferred.

Information concerning any aspect of this order may be obtained by contacting A. Sunday Udoetok, Enforcement Coordinator at 512/239-

0739, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding The Hitting Zone, LLC, Docket No. 2004-0434-EAQ-E on 01/28/2005 assessing \$2,000 in administrative penalties with \$400 deferred.

Information concerning any aspect of this order may be obtained by contacting Laurie Eaves, Enforcement Coordinator at 512/239-4495, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Support Terminals Operating Partnership, L.P., Docket No. 2004-0395-AIR-E on 01/28/2005 assessing \$2,400 in administrative penalties with \$480 deferred.

Information concerning any aspect of this order may be obtained by contacting Suzanne Walrath, Enforcement Coordinator at 512/239-2134, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding West Telemarketing Corporation, Docket No. 2004-0401-PST-E on 01/28/2005 assessing \$1,500 in administrative penalties with \$300 deferred.

Information concerning any aspect of this order may be obtained by contacting Mauricio Olaya, Enforcement Coordinator at 915/834-4967, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Noorani Petroleum, Inc. dba Panther Stop And Broncos Country Corner, Docket No. 2004-0403-PST-E on 01/28/2005 assessing \$16,275 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Steven Lopez, Enforcement Coordinator at 512/239-1896, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Tatum, Docket No. 2004-0429-MWD-E on 01/28/2005 assessing \$4,860 in administrative penalties with \$972 deferred.

Information concerning any aspect of this order may be obtained by contacting Lawrence King, Enforcement Coordinator at 512/239-7037, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Midstate Environmental Services, L.P., Docket No. 2004-0520-MSW-E on 01/28/2005 assessing \$7,110 in administrative penalties with \$1,422 deferred.

Information concerning any aspect of this order may be obtained by contacting Carolyn Lind, Enforcement Coordinator at 903/535-5145, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Al's Crossroads Bait & Tackle, Incorporated dba Al's Crossroads, Docket No. 2004-0532-PST-E on 01/28/2005 assessing \$6,175 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, Enforcement Coordinator at 817/588-5890, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding AA Group, Inc. dba Eagle Mart 1, Docket No. 2004-0538-PST-E on 01/28/2005 assessing \$750 in administrative penalties with \$150 deferred.

Information concerning any aspect of this order may be obtained by contacting Suzanne Walrath, Enforcement Coordinator at

512/239-2134, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Texas Hogs, LLC and Murphy Farms, LLC, Docket No. 2004-0548-AGR-E on 01/28/2005 assessing \$2,500 in administrative penalties with \$500 deferred.

Information concerning any aspect of this order may be obtained by contacting Laura Clark, Enforcement Coordinator at 409/899-8760, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Temple, Docket No. 2004-0570-PWS-E on 01/28/2005 assessing \$2,888 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting David Van Soest, Enforcement Coordinator at 512/239-0468, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Cardenas Autoplex, Inc., Docket No. 2004-0583-PST-E on 01/28/2005 assessing \$2,100 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jaime Garza, Enforcement Coordinator at 956/430-6030, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Ber Lengers dba Triple Dutch 2, Docket No. 2004-0594-AGR-E on 01/28/2005 assessing \$4,920 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Carolyn Lind, Enforcement Coordinator at 903/535-5145, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Justin Rosenfeld, Docket No. 2004-0600-AGR-E on 01/28/2005 assessing \$5,000 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Mike Meyer, Enforcement Coordinator at 512/239-4492, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Aegon Direct Marketing Services, Inc., Docket No. 2004-0624-PST-E on 01/28/2005 assessing \$4,500 in administrative penalties with \$900 deferred.

Information concerning any aspect of this order may be obtained by contacting Michael Limos, Enforcement Coordinator at 512/239-5839, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Richard A. Funderburk dba River Bend Trailer Park, Docket No. 2004-0654-PWS-E on 01/28/2005 assessing \$998 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rebecca Johnson, Enforcement Coordinator at 713/422-8931, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Trinidad, Docket No. 2004-0669-WQ-E on 01/28/2005 assessing \$5,180 in administrative penalties with \$1,036 deferred.

Information concerning any aspect of this order may be obtained by contacting Harvey Wilson, Enforcement Coordinator at 512/239-0321,

Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Robbins & Myers Energy Systems, L.P., Docket No. 2004-0681-AIR-E on 01/28/2005 assessing \$1,975 in administrative penalties with \$395 deferred.

Information concerning any aspect of this order may be obtained by contacting Kimberly Morales, Enforcement Coordinator at 713/422-8938, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding William E. Watson dba Corner Shell, Docket No. 2004-0731-PST-E on 01/28/2005 assessing \$6,000 in administrative penalties with \$1,200 deferred.

Information concerning any aspect of this order may be obtained by contacting Kensley Greuter, Enforcement Coordinator at 512/239-2520, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Gaylord Willit dba Essman Warehouse Complex, Docket No. 2004-0732-PWS-E on 01/28/2005 assessing \$1,103 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Catherine Albrecht, Enforcement Coordinator at 713/767-3672, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Formosa Plastics Corporation, Texas, Docket No. 2004-0781-AIR-E on 01/28/2005 assessing \$24,600 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, Enforcement Coordinator at 817/588-5890, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Chevron U.S.A., Inc., Docket No. 2004-0790-AIR-E on 01/28/2005 assessing \$2,150 in administrative penalties with \$430 deferred.

Information concerning any aspect of this order may be obtained by contacting Ruben Soto, Enforcement Coordinator at 512/239-4571, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Occidental Permian, Ltd., Docket No. 2004-0796-AIR-E on 01/28/2005 assessing \$5,000 in administrative penalties with \$1,000 deferred.

Information concerning any aspect of this order may be obtained by contacting Lawrence King, Enforcement Coordinator at 512/239-7037, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding David Everett dba Cooney Cavern Lodge, Docket No. 2004-0828-PWS-E on 01/28/2005 assessing \$856 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kent Heath, Enforcement Coordinator at 512/239-4575, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Military Highway WSC, Docket No. 2004-0878-MWD-E on 01/28/2005 assessing \$2,200 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Erika Fair, Enforcement Coordinator at 512/239-6673,

Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding EOTT Energy Liquids, L.P., Docket No. 2004-0904-AIR-E on 01/28/2005 assessing \$8,700 in administrative penalties with \$1,740 deferred.

Information concerning any aspect of this order may be obtained by contacting Kimberly Morales, Enforcement Coordinator at 713/422-8938, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Rodrigo Cantu dba Cantu's Gas and Oil Express, Docket No. 2004-0967-PST-E on 01/28/2005 assessing \$3,400 in administrative penalties with \$680 deferred.

Information concerning any aspect of this order may be obtained by contacting Brent Hurta, Enforcement Coordinator at 512/239-6589, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Lyford, Docket No. 2004-1012-PWS-E on 01/28/2005 assessing \$250 in administrative penalties with \$50 deferred.

Information concerning any aspect of this order may be obtained by contacting Michael Limos, Enforcement Coordinator at 512/239-5839, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Bernard Seidel dba Seidel's Country Store, Docket No. 2004-1096-PST-E on 01/28/2005 assessing \$1,600 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Elvia Maske, Enforcement Coordinator at 512/239-0789, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-200500598
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: February 9, 2005

◆ ◆ ◆
Notice of Water Quality Applications

The following notices were issued during the period of February 2, 2005 through February 9, 2005.

The following require the applicants to publish notice in the newspaper. The public comment period, 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 THIS NOTICE.**

AQUA DEVELOPMENT, INC. has applied for a renewal of TPDES Permit No. 14181-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 225,000 gallons per day. The facility is located approximately 2,000 feet southeast of the intersection of Huffsmith-Kohrville Road and Mahaffey Road in Harris County, Texas.

CITY OF BISHOP has applied for a renewal of TPDES Permit No. 10427-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 320,000 gallons per day.

The facility is located approximately 1.25 miles south of the intersection of U.S. Highway 77 and 6th Street, west of U.S. Highway 77 and adjacent to Carreta Creek in Nueces County, Texas.

COLORADO COUNTY has applied for a renewal of TPDES Permit No. 13740-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 50,000 gallons per day. The facility is located 3.5 miles east of Columbus, Texas and 1,000 feet south of Interstate Highway 10 on Farm-to-Market Road 102 in Colorado County, Texas.

CORPUS CHRISTI PEOPLE'S BAPTIST CHURCH has applied for a renewal of TPDES Permit No. 11134-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 20,000 gallons per day. The facility is located approximately one mile west of the intersection of Farm-to-Market Road 665 and Farm-to-Market Road 763 and south of Farm-to-Market Road 665 in Nueces County, Texas.

EAST RIO HONDO WATER SUPPLY CORPORATION has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014558001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 160,000 gallons per day. The facility will be located approximately 2.8 miles north of the intersection of Farm-to-Market Road 1561 and Brown Tract Road in Cameron County, Texas.

LOWER COLORADO RIVER AUTHORITY which operates a surface lignite mine, has applied for a renewal of TPDES Permit No. WQ0002632-000, which authorizes the discharge of storm water on an intermittent and flow variable basis via Outfall 101. The facility is located adjacent to the west side of State Highway 95, approximately 1.5 miles south of the intersection of State Highway 95 and Farm-to-Market Road 2336, near the City of Bastrop, in Bastrop County, Texas.

MINSA CORPORATION which operates a masa (corn) flour manufacturing plant, has applied for a major amendment to Permit No. WQ0003032000 to authorize an increase in the permitted irrigation area from 86.5 acres to 92 acres based on a recent survey of the existing irrigation area and to increase the total Kjeldahl nitrogen application rate from 21 pounds per acre per month (lb/acre/month) to 50 lbs/acre/month, due to the current production rate of 7,500 metric tons per month. The current permit authorizes the disposal of process wastewater (cooking, steeping, and washing) and boiler blowdown from a milling operation, at a daily average flow not to exceed 300,000 gallons per day via irrigation of 86.5 acres. This permit will not authorize a discharge of pollutants into water in the State. The facility and land application site are located adjacent to U.S. Highway 84, approximately 1.8 miles southeast of the intersection of U.S. Highway 84 and U.S. Highway 70, and approximately 1.5 miles southeast of the City of Muleshoe, Bailey County, Texas.

TRAVIS COUNTY WATER CONTROL AND IMPROVEMENT DISTRICT-POINT VENTURE has applied for a major amendment to Permit No. 11385-001 to increase the acreage irrigated from 37.96 acres to 48 acres of golf course. This permit will not authorize a discharge of pollutants into waters in the State. The facility and disposal site are located approximately 6.5 miles south of the intersection (within the Village of Point Venture) of Farm-to-Market Road 1431 and Lohmans Crossing in Travis County, Texas. The wastewater treatment plant is located adjacent to Venture Drive in the Village of Point Venture between the 1st and 2nd holes of the Point Venture Golf Course in Travis County, Texas.

VOPAK LOGISTICS SERVICES USA INC. which operates a rail car/tank truck cleaning operation and commercial waste disposal facility, has applied for a renewal of TPDES Permit No. WQ0001731000,

which authorizes the discharge of treated process wastewater, treated domestic wastewater, and storm water at a daily average flow not to exceed 300,000 gallons per day via Outfall 001. The facility is located at 2759 Battleground Road, in the City of Deer Park, Harris County, Texas.

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 THIS NOTICE.

HARRIS-FORT BEND COUNTIES MUNICIPAL UTILITY DISTRICT NO. 3 has applied for a minor amendment to the Texas Pollutant Discharge Elimination System (TPDES) permit to authorize a change in the permitted daily average flow (from 150,000 gallons per day to 180,000 gallons per day) and two-hour peak (from 313 gallons per minute to 500 gallons per minute) for the Interim I phase. The existing permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 990,000 gallons per day. The facility is located approximately 2,000 feet south of Interstate Highway 10 and 3,300 feet east of Katy-Ft. Bend Road; approximately 4,000 feet southeast of the intersection of Interstate Highway 10 and Katy-Ft. Bend Road in Harris County, Texas.

TRD-200500600

LaDonna Castañuela

Chief Clerk

Texas Commission on Environmental Quality

Filed: February 9, 2005



Notice of Water Rights Application

Notice mailed February 4, 2005.

APPLICATION NO. 5858; Texas Municipal Power Agency, applicant, P.O. Box 7000, Bryan, TX, 77805, seeks a permit pursuant to Texas Water Code §11.121, and Texas Commission on Environmental Quality Rules 30 Texas Administrative Code (TAC) §295.1, et seq. Texas Municipal Power Agency has applied for a Water Use Permit for authorization to maintain 31 existing on-channel reservoirs in the Brazos River Basin and impound therein a combined amount of 8,487.80 acre-feet of water for recreational, domestic, livestock, parks and wildlife, and game preserve purposes in Grimes County. No diversion of water has been requested.

For the complete notice and description of the 31 ponds, you may view the notice on the web by clicking on "Search for TCEQ Public Notices" under the area entitled "Hot Topics" on the TCEQ web site at www.tceq.state.tx.us, or you may call (512) 239-3315 and request a full copy of the notice.

The Commission will review the application as submitted by the applicant and may or may not grant the application as requested. The application was received on August 9, 2004, and additional information was received on September 23, September 29, and October 15, 2004. The application was declared administratively complete and filed with the Office of the Chief Clerk on October 21, 2004. Written public comments and requests for a public meeting should be submitted to the Office of Chief Clerk, at the address provided in the information section below, within 30 days of the date of newspaper publication of the notice.

INFORMATION SECTION

A public meeting is intended for the taking of public comment, and is not a contested case hearing.

The Executive Director can consider approval of an application unless a written request for a contested case hearing is filed. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) applicant's name and permit number; (3) the statement "[I/we] request a contested case hearing;" and (4) a brief and specific description of how you would be affected by the application in a way not common to the general public. You may also submit any proposed conditions to the requested application which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the TCEQ Office of the Chief Clerk at the address provided in the information section below.

If a hearing request is filed, the Executive Director will not issue the requested permit and may forward the application and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

Written hearing requests, public comments or requests for a public meeting should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Office of Public Assistance at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-200500599

LaDonna Castañuela

Chief Clerk

Texas Commission on Environmental Quality

Filed: February 9, 2005



Proposed Enforcement Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (the Code), §7.075, which requires that the commission may not approve these AOs unless the public has been provided an opportunity to submit written comments. Section 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 **March 21, 2005**. Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withhold approval of an AO if a comment discloses facts or considerations that indicate the proposed AO is inappropriate, improper, inadequate, or inconsistent with the requirements of the Code, the Texas Health and Safety Code (THSC), and/or the Texas Clean Air Act (the Act). Additional notice is not required if changes to an AO 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) 239-1864 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on March 21, 2005**. Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that

comments on the AOs should be submitted to the commission in **writing**.

(1) COMPANY: Cedarstone One Investors, Ltd.; DOCKET NUMBER: 2004-1914-MWD-EI; IDENTIFIER: Texas Pollutant Discharge Elimination System (TPDES) Permit Number 0013697001, Regulated Entity Identification Number (RN) 101611309; LOCATION: The Woodlands, Montgomery County, Texas; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number 0013697001, and the Code, §26.121(a), by failing to comply with permit effluent limits for total ammonia nitrogen and total suspended solids (TSS); PENALTY: \$2,100; ENFORCEMENT COORDINATOR: Rebecca Johnson, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(2) COMPANY: City of Cushing; DOCKET NUMBER: 2004-1229-MWD-E; IDENTIFIER: TPDES Permit Number WQ0010437001, RN101917151; LOCATION: Cushing, Nacogdoches County, Texas; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0010437001, and the Code, §26.121(a), by failing to comply with permit effluent limits for biochemical oxygen demand, TSS, dissolved oxygen (DO), and pH; PENALTY: \$7,750; ENFORCEMENT COORDINATOR: Catherine Albrecht, (713) 767-3500; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(3) COMPANY: Davis Net Lease No. 1, L.P.; DOCKET NUMBER: 2004-2024-EAQ-E; IDENTIFIER: RN104378567; LOCATION: Bulverde, Comal County, Texas; TYPE OF FACILITY: tract of land; RULE VIOLATED: 30 TAC §213.23(a)(1)(A) and (B), by failing to submit and obtain commission approval of an Edwards Aquifer contributing zone plan; PENALTY: \$2,400; ENFORCEMENT COORDINATOR: Rebecca Clausewitz, (210) 490-3096; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(4) COMPANY: Muhammad S. Javaid; DOCKET NUMBER: 2004-0375-PST-E; IDENTIFIER: Petroleum Storage Tank (PST) Facility Identification Number 38823; LOCATION: Beaumont, Jefferson County, Texas; TYPE OF FACILITY: retail gasoline station; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and (2)(A)(ii) and the Code, §26.3475(a), by failing to monitor the pressurized piping and tanks for releases; 30 TAC §334.48(c), by failing to conduct inventory control; 30 TAC §334.49(a) and the Code, §26.3475(d), by failing to install a method of corrosion protection; 30 TAC §334.8(c)(4)(B), by failing to ensure that the underground storage tank (UST) registration and self-certification forms were fully and accurately completed; 30 TAC §115.246(1) and (3) and THSC, §382.085(b), by failing to maintain a record of any maintenance conducted on the Stage II equipment and a copy of the California Air Resources Board Executive Order; 30 TAC §115.244 and THSC, §382.085(b), by failing to conduct daily and monthly inspections of the Stage II vapor recovery system (VRS); and 30 TAC §115.248(1) and THSC, §382.085(b), by failing to ensure that at least one facility representative receive training and instruction in the operation and maintenance of the Stage II VRS; PENALTY: \$6,784; ENFORCEMENT COORDINATOR: Merrilee Hupp, (512) 239-4490; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(5) COMPANY: Brian Lucher; DOCKET NUMBER: 2004-1937-OSI-E; IDENTIFIER: On-Site Sewage Facility (OSSF) Installer Identification Number OS0004420, RN103183901; LOCATION: Deanville, Burleson County, Texas; TYPE OF FACILITY: OSSF; RULE VIOLATED: 30 TAC §285.61(4) and (10), by failing to obtain documentation that the owner or owner's agent has the permitting

authority's authorization to construct and by failing to be present at the job site at least once each work day if the OSSF work is supervised and performed by an apprentice; PENALTY: \$300; ENFORCEMENT COORDINATOR: Jaime Garza, (956) 425-6010; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(6) COMPANY: City of Magnolia; DOCKET NUMBER: 2003-1295-MWD-E; IDENTIFIER: TPDES Permit Number 11871-001, RN101919769; LOCATION: Magnolia, Montgomery County, Texas; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number 11871-001, and the Code, §26.121(a), by exceeding the permitted effluent limits for total chlorine, ammonia nitrogen, and DO; PENALTY: \$5,000; ENFORCEMENT COORDINATOR: Michael Meyer, (512) 239-4492; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(7) COMPANY: Maso, Inc. dba Chill City Conoco; DOCKET NUMBER: 2004-1841-PST-E; IDENTIFIER: PST Facility Identification Number 26319, RN100529528; LOCATION: Plano, Collin County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §37.815(a) and (b), by failing to provide acceptable financial assurance; PENALTY: \$1,600; ENFORCEMENT COORDINATOR: Jill Reed, (915) 570-1359; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(8) COMPANY: Masters Resources, LLC; DOCKET NUMBER: 2004-1581-AIR-E; IDENTIFIER: Air Account Number CI0175U, RN100209774; LOCATION: near Galveston Bay, Chambers County, Texas; TYPE OF FACILITY: oil and gas compressor station; RULE VIOLATED: 30 TAC §122.146(2) and THSC, §382.085(b), by failing to submit the annual Title V compliance certifications; and 30 TAC §122.145(2)(B) and THSC, §382.085(b), by failing to submit the deviation reports; PENALTY: \$7,000; ENFORCEMENT COORDINATOR: Brandon Smith, (512) 239-4471; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(9) COMPANY: Newell Recycling Company of El Paso, LP dba Newell Recycling; DOCKET NUMBER: 2004-1584-AIR-E; IDENTIFIER: Air Account Number EE-0058-M, RN100581768; LOCATION: El Paso, El Paso County, Texas; TYPE OF FACILITY: metals recycling; RULE VIOLATED: 30 TAC §101.4 and THSC, §382.085(a) and (b), by failing to prevent particulate matter emissions; 30 TAC §111.155(1) and (2) and THSC, §382.085(b), by failing to comply with the 200 and 400 microgram per cubic meter of air sampled; 30 TAC §101.221(a) and THSC, §382.085(b), by failing to maintain emission abatement equipment; and 30 TAC §116.110(a) and THSC, §382.085(b) and §382.0518(a), by failing to obtain a permit after disconnecting abatement control equipment; PENALTY: \$4,360; ENFORCEMENT COORDINATOR: Jorge Ibarra, (817) 588-5800; REGIONAL OFFICE: 401 East Franklin Avenue, Suite 560, El Paso, Texas 79901-1206, (915) 834-4949.

(10) COMPANY: Pampa Concrete Co., Inc.; DOCKET NUMBER: 2004-1884-AIR-E; IDENTIFIER: Air Account Number 904647P, RN102196631; LOCATION: Clarendon, Donley County, Texas; TYPE OF FACILITY: portable concrete batch plant; RULE VIOLATED: 30 TAC §116.110(a)(1) and THSC, §382.085(b) and §382.0518(a), by failing to obtain a permit or satisfy the conditions of a permit by rule to construct a new facility or engage in the modification of any existing facility; PENALTY: \$10,000; ENFORCEMENT COORDINATOR: Kensley Greuter, (512) 239-2520; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(11) COMPANY: Domingo Pina dba Sonny's Place; DOCKET NUMBER: 2004-1559-PWS-E; IDENTIFIER: Public Water Supply Number 0790139, RN102314887; LOCATION: near East Bernard, Fort Bend County, Texas; TYPE OF FACILITY: nightclub with public water supply; RULE VIOLATED: 30 TAC §290.109(c)(2)(F) and (3)(A), by failing to take at least five bacteriological samples following a positive coliform sample result and by failing to collect the appropriate number of repeat samples following coliform positive sample results; PENALTY: \$625; ENFORCEMENT COORDINATOR: Brandon Smith, (512) 239-4471; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(12) COMPANY: Texas Department of Transportation; DOCKET NUMBER: 2004-1340-PST-E; IDENTIFIER: PST Facility Identification Number 15071, RN102832292; LOCATION: Guthrie, King County, Texas; TYPE OF FACILITY: state highway maintenance; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(a), by failing to monitor the USTs for releases; PENALTY: \$1,500; ENFORCEMENT COORDINATOR: Brent Hurta, (512) 239-6589; REGIONAL OFFICE: 4630 50th Street, Suite 600, Lubbock, Texas 79414-3520, (806) 796-7092.

(13) COMPANY: Tri-Con, Inc.; DOCKET NUMBER: 2004-1699-PST-E; IDENTIFIER: RN102282027; LOCATION: Beaumont, Jefferson County, Texas; TYPE OF FACILITY: fuel distributor; RULE VIOLATED: 30 TAC §334.5(b)(1)(A), by failing to ensure that the owner or operator had a valid, current delivery certificate; PENALTY: \$6,300; ENFORCEMENT COORDINATOR: Erika Fair, (512) 239-6673; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

TRD-200500588

Paul C. Sarahan

Director, Litigation Division

Texas Commission on Environmental Quality

Filed: February 9, 2005

Golden Crescent Workforce Development Board

Public Notice

The Golden Crescent Workforce Development Board will release its Request for Proposals for Independent Auditing Services on February 18, 2005.

The Board is responsible for administering the workforce development system, including job training, employment, and employment-related educational programs in Calhoun, DeWitt, Goliad, Gonzales, Jackson, Lavaca and Victoria counties.

A complete set of specifications may be obtained from James Fawcett at (361) 576-5872. Interested parties must provide a written response no later than 5:00 PM, March 11, 2005.

TRD-200500580

Sandy Heiermann

Director of Planning and Contracts

Golden Crescent Workforce Development Board

Filed: February 8, 2005

Texas Health and Human Services Commission

Public Notice Statement

The Health and Human Services Commission, State Medicaid Office, received approval from the Centers for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Program state plan by Transmittal Number 04-23, Amendment Number 687.

This amendment increases the income limit for adult pregnant women to 185% of the Federal Poverty Income Limit (FPL), and is effective September 1, 2004. The proposed amendment is estimated to result in annual aggregate expenditures of approximately \$52 million for state fiscal year (SFY) 2005, with approximately \$32 million federal funds expenditures and approximately \$20 million state general revenue expenditures.

For additional information, please contact Lesa Ledbetter, Policy Development Support with the Medicaid/CHIP Division, at (512) 491-1199 or by email at lesa.ledbetter@hhsc.state.tx.us.

TRD-200500596

Steve Aragón

Chief Counsel

Texas Health and Human Services Commission

Filed: February 9, 2005

◆ ◆ ◆

Texas Department of Housing and Community Affairs

2005 Housing Tax Credit Program

Notice of Meetings Schedule for Clarification of 2005 Cycle Applications

The Texas Department of Housing and Community Affairs (the "Department") is committed to making the 2005 Housing Tax Credit Program allocation a better, more transparent process. Therefore, the Department will be hosting a series of meetings for 2005 cycle applicants.

The focus of these meetings is to provide Director-level clarification to any specific requests for additional information that have been made by the Department concerning specific applications. These meetings are open to the public and will allow for public discussion with key members of the allocation staff. The schedule of these meetings is provided below:

Friday, March 11, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin
Friday, March 25, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin

Friday, April 08, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin
Friday, April 22, 2005 at 10:00 a.m., 4th Floor Board Room, 507 Sabine, Austin

Friday, May 6, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin
Friday, May 20, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin

Friday, June 03, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin
Friday, June 17, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin

Friday, July 01, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin
Friday, July 15, 2005 at 10:30 a.m., 4th Floor Board Room, 507 Sabine, Austin

Individuals who require auxiliary aids or services for the public hearings should contact Gina Esteves ADA Responsible Employee, at (512) 475-3943 or Relay Texas at 1 (800) 735-2989 at least two days before the meeting so that appropriate arrangements can be made. Individuals who require a language interpreter for the hearing should contact Jennifer Joyce at least three days prior to the hearing date. Personas que

hablan español y requieren un intérprete, favor de llamar a Jorge Reyes al siguiente número (512) 475-4577 por lo menos tres días antes de la junta para hacer los preparativos apropiados.

If you have any questions regarding these meetings, please contact Jennifer Joyce, Program Administrator for the HTC Program at (512) 475-3995 or visit our web site at: www.tdhca.state.tx.us/lihtc.htm.

TRD-200500597

Edwina P. Carrington

Executive Director

Texas Department of Housing and Community Affairs

Filed: February 9, 2005

◆ ◆ ◆

Houston-Galveston Area Council

Public Meeting Notice

Public Meeting on the

Transportation Conformity Determination, the Draft 2025 Regional Transportation Plan

and the Draft 2006-2008 Transportation Improvement Program

Houston-Galveston Area Council

3555 Timmons Lane

Houston, Texas 77027

2nd Floor, Conference Room A

Wednesday, March 30, 2005

6 p.m. - 8 p.m.

On Wednesday, March 30, 2005, the Houston-Galveston Area Council (H-GAC) will host a public meeting on the **Transportation Conformity Determination, the Draft 2025 Regional Transportation Plan (RTP) and the Draft 2006-2008 Transportation Improvement Program (TIP)**. The 2025 RTP provides a framework for identifying transportation priorities and major transportation challenges, such as regional mobility, air quality and safety. The conformity analysis was conducted by H-GAC to ensure that projects within the 2025 RTP meet our region's air quality goals. The TIP is a comprehensive listing of transportation projects approved for funding and implementation within a three-year period. The public is encouraged to attend this important meeting and provide comments to H-GAC on the Transportation Conformity Determination, the Draft 2025 RTP and the Draft 2006-2008 TIP.

The public comment period on the Transportation Conformity Determination, the Draft 2025 RTP and the Draft 2006-2008 TIP begins **Wednesday, February 9, 2005**. Comments must be received by H-GAC no later than **5 p.m., Thursday, March 31, 2005**. Copies of the Transportation Conformity Determination, the Draft 2025 RTP and the Draft 2006-2008 TIP are available on H-GAC's Transportation Web site, www.h-gac.com/transportation, or by contacting Shelley Whitworth at shelley.whitworth@h-gac.com or (713) 499-6695. Written comments may be submitted to Alan Clark, MPO Director, Houston-Galveston Area Council, P.O. Box 22777, Houston, Texas 77227-2777, emailed to alan.clark@h-gac.com or faxed to (713) 993-4508.

In compliance with the Americans with Disabilities Act, H-GAC will provide for reasonable accommodations for persons with disabilities attending H-GAC functions. Requests should be received by H-GAC 24 hours prior to the function. Call Kim Green at (713) 993-4577 to make arrangements.

TRD-200500591
Alan Clark
MPO Director
Houston-Galveston Area Council
Filed: February 9, 2005

◆ ◆ ◆
Texas Department of Insurance

Notice of Public Hearing

The Commissioner of Insurance will hold a public hearing under Docket No. 2611, on February 28, 2005, at 9:30 a.m. in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street in Austin, Texas, to consider the Texas Automobile Insurance Plan Association's (TAIPA) 2005 Private Passenger rate filing pursuant to the Insurance Code, Article 21.81.

Copies of TAIPA's proposed private passenger rate filing are available for review in the Office of the Chief Clerk of the Texas Department of Insurance, 333 Guadalupe Street, Austin, TX 78701 during regular business hours. For further information or to request copies of the filing, please contact Sylvia Gutierrez at (512) 463-6327 (refer to Reference No. A-0205-01).

Written comments on the filing may be submitted to the Office of the Chief Clerk, Texas Department of Insurance, P.O. Box 149104, MC 113-2A, Austin, TX 78714-9104. An additional copy of the comments should be submitted to Phil Presley, Chief Actuary, P.O. Box 149104, MC 105-5F, Austin, TX 78714-9104. Interested persons may also present written or oral comments related to the filing at the public hearing. TAIPA, the public insurance counsel, and any other interested person or entity that has submitted proposed changes or actuarial analyses may ask questions of any person testifying at the hearing.

This notification is made pursuant to the Insurance Code, Article 21.81, Subsection 5(f) which requires notification in the Texas Register of the proposed TAIPA private passenger auto rate filings. A hearing under Article 21.81, §5 is not a contested case hearing under Chapter 2001, Government Code.

TRD-200500544
Brenda Caldwell
Special Regulatory Counsel
Texas Department of Insurance
Filed: February 4, 2005

◆ ◆ ◆
Third Party Administrator Applications

The following third party administrator (TPA) applications have been filed with the Texas Department of Insurance and are under consideration.

Application for incorporation in Texas of TOTAL BENEFIT SOLUTIONS, (using the assumed name of TOTAL BENEFIT SOLUTIONS "ONECHECK"), a domestic third party administrator. The home office is LUBBOCK, TEXAS.

Application for admission to Texas of ALLIED ADMINISTRATORS, INC., a foreign third party administrator. The home office is SAN FRANCISCO, CALIFORNIA.

Any objections must be filed within 20 days after this notice is published in the Texas Register, addressed to the attention of Matt Ray, MC 107-1A, 333 Guadalupe, Austin, Texas 78701.

TRD-200500497
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: February 3, 2005

◆ ◆ ◆
Texas Lottery Commission

Instant Game Number 543 "Cashword"

1.0 Name and Style of Game.

A. The name of Instant Game No. 543 is "CASHWORD". The play style is "key symbol match with a prize legend".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 543 shall be \$3.00 per ticket.

1.2 Definitions in Instant Game No. 543.

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 - One of the symbols which appears under the Latex Overprint on the front of the ticket. Each Play Symbol is printed in Symbol font in black ink in positive. The possible play symbols are: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, and ?.

D. Play Symbol Caption - the small printed material appearing below each Play Symbol which explains the Play Symbol. One and only one of these Play Symbol Captions appears under each Play Symbol and each 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. 543 - 1.2D

PLAY SYMBOL	CAPTION
A	
B	
C	
D	
E	
F	
G	
H	
I	
J	
K	
L	
M	
N	
O	
P	
Q	
R	
S	
T	
U	
V	
W	
X	
Y	
Z	

E. Retailer Validation Code - Three small letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. These three (3) small letters are for

validation purposes and cannot be used to play the game. The possible validation codes are:

Figure 2: GAME NO. 543 - 1.2E

CODE	PRIZE
THR	\$3.00
FIV	\$5.00
TEN	\$10.00
TWN	\$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of Ø, which will only appear on low-tier winners and will always have a slash through it.

(4) digit security number which will be boxed and placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a four

G. Low-Tier Prize - A prize of \$3.00, \$5.00, \$10.00, or \$20.00.

H. Mid-Tier Prize - A prize of \$100 or \$500.

I. High-Tier Prize - A prize of \$5,000 or \$35,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (543), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 125 within each pack. The format will be: 543-0000001-001.

L. Pack - A pack of "CASHWORD" Instant Game tickets contain 125 tickets, which are packed in plastic shrink-wrapping and fanfolded in pages of one (1). Ticket 001 will be shown on the front of the pack; the back of ticket 125 will be revealed on the back of the pack. Every other book will reverse i.e., reverse order will be: the back of ticket 001 will be shown on the front of the pack and the front of ticket 125 will be shown on the back of the pack. All packs will be tightly shrink-wrapped. There will be no breaks between the tickets in a pack.

M. 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.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "CASHWORD" Instant Game No. 543 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 "CASHWORD" Instant Game is determined once the latex on the ticket is scratched off to expose 139 (one hundred thirty-nine) possible play symbols. The player must scratch off all 18 (eighteen) boxed squares in the YOUR LETTERS to reveal 18 play symbol letters; then scratch the corresponding letters found in the CASHWORD puzzle grid play area. If a player scratches at least three (3) complete "words" in the CASHWORD puzzle grid play area, the player will win the corresponding prize indicated in the prize legend. For each of the 18 play symbol letters revealed in YOUR LETTERS play area, the player must reveal the identical key play symbol letter in the CASHWORD puzzle grid play area. Letters combined to form a complete "word" must appear in an unbroken horizontal (left to right) sequence or vertical (top to bottom) sequence of letters within the CASHWORD puzzle grid. Only letters within the CASHWORD puzzle grid that are matched with the YOUR LETTERS can be used to form a complete "word". The three (3) small letters outside the squares in the YOUR LETTERS area are for validation purposes and cannot be used to play CASHWORD. In the CASHWORD puzzle grid, every lettered square within an unbroken horizontal or vertical sequence must be matched with the YOUR LETTERS to be considered a complete "word". Words within a words are not eligible for a prize. For example, all the YOUR LETTERS play symbols S, T, O, N, E, must be revealed for this to count as one complete "word". TON, ONE or any other portion of the sequence of STONE would not count as a complete "word". A complete "word" must contain at least three letters. Letters combined to form a complete "word" must appear in an unbroken vertical (top to bottom) or horizontal (left to right) string of letters in the CASHWORD. To form a complete word, an unbroken string of letters cannot be interrupted by a block space. Any other words contained within a complete word are not added or counted for purposes

of prize legend. Every single letter in the vertical or horizontal (left to right) unbroken string must: (a) be one of the 18 larger outlined play symbols letters revealed in the play area, YOUR LETTERS, and (b) be included to form a complete "word". The possible complete words for this ticket are contained in the CASHWORD play area. Each possible complete word must consist of three (3) or more letters and occupy an entire word space. Players must match all of the play symbol letters to the identical key play symbols in a possible complete word in order to complete the word. If the letters revealed form three (3) or more complete words each of which occupy a complete word space on the CASHWORD play area, the player will win the corresponding prize shown in the prize legend for forming that number of complete words. 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. One hundred thirty-nine (139) possible 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, 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;
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 139 (one hundred thirty-nine) possible 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 139 (one hundred thirty-nine) possible Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.
17. Each of the 139 (one hundred thirty-nine) possible 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 Instant Lottery 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 within a book will not have identical patterns.

B. Adjacent tickets in a pack will not have identical patterns.

C. Each ticket consists of a Your Letters area and one Crossword Puzzle Grid.

D. The Crossword Puzzle Grid will be formatted with at least 1000 configurations (i.e. puzzle layouts not including words).

E. All Crossword Puzzle Grid configurations will be formatted within a grid that contains 11 spaces (height) by 11 spaces (width).

F. Each word will appear only once per ticket on the Crossword Puzzle Grid.

G. Each letter will only appear once per ticket in the YOUR LETTERS play area.

H. Each Crossword Puzzle Grid will contain the following: a) 4 sets of 3 letter words b) 5 sets of 4 letter words c) 3 sets of 5 letter words d) 3 sets of 6 letter words e) 1 set of 7 letter words f) 2 sets of 8 letter words g) 1 set of 9 letter words. h) 19 words per puzzle per ticket.

I. There will be a minimum of three (3) vowels in the YOUR LETTERS play area.

J. The length of words found in the Crossword Puzzle Grid will range from 3-9 letters.

K. Only words from the approved word list will appear in the Crossword Puzzle Grid.

L. None of the prohibited words (see attached list) will appear horizontally (in either direction), vertically, (in either direction) or diagonally (in either direction) in the Cashword puzzle grid.

M. You will never find a word horizontally (in either direction), vertically (in either direction) or diagonally (in either direction) in the YOUR LETTERS play area that matches a word in the Crossword Puzzle Grid.

N. Each Crossword Puzzle Grid will have a maximum number of different grid formations with respect to other constraints. That is, for

identically formatted Crossword puzzles (i.e. the same grid), all "approved words" will appear in every logical (i.e. 3 letter word = 3 letter space) position, with regards to limitations caused by the actual letters contained in each word (i.e. will not place the word ZOO in a position that causes an intersecting word to require the second letter to be "Z", when in fact, there are no approved words with a "Z" in the second letter position).

O. No one (1) letter, with the exception of vowels, will appear more than nine (9) times in the Crossword Puzzle grid.

P. No ticket will match eleven (11) words or more.

Q. Each ticket may only win one (1) prize.

R. Three (3) to ten (10) completed words will be revealed as per the prize structure.

S. All non-winning tickets will contain: a) One (1) completed word approximately 20% of the time b) Two (2) completed words approximately 80% of the time.

T. NON-WINNING TICKETS: Sixteen (16) to eighteen (18) YOUR LETTERS will open at least one (1) letter in the CASHWORD Puzzle Grid.

U. NON-WINNING TICKETS: At least 15% of tickets will open at least one (1) letter in the Crossword Puzzle Grid with all 18 letters.

V. NON-WINNING TICKETS 100% of the tickets will have at least five (5) words as a near-win. A near win is defined as a word with all letters less one (1) revealed in the Crossword Puzzle Grid. (For example, using the word EYE and EAGLE. If missing the letter "E" these words would be considered a near-win).

2.3 Procedure for Claiming Prizes.

A. To claim a "CASHWORD" Instant Game prize of \$3.00, \$5.00, \$10.00, \$20.00, \$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, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a \$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 2.3.C of these Game Procedures.

B. To claim a "CASHWORD" Instant Game prize of \$5,000 or \$35,000, 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 "CASHWORD" 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 risk of sending a ticket remains with the claimant. 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 a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;
2. delinquent in making child support payments administered or collected by the Attorney General; or
3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;
4. in default on a loan made under Chapter 52, Education Code; or
5. in default on a loan guaranteed under Chapter 57, Education 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 of less than \$600 from the "CASHWORD" 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 more than \$600 from the "CASHWORD" 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 Section 466.408. Any prize 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 therefor, 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 therefor, 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 therefor. 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 6,960,000 tickets in the Instant Game No. 543. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 543 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
\$3	1,099,680	6.33
\$5	876,960	7.94
\$10	167,040	41.67
\$20	69,600	100.00
\$100	14,616	476.19
\$500	2,552	2,727.27
\$5,000	31	224,516.13
\$35,000	10	696,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.12. 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.

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. 543 without advance notice, at which point no further tickets in that game may be sold.

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. 543, 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-200500501
 Kimberly L. Kiplin
 General Counsel
 Texas Lottery Commission
 Filed: February 3, 2005

Contact: Jim R. Hicks, P.O. Box 12489, Austin, Texas 78711-2489, (512) 475-3589, james.hicks@tdhca.state.tx.us

TRD-200500506
 Timothy K. Irvine
 Executive Director
 Manufactured Housing Division
 Filed: February 4, 2005

◆ ◆ ◆

Texas Parks and Wildlife Department

Notice of Hearing and Opportunity for Public Comment

This is a notice of an opportunity for public comment and a public hearing on Farakel Company's application to obtain a Texas Parks and Wildlife Department (TPWD) permit to dredge state-owned sand and gravel from the Nueces River bed approximately 4 miles downstream from Barksdale and 4 miles upstream from Vance in Real and Edwards counties.

The hearing will be held on Thursday, March 10, 2005, at 1:30 p.m. at TPWD Headquarters, 4200 Smith School Road, Austin, Texas 78744.

The hearing is not a contested case hearing under the Administrative Procedure Act.

Written comments must be submitted within 30 days of the publication of this notice in the *Texas Register* or the newspaper, whichever is later, or at the public hearing.

Submit written comments, questions, or requests to review the application to: Lisa Belli, TPWD, by mail; fax (512) 389-4482; e-mail lisa.belli@tpwd.state.tx.us; phone (512) 389-4770.

TRD-200500589
 Gene McCarty
 Chief of Staff
 Texas Parks and Wildlife Department
 Filed: February 9, 2005

◆ ◆ ◆

Manufactured Housing Division

Notice of Administrative Hearing

Thursday, March 3, 2005, 1:00 p.m.

State Office of Administrative Hearings, William P. Clements Building, 300 West 15th Street, 4th Floor,

Austin, Texas

AGENDA

Administrative Hearing before an administrative law judge of the State Office of Administrative Hearings in the matter of the complaint of the Manufactured Housing Division of the Texas Department of Housing and Community Affairs vs. Mobile Home Mall LP, to hear alleged violations of Sections 1201.151 and 1201.151(a) of the Act by refusing to refund a deposit given on a manufactured home. SOAH 332-05-3792. Department MHD2005000246-LRV

Public Utility Commission of Texas

Notice of Application for Amendment to Certificated Service Area Boundary

Notice is given to the public of an application filed on February 7, 2005, with the Public Utility Commission of Texas, for an amendment to a certificated service area boundary.

Docket Style and Number: Application of Southwestern Bell Telephone, L.P. d/b/a SBC Texas to Amend Certificate of Convenience and Necessity to Modify the Service Area Boundaries of the Apollo Zone of the Houston Metropolitan Exchange (SBC Texas) and the League City Exchange (Verizon). Docket Number 30736.

The Application: The minor boundary amendment is being filed to transfer a small portion of Verizon's serving area to SBC Texas so that SBC Texas can provide local exchange telephone service to a proposed new apartment complex (Alexan Landing). The majority of the proposed complex property currently lies within SBC Texas' service area. Verizon has provided a letter of concurrence endorsing this proposed change.

Persons wishing to comment on the action sought or intervene should contact the Public Utility Commission of Texas by February 28, 2005, by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 30736.

TRD-200500585
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 8, 2005



Notice of Application for Amendment to Service Provider Certificate of Operating Authority

On February 3, 2005, Computer Network Technology Corporation filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60665. Applicant intends to reflect a change in ownership/control.

The Application: Application of Computer Network Technology Corporation for an Amendment to its Service Provider Certificate of Operating Authority, Docket Number 30723.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas, 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 24, 2005. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30723.

TRD-200500578
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 8, 2005



Notice of Application for Certificate of Convenience and Necessity for a Proposed Transmission Line in Wood County, Texas

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) an application for February 4, 2005, for a certificate of convenience and necessity for a proposed transmission line in Wood County, Texas.

Docket Style and Number: Application of Wood County Electric Cooperative, Inc. for a Certificate of Convenience and Necessity (CCN) for a Proposed Transmission Line in Wood County, Texas. Docket Number 30254.

The Application: The proposed project is designated as the Dallas Water Utilities 69/138 kV D.C. Transmission Line Project. Wood County Electric Cooperative, Inc. (the cooperative) is proposing construction of certain transmission facilities to provide service to a raw-water pump station on Lake Fork Reservoir for the City of Dallas. The cooperative is proposing to construct the Dallas Water Utilities Substation in conjunction with the proposed new transmission line. The new 138 kV transmission line will be approximately 6 miles long of which approximately one mile involves crossing the Lake Fork Reservoir. The 69 kV line, approximately 2 miles long, will be constructed on existing acquired right-of-way.

Persons wishing to intervene or comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. The deadline for intervention in this proceeding is March 21, 2005. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 30254.

TRD-200500579
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 8, 2005



Notice of Application for Designation as an Eligible Telecommunications Carrier Pursuant to P.U.C. Substantive Rule §26.418

Notice is given to the public of an application filed with the Public Utility Commission of Texas on January 28, 2005, for designation as an eligible telecommunications carrier (ETC) in certain areas served by rural telephone companies pursuant to P.U.C. Substantive Rule §26.418.

Docket Title and Number: Application of WWC Texas RSA Limited Partnership, doing business as CellularOne ("Western Wireless"), for Designation as an Eligible Telecommunications Carrier in Certain Areas Served by Rural Telephone Companies. Docket Number 30710.

The Application: The company is seeking ETC designation as a competitive federal ETC for purposes of qualifying to receive federal universal service support in the rural telephone company study areas designated in its application without limitation on the type of customer equipment used.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than March 4, 2005. Hearing and speech-

impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30710.

TRD-200500489
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 2, 2005



Notice of Application to Amend Certificated Service Area Boundaries

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application filed on January 31, 2005, for an amendment to certificated service area boundaries.

Docket Style and Number: Application of Central Texas Electric Cooperative, Incorporated and Kerrville Public Utility Board for a Certificate of Convenience and Necessity for Service Area Boundaries within Kerr County, Texas. Docket Number 30711.

The Application: The proposed boundary modification will realign the boundaries between the two applicants to reflect their existing lines and services to customer. Central Texas Electric Cooperative, Incorporated and Kerrville Public Utility Board are the only utilities that are affected by the proposed boundary change and both have agreed to the proposed amendment.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas no later than February 25, 2005, by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 30711.

TRD-200500507
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 4, 2005



Notice of Application to Amend Certificated Service Area Boundaries

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application filed on February 7, 2005, for an amendment to certificated service area boundaries within Cameron County, Texas.

Docket Style and Number: Application of the Brownsville Public Utilities Board (BPUB) to Amend a Certificate of Convenience and Necessity for Service Area Boundaries within Cameron County (Brownsville Community Improvement Corporation Sports Park). Docket Number 30732.

The Application: The application encompasses an area of land which is singly certificated to American Electric Power Company (AEP), formerly known as Central Power & Light (CP&L), and is within the corporate limits of the City of Brownsville. BPUB received a letter request to provide electric utility service to the proposed Brownsville Sports Park consisting of approximately 155.585 acres of land. The estimated cost to BPUB to provide service to this proposed area is \$113,154.50.

If the application is granted the area would be dually certificated for electric service.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas no later than February 28, 2005, by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 30732.

TRD-200500583
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 8, 2005



Notice of Application to Amend Certificated Service Area Boundaries

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application filed on February 7, 2005, for an amendment to certificated service area boundaries within Cameron County, Texas.

Docket Style and Number: Application of the Brownsville Public Utilities Board (BPUB) to Amend a Certificate of Convenience and Necessity for Service Area Boundaries within Cameron County (Los Vecinos Subdivision). Docket Number 30733.

The Application: The application encompasses an area of land which is singly certificated to American Electric Power Company (AEP), formerly known as Central Power & Light (CP&L), and is within the corporate limits of the City of Brownsville. BPUB received a letter request to provide electric utility service to a proposed subdivision called Los Vecinos Subdivision consisting of 120.45 acres of land. The estimated cost to BPUB to provide service to this proposed area is \$628,000.00. If the application is granted the area would be dually certificated for electric service.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas no later than February 28, 2005, by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 30733.

TRD-200500584
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 8, 2005



Notice of Petition for Waiver of Denial of Request for NXX Code

Notice is given to the public of the filing with the Public Utility Commission of Texas of a petition on January 31, 2005, for waiver of denial by the North American Numbering Plan Administrator (NANPA) Pooling Administrator (PA) of Verizon Southwest's request for two 1,000 blocks of numbers in Boerne, Texas.

Docket Title and Number: Petition of Verizon Wireless for Waiver of Denial of Numbering Resources in Boerne, Texas. Docket Number 30713.

The Application: Verizon Southwest submitted an application to the Pooling Administrator (PA) for numbering resources in the Boerne rate center. The PA denied the request based on the grounds that Verizon Southwest had not met the rate center based months-to-exhaust criteria set forth in the Thousands-Block Number (NXX-X) Pooling Administration Guidelines.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 25, 2005. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30713.

TRD-200500499
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 3, 2005



Notice of Petition for Waiver of Denial of Request for NXX Code

Notice is given to the public of the filing with the Public Utility Commission of Texas of a petition on January 31, 2005, for waiver of denial by the North American Numbering Plan Administrator (NANPA) Pooling Administrator (PA) of Consolidated Communications of Fort Bend Company's request for one 1,000 block of numbers in Katy, Texas.

Docket Title and Number: Petition of Consolidated Communications of Fort Bend Company for Waiver of Denial of Numbering Resources in Katy, Texas. Docket Number 30714.

The Application: Consolidated Communications of Fort Bend submitted an application to the Pooling Administrator (PA) for numbering resources in the Katy rate center. The PA denied the request based on the grounds that Consolidated Communications of Fort Bend had not met the utilization threshold necessary in order to obtain growth number resources.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 25, 2005. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30714.

TRD-200500500
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 3, 2005



Public Notice of Workshop on Pro-Forma Delivery Service Tariff Issues and Request for Redlines

The staff of the Public Utility Commission of Texas (commission) will hold a workshop to discuss issues with the Pro-Forma Delivery Service Tariff (Tariff). The workshop will be held on Monday, March 7, 2005

at 10:30 a.m. in the Commissioners' Hearing Room, located on the 7th floor of the William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701. Project Number 29637, *Rulemaking to Amend P.U.C. Substantive Rule 25.214 and Pro-Forma Retail Delivery Service Tariff*, has been established for this proceeding. Anyone who would like to make a presentation concerning issues with the Tariff at this workshop, should contact Shawnee Claiborn-Pinto at 512-936-7388 prior to February 28, 2005, to make arrangements to be included on the agenda. The commission shall make available in Central Records on March 1, 2005, under Project Number 29637, an agenda for the format of the workshop

Additionally, to assist the commission in development of its proposed rule amendment, the commission will be accepting comments on or redlines of P.U.C. Substantive Rule 25.214 until March 14, 2005. Comments or redlines 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. All responses should reference Project Number 29637.

Questions concerning the workshop or this notice should be referred to Shawnee Claiborn-Pinto, Retail Market Analyst, Electric Division, 512-936-7388. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136.

TRD-200500498
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 3, 2005



Texas Department of Transportation

Public Notice - Availability of Draft Environmental Impact Statement

Pursuant to Title 43, Texas Administrative Code, §2.43(c)(9)(A)(i), the Texas Department of Transportation (TxDOT) is advising the public of the availability of the approved draft environmental impact statement (DEIS) for the proposed construction of the Trinity Parkway reliever route from the IH-35E/SH-183 interchange to US-175/SH-310 interchange in the City of Dallas, Dallas County, Texas. The proposed project is being developed jointly by the Federal Highway Administration (FHWA), the Texas Department of Transportation (TxDOT) and the North Texas Tollway Authority (NTTA).

The corridor is approximately 9 miles long and includes the Dallas Floodway portion of the Trinity River located on the west side of downtown Dallas. The proposed project involves the proposed construction of a four- to six-lane controlled access tollway. This project would assist in reducing local, regional, national, and international traffic congestion on IH-35E and IH-30 in the City of Dallas and improve mobility in the north central Texas region. The social, economic, and environmental impacts of the proposed project have been analyzed in the DEIS.

The No-Build Alternative (Alternative 1) and six build alternatives (Alternatives 2A, 2B, 3A, 3B, 4, and 5) are evaluated in the DEIS. Each build alternative is approximately 9-miles long and begins at IH-35E/SH-183 and ends at US-175/SH-310. Alternatives 2A and 2B generally follow existing Irving/Industrial Boulevard. Alternatives 3A, 3B, 4, and 5 generally follow along the east and/or west Dallas Floodway levees.

The proposed action has the potential to impact (beneficial and/or adverse) land use, single-family residents, businesses, socio-economic conditions, wetlands and jurisdictional waters of the U.S., floodplains, water quality, air quality, cultural resources, and hazardous/regulated

materials. Right-of-way requirements for the build alternatives range from approximately 252 to 495 acres.

Copies of the DEIS are also available for review in hard copy and/or CD format at the following locations:

Dallas: J. Erik Jonsson Central Library, 1515 Young Street, Dallas 75201; Martin L. King Jr. Branch Library, 2922 Martin Luther King Boulevard, Dallas 75215; Dallas West Branch Library, 2332 Singleton Boulevard, Dallas 75212; North Oak Cliff Branch Library, 302 W. Tenth Street, Dallas 75208; Oak Lawn Branch Library, 4100 Cedar Springs Road, Dallas 75219; Pleasant Grove Branch Library, 1125 S. Buckner Boulevard, Dallas 75217; Greater Dallas Chamber of Commerce, 700 North Pearl Street, Suite 1200, Dallas 75201; Oak Cliff Chamber of Commerce, 660 South Zang Boulevard, Dallas 75208; West Dallas Chamber of Commerce, 2424 North Westmoreland Road, Dallas 75212; Dallas Black Chamber of Commerce, 2838 Martin L. King Jr. Boulevard, Dallas 75215; Greater Dallas Hispanic Chamber of Commerce, 4622 Maple Avenue, Suite 207, Dallas 75219; Greater Dallas Asian American Chamber of Commerce, 11171 Harry Hines Boulevard, Suite 115, Dallas 75229; Central Dallas Association, 1412 Main Street, Suite 2500, Dallas 75202; Clean South Dallas, Inc., 2809 Birmingham Avenue, Dallas 75215; West Dallas Multipurpose Center, 2828 Fish Trap Road, Dallas 75212; TR Hoover Development Corporation, 5106 Bexar Street, Dallas 75215; New Hope Baptist Church, 5002 South Central Expressway, Dallas 75215; St. Philips Neighborhood Development Corporation, 1622 Panama Place, Dallas 75215; Kingbridge Crossing Community Center, 3131 Kingbridge Road, Dallas 75212; Dallas City Hall, 1500 Marilla Street, Room L1BN, Dallas 75201; and Dallas County, 411 Elm Street, 4th Floor, Dallas 75202.

Plano: NTTA Offices, 5900 W. Plano Parkway, Suite 100, Plano 75026.

Mesquite: TxDOT - Dallas District Library, 4777 E. Highway 80, Mesquite 75150.

Arlington: North Central Texas Council of Governments (NCTCOG) Headquarters - Center Point Two, 2nd Floor, 616 Six Flags Drive, Arlington 76011.

Copies of the DEIS may be obtained for the cost of actual reproduction. A bound copy of the DEIS may be purchased for \$80.00 per copy, plus \$7.00 for shipping and handling, or a CD version of the document in Adobe Acrobat format for \$5.00, plus \$2.00 for shipping and handling. Requests for a copy of the DEIS may be addressed to John Hoffman, c/o Half Associates, Inc., 8616 Northwest Plaza Drive, Dallas 75225-4292 or by phone: (214) 346-6394. The DEIS may also be obtained on the NTTA homepage via the internet at www.ntta.org. Select 'Projects' on the NTTA homepage, and then click on Trinity Parkway. Comments regarding the DEIS should be submitted to Christopher Anderson, Planning Director, NTTA, P.O. Box 260729, Plano, Texas 75026. Comments must be received or postmarked on or before April 8, 2005.

TRD-200500575
Richard Monroe
General Counsel
Texas Department of Transportation
Filed: February 8, 2005



Request for Proposal Addendum 1 - Collin County Regional Airport

The Texas Department of Transportation (TxDOT) published a request for proposal regarding the Collin County Regional Airport in the *Texas Register* on January 28, 2005 (30 TexReg 436).

This notice clarifies the DBE goal as follows:

FROM: The DBE goal is set at 9%. TxDOT Project Manager is Alan Schmidt, P.E.

TxDOT Planning Project Manager is Bruce Ehly.

TO: The DBE goal is set at 9% and is for the current scope only. TxDOT Project Manager is Alan Schmidt, P.E. TxDOT Planning Project Manager is Bruce Ehly.

TRD-200500576
Richard Monroe
General Counsel
Texas Department of Transportation
Filed: February 8, 2005



Request for Proposal for Aviation Engineering Services

The County of Hale, through its agent, the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT, Aviation Division will solicit and receive proposals for professional aviation engineering design services described in this notice.

Airport Sponsor: Hale County, Hale County Airport. **TxDOT CSJ No.:** 0505PLNVW. **Scope:** Provide engineering/design services for drainage improvements to Runway 22 runway safety area; to widen hangar access taxiway; for drainage improvements to Taxiway A; and replacement of a constant current regulator at the Hale County Airport.

The DBE goal is set at 5%. TxDOT Project Manager is Russell Deason.

To assist in your proposal preparation the most recent Airport Layout Plan, 5010 drawing, and project narrative are available online by selecting "Hale County Airport" at:

www.dot.state.tx.us/avn/avninfo/notice/consult/index.htm

Interested firms shall utilize the latest version of Form AVN-550, titled "Aviation Engineering Services Proposal." The form may be requested from TxDOT, Aviation Division, 125 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, URL address:

<http://www.dot.state.tx.us/avn/avn550.doc>

The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. Proposals shall be stapled but not bound in any other fashion. **PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.** (Attention: To ensure utilization of the latest version of Form 550, firms are encouraged to download Form 550 from the TxDOT website as addressed above. Utilization of Form 550 from a previous download may not be the exact same format. Form 550 is an MS Word Template).

Four completed, unfolded copies of Form AVN 550 must be post-marked by U. S. Mail by midnight March 14, 2005. (CDST). Mailing address: TxDOT, Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483. Overnight delivery must be received by 4:00 p.m. (CDST) on March 15, 2005; overnight address: TxDOT, Aviation Division, 200 E. Riverside Drive, Austin, Texas, 78704. Hand delivery must be received by 4:00 p.m. March 15, 2005 (CDST); hand delivery

address: 150 E. Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704. Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Edie Stimach.

The consultant selection committee will be composed of local government members.

The final selection by the committee will generally be made following the completion of review of proposals. The committee will review all proposals and rate and rank each. The criteria for evaluating engineering proposals can be found at:

www.dot.state.tx.us/business/avnconsultinfo.htm

All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews of the top rated firms if the committee deems it necessary. In such case, selection will be made following interviews.

If there are any procedural questions, please contact Edie Stimach, Grant Manager, or Russell Deason, Project Manager, for technical questions at 1-800-68-PILOT (74568).

TRD-200500577

Richard Monroe

General Counsel

Texas Department of Transportation

Filed: February 8, 2005

Texas Workers' Compensation Commission

Invitation to Apply to the Medical Advisory Committee (MAC)

The Texas Workers' Compensation Commission seeks to have a diverse representation on the MAC and invites qualified individuals from all regions of Texas to apply for openings on the MAC in accordance with the eligibility requirements of the *Procedures and Standards for the Medical Advisory Committee*. The Medical Review Division is currently accepting applications for the following Medical Advisory Committee representative vacancies:

Primary

* Public Health Care Facility

Alternate

* Public Health Care Facility

* Dentist

* Pharmacist

* Podiatrist

* Employer

* Employee

* General Public Representative 1

* General Public Representative 2

Commissioners for the Texas Workers' Compensation Commission appoint the Medical Advisory Committee members who are composed of 18 primary and 18 alternate members representing health care providers, employees, employers, insurance carriers, and the general public. Primary members are required to attend all Medical Advisory Committee meetings, subcommittee meetings, and work group meetings to which they are appointed. The alternate member may attend all meetings, however during a primary member's absence, the

alternate member must attend meetings to which the primary member is appointed. Requirements and responsibilities of members are established in the Procedures and Standards for the Medical Advisory Committee as adopted by the Commission.

The Medical Advisory Committee meetings must be held at least quarterly each fiscal year during regular Commission working hours. Members are not reimbursed for travel, per diem, or other expenses associated with Committee activities and meetings. Voluntary service on the Medical Advisory Committee is greatly appreciated by the TWCC Commissioners and the TWCC Staff.

The purpose and task of the Medical Advisory Committee, which includes advising the Commission's Medical Review Division on the development and administration of medical policies, rules and guidelines, are outlined in the Texas Workers' Compensation Act, §413.005.

Applications and other relevant Medical Advisory Committee information may be viewed and downloaded from the Commission's website at <http://www/twcc.state.tx.us>. Click on 'Commission Meetings', then 'Medical Advisory Committee'. Applications may also be obtained by calling Jane McChesney, MAC Coordinator, at 512-804-4855 or Ruth Richardson, Manager of Monitoring, Analysis and Education, Medical Review Division at 512-804-4850.

The qualifications as well as the terms of appointment for all positions are listed in the Procedures and Standards for the Medical Advisory Committee. These Procedures and Standards are as follows:

LEGAL AUTHORITY The Medical Advisory Committee for the Texas Workers' Compensation Commission, Medical Review Division is established under the Texas Workers' Compensation Act, (the Act) §413.005.

PURPOSE AND ROLE The purpose of the Medical Advisory Committee (MAC) is to bring together representatives of health care specialties and representatives of labor, business, insurance and the general public to advise the Medical Review Division in developing and administering the medical policies, fee guidelines, and the utilization guidelines established under §413.011 of the Act.

COMPOSITION Membership. The composition of the committee is governed by the Act, as it may be amended. Members of the committee are appointed by the Commissioners and must be knowledgeable and qualified regarding work-related injuries and diseases.

Members of the committee shall represent specific health care provider groups and other groups or interests as required by the Act, as it may be amended. As of September 1, 2001, these members include a public health care facility, a private health care facility, a doctor of medicine, a doctor of osteopathic medicine, a chiropractor, a dentist, a physical therapist, a podiatrist, an occupational therapist, a medical equipment supplier, a registered nurse, and an acupuncturist. Appointees must have at least six (6) years of professional experience in the medical profession they are representing and engage in an active practice in their field.

The Commissioners shall also appoint the other members of the committee as required by the Act, as it may be amended. An insurance carrier representative may be employed by: an insurance company; a certified self-insurer for workers' compensation insurance; or a governmental entity that self-insures, either individually or collectively. An insurance carrier member may be a medical director for the carrier but may not be a utilization review agent or a third party administrator for the carrier.

A health care provider member, or a business the member is associated with, may not derive more than 40% of its revenues from workers

compensation patients. This fact must be certified in their application to the MAC.

The representative of employers, representative of employees, and representatives of the general public shall not hold a license in the health care field and may not derive their income directly from the provision of health care services.

The Commissioners may appoint one alternate representative for each primary member appointed to the MAC, each of whom shall meet the qualifications of an appointed member.

Terms of Appointment: Members serve at the pleasure of the Commissioners, and individuals are required to submit the appropriate application form and documents for the position. The term of appointment for any primary or alternate member will be two years, except for unusual circumstances (such as a resignation, abandonment or removal from the position prior to the termination date) or unless otherwise directed by the Commissioners. A member may serve a maximum of two terms as a primary, alternate or a combination of primary and alternate member. Terms of appointment will terminate August 31 of the second year following appointment to the position, except for those positions that were initially created with a three-year term. For those members who are appointed to serve a part of a term that lasts six (6) months or less, this partial appointment will not count as a full term.

Abandonment will be deemed to occur if any primary member is absent from more than two (2) consecutive meetings without an excuse accepted by the Medical Review Division Director. Abandonment will be deemed to occur if any alternate member is absent from more than two (2) consecutive meetings which the alternate is required to attend because of the primary member's absence without an excuse accepted by the Medical Review Division Director.

The Commission will stagger the August 31st end dates of the terms of appointment between odd and even numbered years to provide sufficient continuity on the MAC.

In the case of a vacancy, the Commissioners will appoint an individual who meets the qualifications for the position to fill the vacancy. The Commissioners may re-appoint the same individual to fill either a primary or alternate position as long as the term limit is not exceeded. Due to the absence of other qualified, acceptable candidates, the Commissioners may grant an exception to its membership criteria, which are not required by statute.

RESPONSIBILITY OF MAC MEMBERS Primary Members. Make recommendations on medical issues as required by the Medical Review Division.

Attend the MAC meetings, subcommittee meetings, and work group meetings to which they are appointed.

Ensure attendance by the alternate member at meetings when the primary member cannot attend.

Provide other assistance requested by the Medical Review Division in the development of guidelines and medical policies.

Alternate Members. Attend the MAC meetings, subcommittee meetings, and work group meetings to which the primary member is appointed during the primary member's absence.

Maintain knowledge of MAC proceedings.

Make recommendations on medical issues as requested by the Medical Review Division when the primary member is absent at a MAC meeting.

Provide other assistance requested by the Medical Review Division in the development of guidelines and medical policies when the primary member is absent from a MAC meeting.

Committee Officers. The TWCC Commissioners designate the chairman of the MAC. The MAC will elect a vice chairman. A member shall be nominated and elected as vice chairman when he/she receives a majority of the votes from the membership in attendance at a meeting at which nine (9) or more primary or alternate members are present.

Responsibilities of the Chairman: Preside at MAC meetings and ensure the orderly and efficient consideration of matters requested by the Medical Review Division; prior to meetings, confer with the Medical Review Division Director, and when appropriate, the TWCC Executive Director to receive information and coordinate:

- a. Preparation of a suitable agenda.
- b. Planning MAC activities.
- c. Establishing meeting dates and calling meetings.
- d. Establishing subcommittees.
- e. Recommending MAC members to serve on subcommittees.

If requested by the Commission, appear before the Commissioners to report on MAC meetings.

COMMITTEE SUPPORT STAFF The Director of Medical Review will provide coordination and reasonable support for all MAC activities. In addition, the Director will serve as a liaison between the MAC and the Medical Review Division staff of TWCC, and other Commission staff if necessary.

The Medical Review Director will coordinate and provide direction for the following activities of the MAC and its subcommittees and work groups:

Preparing agenda and support materials for each meeting.

Preparing and distributing information and materials for MAC use.

Maintaining MAC records.

Preparing minutes of meetings.

Arranging meetings and meeting sites.

Maintaining tracking reports of actions taken and issues addressed by the MAC.

Maintaining attendance records.

SUBCOMMITTEES The chairman shall appoint the members of a subcommittee from the membership of the MAC. If other expertise is needed to support subcommittees, the Commissioners or the Director of Medical Review may appoint appropriate individuals.

WORK GROUPS When deemed necessary by the Director of Medical Review or the Commissioners, work groups will be formed by the Director. At least one member of the work group must also be a member of the MAC.

WORK PRODUCT No member of the MAC, a subcommittee, or a work group may claim or is entitled to an intellectual property right in work performed by the MAC, a subcommittee, or a work group.

MEETINGS Frequency of Meetings. Regular meetings of the MAC shall be held at least quarterly each fiscal year during regular Commission working hours.

CONDUCT AS A MAC MEMBER Special trust has been placed in members of the Medical Advisory Committee. Members act and serve

on behalf of the disciplines and segments of the community they represent and provide valuable advice to the Medical Review Division and the Commission. Members, including alternate members, shall observe the following conduct code and will be required to sign a statement attesting to that intent.

Comportment Requirements for MAC Members:

Learn their duties and perform them in a responsible manner;

Conduct themselves at all times in a manner that promotes cooperation and effective discussion of issues among MAC members;

Accurately represent their affiliations and notify the MAC chairman and Medical Review Director of changes in their affiliation status;

Not use their memberships on the MAC: a. in advertising to promote themselves or their business. b. to gain financial advantage either for themselves or for those they represent; however, members may list MAC membership in their resumes;

Provide accurate information to the Medical Review Division and the Commission;

Consider the goals and standards of the workers' compensation system as a whole in advising the Commission;

Explain, in concise and understandable terms, their positions and/or recommendations together with any supporting facts and the sources of those facts;

Strive to attend all meetings and provide as much advance notice to the Texas Workers' Compensation Commission staff, attn: Medical Review Director, as soon as possible if they will not be able to attend a meeting; and

Conduct themselves in accordance with the MAC Procedures and Standards, the standards of conduct required by their profession, and the guidance provided by the Commissioners, Medical Review Division or other TWCC staff.

TRD-200500581

Susan Cory

General Counsel

Texas Workers' Compensation Commission

Filed: February 8, 2005



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 29 (2004) is cited as follows: 29 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 "29 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 29 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 through the Internet. The address is: <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 subscription information, see the back cover or call the Texas Register at (800) 226-7199.

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 (using Arabic numerals) and Parts (using Roman 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 (1-800-356-6548), and West Publishing Company (1-800-328-9352).

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 *Table of TAC Titles Affected*. The table is published cumulatively in the blue-cover quarterly indexes to the *Texas Register* (January 16, April 9, July 9, and October 8, 2004). If a rule has changed during the time period covered by the table, the rule's TAC number will be printed with one or more *Texas Register* page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE

Part I. Texas Department of Human Services

40 TAC §3.704.....950, 1820

The *Table of TAC Titles Affected* is cumulative for each volume of the *Texas Register* (calendar year).

Please use this form to order a subscription to the *Texas Register*, to order a back issue, or to indicate a change of address. Please specify the exact dates and quantities of the back issues required. You may use your VISA or Mastercard. All purchases made by credit card will be subject to an additional 2.1% service charge. Return this form to the Texas Register, P.O. Box 13824, Austin, Texas 78711-3824. For more information, please call (800) 226-7199.

Change of Address

(Please fill out information below)

Paper Subscription

One Year \$200 First Class Mail \$300

Back Issue (\$10 per copy)

_____ Quantity

Volume _____, Issue # _____.

(Prepayment required for back issues)

NAME _____

ORGANIZATION _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE NUMBER _____

FAX NUMBER _____

Customer ID Number/Subscription Number _____

(Number for change of address only)

Payment Enclosed via Check Money Order

Mastercard/VISA Number _____

Expiration Date ____/____ Signature _____

Please make checks payable to the Secretary of State. Subscription fees are not refundable. Do not use this form to renew subscriptions.

Visit our home on the internet at <http://www.sos.state.tx.us>.

Periodical Postage

PAID

Austin, Texas
and additional entry offices

