ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

The Texas Health and Human Services Commission (HHSC) adopts amendments to §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology, §355.8066, concerning Hospital-Specific Limit Methodology, and §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care. Sections 355.8065, 355.8066, and 355.8212 are adopted with changes to the proposed text as published in the April 14, 2023, issue of the *Texas Register* (48 TexReg 1903). These rules will be republished.

BACKGROUND AND JUSTIFICATION

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

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

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

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

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

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

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

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

-no financial harm to state entities;

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

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

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

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

-increase clarity of the regulations;

-increase transparency of the existing administrative practices; and

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

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

State Payment Cap

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

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

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

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

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

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

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

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

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

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

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

HHSC received comments regarding some language that providers felt required additional specificity. HHSC also received comments related to certain determinations that will be made by CMS. HHSC is adopting the proposed changes to the SPC rules with amendments in response to these comments with an immediate effective date.

Disproportionate Share Hospital Program

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

DSH program payments are made by HHSC to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. Federal law also limits FFP for DSH payments through the hospital-specific DSH limit. In Texas, the state has established a State Payment Cap that limits the amount of payments that a provider receives through the interim payment process. This adoption amends the calculation of the State Payment Cap effective for fiscal year 2023.

Effective for fiscal year 2024, the adoption also amends the definition of the rural provider classes, establishes a new rural DSH pool, describes a methodology for redistribution of certain recouped funds, modifies the calculation of the Low-Income Utilization Rate to reflect federal law, updates the payment allocation methodology, establishes changes to qualifications of the program, revises the advance payment methodology for federal fiscal year 2024, and makes other clarifying amendments. HHSC has decided to delay implementation of the rule changes in §355.6065 to fiscal year 2024 in response to concerns that providers had not budgeted for potential recoupments that might occur from their interim/advance payments as a result of the methodological changes.

HHSC will modify the advance payment methodology for DSH 2024 to pay providers based upon the estimated amount that they will receive in the 2024 final DSH payment in an effort to help providers avoid reliance on interim or advance payments that are inconsistent with the final payment methodology. Multiple commenters were concerned about recoupment of 2023 advance DSH payments due to the alteration of the DSH methodology and the mismatch of the advance payment methodology and the final payment methodology, and this issue will be perpetuated if the advance payment methodology does not align with the rule changes.

This rule amendment will establish an allocation methodology that is separate from the SPC to allocate Pool 2. This payment will consist of two sub-pools: Pool 2a and Pool 2b.

Pool 2a, the Standard DSH pool, was created in response to comments received that were concerned that providers that qualified for DSH might not receive a payment, that DSH is the program of last resort for Medicaid costs, and that teaching hospitals need financial support to continue their residency programs. To address these concerns Pool 2a pays every hospital the maximum of a standard payment amount or their Medicaid shortfall (based on the minimum of the full offset and MACPAC Medicaid shortfall). Two standard payment amounts will be used: an amount for hospitals with residents (to support the existence of residency programs across the state), and an amount for hospitals that do not have residents. The payment will be capped at their minimum SPC after considering the non-federal share associated with Pool 2a for all hospitals other than the transferring hospitals' portion of non-federal share

transferred on behalf of private hospitals. The Standard DSH payment ensures that remaining uncovered Medicaid costs are reimbursed first and creates a predictable standard payment amount. This pool will protect smaller hospitals by allocating them a simple, predictable payment amount.

Pool 2b will consider hospitals' payment to cost ratio against the set percentage. Hospitals will receive payment based on a set percentage of their total costs after consideration of payments, including Pool 2a All Funds payments excluding the amount of IGT transferring hospitals transfer for private hospitals. DSH is the only Medicaid reimbursement option that remains to reimburse for any uncompensated Medicaid costs or non-charity uncompensated care. As such, providers who have high levels of non-Medicaid utilization, which is common among rural and large public providers, may benefit from a method that considers the unique opportunity for reimbursement available under DSH. Additionally, a reimbursement methodology that considers the proportion of total costs covered could help providers achieve more similar percentages of total costs reimbursed.

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

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

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

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

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

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

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

To more transparently and clearly achieve this purpose, HHSC is proposing the creation of a rural DSH sub-pool for hospitals that meet the same definition of rural in the inpatient reimbursement are categorized. The amount of the sub-pool will be equivalent to the amount that has been reserved for Pass 3 in recent years. If rural public hospitals cannot fully utilize the allocated funds, a percentage of any remaining funds will be made available to the rural private hospitals with any other funds being redirected back to the Pool 1 and Pool 2 secondary allocation.

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

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

Uncompensated Care Program

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

Under the terms of the January 15, 2021 1115 Waiver, HHSC negotiated for the continuation and resizing of the UC pool. The result of the first pool resizing is an increase in the pool by approximately $600 million annually, for a total of $4.5 billion for demonstration years 12 through 16. This expenditure authority may be utilized only for providers that are authorized to participate in UC who demonstrate charity care expenses. HHSC is adopting a methodology that the new, additional UC funding be considered for a different allocation methodology than the previously extant $3.9 billion. HHSC is defining this sub-pool as the High Impecunious Charge Hospital (HICH pool). HHSC had proposed that eligibility to receive funds from this pool would be

restricted to rural hospitals, state-owned hospitals, and hospitals that have at least 30 percent of their charges from serving uninsured persons.

HHSC received several comments that requested that HHSC add specific hospital classes to be included in the HICH pool. HHSC will not make changes to add additional hospital classes, but recognizes that the 30 percent charge threshold that had been proposed might be too restrictive. Therefore, upon adoption, HHSC will amend the rule to lower the threshold of charges to 27.5 percent. HHSC will use 27.5 percent of charges as this threshold because it continues to represent a small number of hospitals - indicating that 27.5 percent is truly rare and a high portion of charges. This will target these funds to hospitals that serve a large volume of uninsured persons as part of their patient-mix as well as rural hospitals and state-owned facilities, consistent with HHSC's established goals.

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

Clarifying Amendments

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

COMMENTS

The 31-day comment period ended May 15, 2023.

During this period, HHSC received comments regarding the proposed rules from 55 organizations and one individual, including Texas Organization of Rural and Community Hospitals (TORCH); Texas Association of Behavioral Health Systems (TBHS); Sun Behavioral Health; Summit Behavioral Healthcare; Texas Essential Healthcare Partnership; Baylor Scott and White Health; Children's Hospital Association of Texas; Preferred Management; Texas Essential Healthcare Partnership; Mission Regional Medical Center and Knapp Medical Center; DHR Health; Christus Health; Huntsville Memorial Hospital; JPS Health Network; Teaching Hospitals of Texas (THOT); Parkland Health; UMC Health System; University Health; University Medical Center El Paso; Harris Health Systems; South Texas Delegation; UTHealth East Texas; BSA Health System; Seton Medical Center Harker Heights; Baptist Hospital of Southeast Texas; Oakbend Medical Center; Big Bend Regional Medical Center; Unidos Contra La Diabetes; Hope Family Health Center; Regional Vice President; Tenet Health; Su Clinica; Memorial Hermann; HCA Healthcare; Texas Health Resources; Texas Children's Financial Services; UT Health East Texas; Medical Center of Southeast Texas (MCSET); Texas Association of Voluntary Hospitals (TAVH); Medical Center Health Systems; Tenet Healthcare Corporation; Signature Healthcare Services; Universal Health Services (UHS); Nuestra Clinica Del Valle, INC; Seton Medical Center Harker Heights; Texas Hospital association; Oceans Healthcare; St. Luke's Health and its hospitals; Lifepoint Health; Odessa Regional Medical Center; Community health Systems; Acadia Healthcare; Texas Scottish Rite Hospital for Children.

A summary of comments relating to the rules §355.8065, §355.8066, and §355.8212, and HHSC's responses follows.

Regarding §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology:

Allocation Methodology.

Comment: Multiple commenters provided comments in support of the proposed allocation methodology. They stated that the proposed amendments are a comprehensive and transparent approach to consider all Medicaid payment programs and the costs of caring for those covered by Medicaid and those without insurance. They expressed support for the comprehensive approach of the proposed amendments as a measure to compare Medicaid payments made to different provider groups and as a way to achieve better equity between provider groups.

Response: HHSC appreciates the support. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters provided comments opposed to the proposed allocation methodology. They stated that moving to a cost-based methodology disadvantages certain hospital classes and regions of the state because under the proposed rules some providers that qualify for DSH will not receive any payment, in particular private IMD hospitals and hospitals in the South Texas border region.

Response: HHSC disagrees that the proposed rules would have disadvantaged certain hospital classes or regions of the state as the changes proposed did not specifically exclude any geographic area or hospital class from receiving payment. HHSC does agree that the determination that a hospital is qualified and eligible for DSH indicates that a hospital should receive some payment from DSH, if the hospital has room under their state payment cap. Therefore, as a result of these comments, HHSC will amend the rules upon adoption to incorporate an updated allocation methodology to include a new standard DSH payment before the payment-to-cost pool. This addresses the commenters' concerns ensuring that providers that qualify for DSH from all hospital classes and geographic regions receive a payment. HHSC updated 355.8065(g) and 355.8065(h) to describe the methodology and updated 355.8065(b)(24) to ensure the appropriate cross-reference.

Comment: Multiple commenters provided comments opposed to the proposed allocation methodology stating that the methodology incentivizes increasing costs to increase payments and does not incentivize hospitals to serve Medicaid and uninsured patients.

Response: HHSC disagrees with the comment that moving to a payment-to-cost-based methodology would incentivize hospitals to inflate costs to increase payments because a provider is unlikely to receive full cost reimbursement through DSH and is therefore unlikely to inflate costs in order to receive a fractional reimbursement of those costs. HHSC declines to make changes to the rule text in response to this comment.

Comment: Several commenters provided comments opposed to the proposed allocation methodology stating that it limits the potential for a hospital that has uncompensated Medicaid costs to be reimbursed because the UC program is only for uninsured charity care.

Response: HHSC disagrees that the proposed allocation methodology inherently limits the potential for a hospital that has uncompensated Medicaid cost to be reimbursed because, to the extent that a hospital has uncompensated Medicaid costs and does not have a higher than typical payment-to-cost ratio, the provider would receive DSH payments that could compensate for unreimbursed Medicaid costs. However, HHSC does acknowledge that DSH is the payment of last option for Medicaid

costs as the UC program is only for uninsured charity care. Therefore, as a result of these comments, HHSC will amend the rules upon adoption to incorporate an updated the allocation methodology to include a new standard DSH payment that will allocate payments to providers in an amount that is the greater of the Standard amount or the provider's Medicaid shortfall (capping all payments at the provider's state payment cap) to ensure that to the greatest extent possible Medicaid costs are reimbursed. HHSC updated 355.8065(g) and 355.8065(h) to describe the methodology and updated 355.8065(b)(24) to point to the appropriate reference.

Comment: Several commenters provided comments opposed to the proposed allocation methodology stating that it treats hospitals homogenously when they are not.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. With regard to hospitals being treated homogenously, the rule has multiple different hospital classes and definitions because HHSC recognizes that different needs exist among different hospital classes.

Comment: Several commenters provided comments opposed to the proposed allocation methodology stating that it favors inefficient hospitals with higher costs resulting from their inability to better manage the level of care.

Response: HHSC disagrees that the proposed method favors inefficient hospitals with higher costs and declines to make changes to the rule text in response to this comment. The prior allocation methodology of days could result in providers prioritizing extending inpatient stays which is inefficient.

Comment: Multiple commenters provided comments opposed to the proposed allocation methodology stating that it introduces instability and unpredictability with a percentage of cost paid floor that changes every year.

Response: HHSC acknowledges the changes in funding for certain hospital classes and areas of the state, and the importance of stability and predictability for hospitals' financial health. As a result of these comments, HHSC updated the allocation methodology to include a new standard DSH payment before the cost pool. This addresses the commenters' concerns by lessening the total funds in the cost-based pool, resulting in a redistribution of funds as a result. HHSC updated 355.8065(g) and 355.8065(h) to describe the methodology and updated 355.8065(b)(24) to point to the appropriate reference.

Exclusion of advance UC payment in DSH percentage of cost calculation.

Comment: One commenter requested that HHSC consider excluding advance UC payments when calculating a hospital's percentage of reimbursed DSH costs, stating that doing so would not result in hospitals receiving reimbursement twice for the same costs as the UC program reimbursement is generally considered after the DSH program.

Response: HHSC disagrees and declines to make changes to the rule text as a result of this comment as the State Payment Cap has historically had an offset for UC advance payments that exceed UC only costs; this practice is continued in the percentage of cost covered calculation. This structure avoids reimbursing providers in DSH for costs that may have already been reimbursed in UC.

LIUR.

Comment: Multiple commenters commented against the change in the LIUR calculation to align with Federal LIUR calculation, stating that the updated calculation methodology could be devastating to many hospitals including rural hospitals. Commenters request for HHSC to retain the historical LIUR calculation.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment as the updated text is based on the Federal LIUR calculation which is a part of the Federal statute for the DSH program as described in 42 U.S.C. §1396r-4 (b)(3).

Comment: Several commenters made suggestions on the calculation methodology of the LIUR calculation stating that the LIUR calculation should include all Medicaid payments.

Response: HHSC declines to make changes to the rule text in response to this comment as the updated text is based on the Federal LIUR definition. HHSC will adhere to the Federal LIUR as described in 42 U.S.C. §1396r-4 (b)(3).

Local Provider Participation Funds.

Comment: Multiple commenters commented against the proposed changes stating that the changes would lead to strain on local provider participation funds (LPPFs) across the state as private hospitals' payments would shift from DSH to UC, which may lead to LPPFs being pushed to their caps.

Response: HHSC disagrees with this comment and declines to make changes to the rule text in response to this comment. HHSC has observed a willingness on the part of governmental entities that operate LPPFs to support through IGT all the varied Medicaid programs that have been created under the Medicaid state plan and the 1115 Waiver. HHSC has not received any requests asking HHSC to halt the growth in size of other programs, such as the Comprehensive Hospital Increased Reimbursement Program (CHIRP) or the Uncompensated Care program due to a lack of available local public funds. Rather, HHSC has consistently received requests for HHSC to pursue the approval of new and additional programs, which would utilize, at least in part, LPPF-derived local funds as the source of non-federal share. This indicates to HHSC that there is an availability of local funds sufficient to support hospital payment programs held by local governments that IGT for such programs. All governmental entities are required to comply with all federal and state laws and regulations related to the operation of LPPFs, including the limitations on the percentage of net patient revenue that may be assessed as a mandatory payment and HHSC designs programs and payment methodologies that are distinct from the method of finance that a local government may utilize. As result, no revision to the rule text was made in response to this comment.

Modeling.

Comment: Multiple commenters stated that the posted models on the DSH proposed changes included an error where private rural providers were included in the model for the public rural pool and requested an updated model based on 2023 data.

Response: Models are for informational purpose only and are not to be used as the basis of actual payments. However, HHSC identified due to the comment that the rule text did not describe participation of private rural hospitals in the rural pool in DSH. HHSC will amend the rule upon adoption to clarify that private hospitals are eligible to receive a percentage of the remaining

rural pool if the public rural hospitals do not fully exhaust the rural public pool.

Recoupments.

Comment: Multiple commenters provided comments that they are against the retroactive application of the rule changes as it would lead to recoupment for many hospitals and lead to harm for hospitals that will be recouped based on the rule changes.

Response: HHSC disagrees that the rule changes proposed could be considered retroactive as any payments that providers have received to date are either interim or advance payments that are subject to being recouped at the time that the final payments are calculated for DSH and UC respectively. As such, the potential recoupments a provider might experience at the time of a final payment are fully within the current practice of rebalancing payments at the time of the final payment, which is made based upon the rule in effect at the time HHSC makes the final payment. However, HHSC understands that providers may have made budgetary assumptions that did not contemplate the proposed changes and, in response to commenters' concerns, HHSC will defer the application of the changes in 355.8065 to the DSH 2024 program period. Additionally, to assist providers with appropriate financial planning next year, HHSC will modify the advance payment methodology for DSH 2024 to pay providers based upon the estimated amount that they will receive in the 2024 final DSH payment in an effort to help providers avoid reliance on interim or advance payments that are inconsistent with the final payment methodology. HHSC updated 355.8065(a) and 355.8065(q)(5) in response to this comment.

General Comments.

Comments: Multiple providers provided general comments in support for all of the proposed rule changes.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters provided general comments against the proposed rule changes including observations that there is a disparity between the DSH and UC funding sources, stating the UC reimbursements are diminished in comparison to DSH reimbursements.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. Qualifications for participation in the DSH program are updated to align with federal rules and UC reimbursement has increased by $600 million dollars annually so it is unclear what the basis is used for this comparison.

Rural definition.

Comment: Multiple commenters provided comment against the change in the rural definition and stated that the change would deny many hospitals of a vital payment. Several commenters have also requested maintaining the current rural definition or modifying the rural definition to be more inclusive and to account for population growth in Texas.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. It is HHSC's intention to align the rural definition to the Inpatient rate rule for consistency and transparency. A non-urban public definition is retained for Pass 3 in DSH.

Public Rural pool.

Comment: A commenter provided comment in support of the establishment of the public rural pool.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Timing.

Comment: Multiple commenters provided comments against the timing of the proposed rule changes, stating that the proposed rule changes are happening in the midst of many other program and rate changes affecting hospitals including the comprehensive hospital increase reimbursement program, enhanced ambulatory patient groups, inpatient rate rebasing, and changes in federal policies and that proposed changes were based on planning that began prior to the pandemic and public health emergency and that proposed changes should be revisited.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC has carefully evaluated options the last few years, both before and during the COVID-19 public health emergency. It is HHSC's intention to implement these changes at this time after careful analysis, and HHSC will continue to monitor the DSH and UC programs in subsequent years as we administer the programs. Discussion of other program changes, audits, or federal policies is outside of scope of the current DSH/UC rule updates.

Comment: Several commenters provided comment in support of the timing of the proposed rule changes.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

IGT.

Comment: A commenter requested the treatment of IGT as costs in the DSH program and several commenters requested for the continuation and expansion of IGT credits in the UC program.

Response: HHSC acknowledges this comment. HHSC declines to expand the IGT credits for either DSH or UC and the treatment of IGT because these requests are outside the scope of the proposed rule changes. HHSC will take this into consideration for future analysis. No revision to the rule text was made in response to this comment.

Condition of Participation.

Comment: Multiple commenters provided comments in support of the new condition of participation requiring hospitals to participate in directed and supplemental Medicaid payment programs they are eligible for.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: A commenter requested the inclusion of language for exemption for hospitals that do not qualify for programs or would receive zero dollars or less from programs during the program year.

Response: HHSC agrees and has updated §355.8065(e)(9) and §355.8212(c)(1)(F) to include language outlining an exemption from this eligibility requirement for any directed or supplemental payment programs for which hospitals are eligible if their estimated payment will be $25,000 or less.

Comment: Several commenters provided comments against the condition of participation, stating that this requirement in effect creates application fees for the DSH program, especially for private IMDs that may receive less reimbursement through the program than the application fee for other programs.

Response: HHSC acknowledges this comment. HHSC updated §355.8065(e)(9) and §355.8212(c)(1)(F) to include language for an exemption from this eligibility requirement for any directed or supplemental payment programs for which hospitals are eligible if their estimated payment from that program will be $25,000 or less.

Comment: A commenter requested the removal of application fees for Medicaid directed and supplemental payment programs.

Response: This is outside the scope of the proposed rule changes. No revision to the rule text was made in response to this comment.

Comment: A commenter provided feedback that IMDs are often not eligible for an average commercial incentive award (ACIA) increase in CHIRP and many IMDs have not applied for the ACIA component because they would not receive any additional benefit while being subjected to increased quality reporting requirements.

Response: HHSC acknowledges this feedback and has clarified the rule text in §355.8065(e)(9) and §355.8212(c)(1)(F) to state that hospitals are required to "enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all required components of those programs" if the hospital is estimated to receive at least $25,000 from the program or the program component.

Comment: A commenter provided comment against the timing of the condition of participation stating that by proposing for this change to begin in program year 2024, the proposed change would occur more than six months after CHIRP enrollment period has ended for the 2024 program year. As this was known after the fact, HHSC should not penalize hospitals for failing to meet a condition of participation for program year 2024.

Response: HHSC agrees and has updated the rule text in §355.8065(e)(9) and §355.8212(c)(1)(F) to clarify that this requirement applies for all programs for which the enrollment period begins after this rule is effective.

Impact statements.

Comment: One commenter provided comments against the proposed rule changes, stating the proposed rule changes will affect local businesses, economies, and the State at large.

Response: HHSC disagrees with the comment. The rule does not directly regulate local business or economies, and the proposed rules did not impede the ability of any community or hospital within a community to receive payments if the hospital has a lower payment-to-cost ratio. Further, the same aggregate funding level was available to the State at large. Nevertheless, HHSC made changes in the adopted rule to mitigate funding shifts while still promoting stated policy goals.

DSRIP.

Comment: Multiple commenters have commented that DSH is not an appropriate vehicle for restoring hospitals' DSRIP payments because the goal of DSRIP was to incentivize performance which is not aligned with the purpose of the DSH program which supports hospitals serving a higher volume of Medicaid and low-income patients.

Response: HHSC acknowledges this comment but declines to make any changes to the rules as a result. Funding is complex with multiple interdependencies and DSH is not being used as the mechanism to fully replace the DSRIP program, but the changes to DSH are in part necessary as the impact of other programs that were designed to replace DSRIP have resulted in imbalance in overall hospital financing stability.

Comment: Several commenters stated that the DSRIP funding was inequitably allocated and noted that numerous private providers were unable to participate in DSRIP. The commenters further noted that as such the proposed changes perpetuate the inequity by shifting funds away from certain hospital classes to other hospital classes.

Response: The allocation of DSRIP funding and prior DSRIP participation is outside the scope of the current proposed rules. In the development of the proposed rules, HHSC examined the DSH and UC programs in their entirety with the intent of ensuring that the funds are allocated in accordance with their purpose, where the funds were most likely to benefit a large number of Texans receiving care, and in accordance with established state policy goals. No changes were made in response to this comment.

Comment: One commenter stated that they disagree with the assessment that large urban public hospitals have not already replaced their DSRIP funding.

Response: HHSC disagrees with the commenter. Pursuant to HHSC's Rider 15(j) report, our analysis indicates that the reimbursement levels for certain classes of hospitals including large urban publics is not at an equivalent level overall compared to FFY 2020, the last year that DSRIP was operational. No changes were made in response to this comment.

Private IMDs.

Comment: Multiple commenters have submitted comments against the proposed rule changes, stating that the changes would negatively impact private IMDs. Commenters requested protection for private IMD hospitals through creation of a protected private IMD pool, maintaining state hospitals allocation at 90 percent of their state payment caps in DSH to avoid future recoupments and private IMDs exceeding the statewide aggregate IMD limit and stated that the proposed rule would reduce non-state IMDs before reducing state IMD DSH payments for the IMD allotment cap which would further diminish non-state IMDs in participation of the DSH Program.

Response: HHSC has added a new standard DSH pool to provide a minimum payment to all hospitals, including private IMDs, that have room under their state payment cap. However, IMD hospitals can only receive a limited portion of the DSH funds under federal statute. HHSC annually determines the percentage of the state payment caps that will be paid to state-owned providers. HHSC will consider the impact to non-state-owned IMDs as those amounts are established each year, as is the current practice. HHSC updated 355.8065(b)(22), 355.8065(g) and 355.8065(h) in response to this comment.

CHIRP adjustment appeal.

Comment: Two commenters submitted comments requesting HHSC to allow hospitals to use historical UHRIP /CHIRP pay-

ment projections and actual payments in appeals of HHSC's CHIRP adjustments in the DSH and UC programs.

Response: This is outside the scope of the proposed rule changes. No revision to the rule text was made in response to this comment.

Graduate Medical Education Payments.

Comment: One commenter is in support of the proposed DSH methodology and states that inclusion of Medicaid GME payments in the proposed DSH rules is appropriate and further states that while teaching hospitals are in support of the proposed changes, teaching hospitals are still left with unfunded healthcare workforce teaching and training costs within GME.

Response: HHSC appreciates the support for the proposed amendment and acknowledges the comment on the needs of teaching hospitals. In the amended rule text, the standard DSH payment for hospitals with residents will be a higher payment than hospitals without residents.

Ambiguous Rule text.

Comment: Several commenters submitted comments against the ambiguity of the wording of §355.8065(c)(2)(B) and (c)(3)(B), stating that the words "may" and "if necessary" does not provide sufficient justification and allows HHSC too much discretion to make changes to the payment ceiling calculations of hospitals.

Response: HHSC disagrees with the suggested update. The commenters had mistakenly provided the incorrect rule text reference for this comment. No revision to the §355.8065 rule text was made in response to this comment. However, HHSC believes that the commenters intention was to reference §355.8066(c)(2)(B) and (c)(3)(B). As a result, HHSC has review the §355.8066(c)(2)(B) and (c)(3)(B) rule text and amended the "may" to "shall" and removed "if necessary" for greater clarity.

Regarding §355.8066, concerning Hospital-Specific Limit Methodology:

Lesser of methodology.

Comment: Multiple commenters submitted comments in support of the lesser of methodology for the State Payment Cap.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters submitted comments against the lesser of methodology citing that it is unnecessarily complicated and requesting the use of the MACPAC definition as the sole SPC.

Response: HHSC disagrees and declines to make revisions to the rule as a result of this comment. The lesser of methodology protects hospitals against future recoupments which outweighs the noted complexity of the methodology.

Comment: One commenter submitted comment against the lesser of methodology and stated that HHSC's proposal to continue to use the full-offset state-payment cap calculation in the lesser of approach goes against the cost reporting principles of the DSH HSL calculation as supported by the now withdrawn CMS FAQs 33 and 34.

Response: HHSC disagrees. The state has the authority to calculate a state-specific limit, which is the state payment cap, as a basis for distributing interim DSH funds. CMS has adopted rules that describe how the final HSL is calculated, and HHSC is adhering to federal direction on the DSH audit.

Comment: Multiple commenters stated that using the lesser of methodology is inequitable because it applies different standard calculations across hospitals with some hospitals including dual eligible populations in their percentage of cost calculations, while others will have that population excluded. These commenters requested the use of only the MACPAC SPC.

Response: HHSC disagrees and declines to make revisions to the rule as a result of this comment. The lesser of methodology protects hospitals from recoupments, and the cost and payments used in the percentage of cost covered pool correspond to the minimum SPC.

Exceptions.

Comment: One commenter requested that HHSC revise §355.8066(c)(3)(D) and (d)(3) before adoption to remove the requirement that hospitals request HHSC determine whether they meet the 97th percentile exception; and add language that HHSC will rely on the eligibility determination made by CMS.

Response: HHSC agrees and has revised §355.8066(c)(3)(D) and (d)(3) to include the statement "HHSC will adhere to CMS' determination on eligibility for exceptions authorized by Section 1923(g) of the Social Security Act."

Regarding §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care:

Rural Definition

Comment: A commenter stated that HHSC did not change from 2010 to 2020 census definition for the standard definition of rural hospital.

Response: HHSC agrees and has revised §355.8212(b)(17)(A) to state "most recent decennial census" instead of citing the 2010 U.S. Census to conform with anticipated definition changes that will also be made to the inpatient rate rule definitions.

Charity Care calculation.

Comment: A commenter provided a suggestion for rural providers to be allowed to choose between a cost spread methodology or their overall Cost to Charge Ratio as reported on S-10 for charity care cost calculations.

Response: This is outside the scope of the proposed rule changes. No revision to the rule text was made in response to this comment.

HICH.

Comment: Multiple commenters submitted comments in support of the establishment of the HICH pool.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: One commenter suggested that the HICH ratio should exclude uninsured charity charges and duplicates in the numerator and simply utilize DSH uninsured charges for total uninsured charges in the numerator to calculate uninsured volume, and that the HICH ratio's denominator should equal total charges drawn from the same time period as total uninsured charges in the numerator.

Response: HHSC disagrees and declines to make changes to the rule text as a result. As the HICH pool and the HICH ratio

is a part of the UC program which reimburses hospitals for uninsured charity care, the usage and inclusion of uninsured charity charges is appropriate, as is the consideration of any duplicated uninsured charges from the DSH and UC programs to ensure accuracy in the calculation of the numerator. The intention of the HICH pool is to allocate funds amongst hospitals with a high proportion of uncompensated care charges, using total allowable revenue would provide a more accurate picture of the proportion of uncompensated care charges than the suggested total charges from the same time period as the denominator.

Comment: Multiple commenters requested modification of HICH pool eligibility. Requests for HICH pool eligibility qualifications included requests to include non-transferring and transferring public hospitals and request to exclude rural public hospitals.

Response: HHSC declines to add transferring and non-transferring public hospitals to the HICH pool eligibility based on the comments. However, HHSC understands that the 30 percent HICH ratio may be too restrictive and will be lowering that threshold to 27.5 percent in 355.8212(f)(2)(D)(ii).

Rule text language.

Comment: A commenter requested retaining the language "to that hospital and private hospitals" in 1 TAC §355.8212(g)(2)(A)(iv) to add clarity related to transferring public hospitals.

Response: HHSC agrees and has retained the language "to that hospital and private hospitals" in §355.8212(g)(2)(A)(iv). This update to the rule does not change the calculations or methodology of the updated rule text.

Regional Healthcare partnership.

Comment: A commenter stated that the removal of Regional Healthcare partnership (RHP) from the rule would contradict the waiver standard term and condition (STC) (38)(a)(ii)(2) that requires a hospital to participate in an RHP in order to qualify for UC payments and that a waiver amendment to that STC should be considered.

Response: HHSC has submitted a request for a technical correction for the waiver to update the standard term and condition (STC) to align with the removal of Regional Healthcare partnership (RHP) and requirement of affiliation agreements. Until such a time as the STC technical correction is approved by CMS, 1 TAC §355.8212(a) continues to require providers to comply with all underlying federal requirements, including the STCs.

IMD age exclusion.

Comment: Several commenters stated that the rule changes disadvantages IMDs in particular because in addition to expected reduction in DSH payments, IMDs are subject to the age exclusion for charity costs for patients ages 21-64 in the UC program.

Response: HHSC did not propose any changes for this topic, but we will take this into consideration for future rule making. No revision to the rule text was made in response to this comment.

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8065, §355.8066

STATUTORY AUTHORITY

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

§355.8065. Disproportionate Share Hospital Reimbursement Methodology.

(a) Introduction. Hospitals participating in the Texas Medicaid program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for reimbursement from the disproportionate share hospital (DSH) fund. The Texas Health and Human Services Commission (HHSC) will establish each hospital's eligibility for and amount of reimbursement using the methodology described in this section beginning with the DSH program year corresponding with federal fiscal year 2024. For program periods that correspond with federal fiscal year 2023, eligibility and payments will be made in accordance with the rule text as it existed on June 1, 2023.

(b) Definitions.

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

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

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

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

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

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

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

(8) Children's hospital--A hospital that is a Children's hospital as defined in §355.8052 of this chapter (relating to Inpatient Hospital Reimbursement).

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

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

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

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

(13) Governmental entity--A state agency or a political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county, or state entity.

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

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

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

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

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

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

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

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

(22) Institution for mental diseases (IMD) cap--An IMD limit determined each fiscal year and as described under Section 1923(h) of the Social Security Act.

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

(24) Low-income days--Number of inpatient days attributed to indigent patients are calculated using the following methodology. Low-income days are equal to the hospitals low-income utilization rate as calculated in subsection (d)(2) of this section multiplied by the hospitals total inpatient days.

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

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

(27) Medicaid contractor--Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.

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

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

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

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

(32) Non-federal percentage--The non-federal percentage equals one minus the federal medical assistance percentage (FMAP) for the program year.

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

(34) Non-urban public hospital--A hospital other than a transferring public hospital that is:

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

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

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

(36) PMSA--Primary Metropolitan Statistical Area as defined by the United States Office of Management and Budget.

(37) Public funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

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

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

(40) Rural public hospital--A hospital that is a rural hospital as defined in §355.8052 of this chapter and is either:

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

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

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

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

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

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

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

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

(47) Total Medicaid inpatient days--Total number of inpatient days based on adjudicated claims data for covered services for the relevant DSH data year.

(A) The term includes:

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

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

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

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

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

(B) The term excludes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Merged Hospitals.

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

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

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

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

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

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

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

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

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

(3) Total Medicaid inpatient days.

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

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

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

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

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

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

(1) Two-physician requirement.

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

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

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

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

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

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

(3) Trauma system.

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

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

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

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

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

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

(7) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. If HHSC receives documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to continue receiving DSH payments for the remainder of the DSH program year.

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

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

(A) a hospital is not required to enroll, participate in, and comply with the requirements:

(i) of a program without multiple components if the hospital's estimated payment from the entire program is less than $25,000; or

(ii) of a program's component for programs that have multiple components if the hospital's estimated payment from the program's component is less than $25,000; and

(B) enrollment for the program concluded after the effective date of this requirement.

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

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

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

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

(3) Rural private hospitals. If funds remain from the amount set aside in subsection (g)(2) of this section for rural public hospitals after paying all hospitals up to their state payment caps, HHSC may set aside a portion of the remaining funds for rural private hospitals.

(4) Non-state hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in subsection (h) of this section, including rural public and rural private hospitals.

(A) The remaining available DSH funds equal the lesser of the funds as defined in subsection (b)(2) of this section less funds expended under paragraph (1), (2), and (3) of this subsection or the sum of remaining qualifying hospitals' state payment caps.

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

(h) DSH payment calculation.

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

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

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

(C) an opportunity for hospitals to request HHSC review of disputed data.

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

(A) Pool One.

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

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

(B) Pool Two.

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

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

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

(ii) Pool Two payments are available to all non-state-owned hospitals except for any transferring public hospitals as defined in subsection (b) of this section; or non-urban public hospital as defined in subsection (b) of this section that does not transfer any funds to HHSC for Pool Three as described in subparagraph (C)(iii) of this paragraph.

(C) Pool Three.

(i) Pool Three is equal to the sum of intergovernmental transfers for DSH payments received by HHSC from governmental entities that own and operate transferring public hospitals and non-urban public hospitals.

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

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

(I) Non-urban public hospitals. Each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for funding the non-federal share of the hospital's DSH payments from Pool Two (calculated as described in paragraphs (3) and (4) of this subsection) to that hospital.

(II) Transferring public hospitals. Each governmental entity that owns and operates a transferring public hospital is responsible for funding the non-federal share of the DSH payments from Pool Two (calculated as described in paragraphs (3) and (4) of this subsection) to its affiliated hospital and a portion of the non-federal share of the DSH payments from Pool Two to private hospitals. For funding payments to private hospitals, HHSC will initially suggest an amount in proportion to each transferring public hospitals' individual state payment cap relative to total state payment caps for all transferring public hospitals. If an entity transfers less than the suggested amount, HHSC will take the steps described in paragraph (4)(H) of this subsection.

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

(3) Distribution and payment calculation for Pools One and Two initial payment, Standard DSH payment.

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

(B) All hospitals that meet DSH qualification and eligibility criteria will be allocated an initial payment from Pools One and Two. Initial payments will be allocated as follows.

(i) A hospital will receive a payment that is the greater of:

(I) the hospital's Medicaid shortfall; or

(II) a standard DSH payment.

(ii) If the amount calculated in clause (i) of this subparagraph is greater than the hospital's state payment cap after considering the state share required to fund the standard DSH payment, the hospital will receive their state payment cap.

(C) HHSC will determine the standard DSH payment amount described in subparagraph (B)(i)(II) of this paragraph annually in an amount not to exceed $10,000,000 per hospital for hospitals that have reported residents on their Medicare cost report or in an amount not to exceed $10,000,000 per hospital for hospitals that have not reported residents on their Medicare cost report.

(D) For a privately-owned institution of mental disease their minimum payment amount may be reduced to ensure that payments for all IMDs remain below the IMD cap.

(4) Distribution and payment calculation for Pools One and Two secondary payment, percentage of costs covered.

(A) The costs considered for the percentage of costs covered will be the costs included in the state payment cap in paragraph (3)(A) of this subsection.

(B) The payments considered for the percentage of costs covered will be the payments included in the state payment cap in paragraph (3)(A) of this subsection plus the standard DSH payment after considering the state share required to fund the hospital's payment. Transferring hospitals will not have IGT paid for private hospitals for the standard DSH payment included in their percentage of cost covered.

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

(D) HHSC will determine an allocation percentage such that all hospitals receive a uniform percentage of their costs covered to fully utilize Pools One and Two, Pass Two.

(E) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for a Pool One and Two secondary payment.

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

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

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

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

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

(5) Pass One distribution and payment calculation for Pool Three.

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

(i) For each transferring public hospital:

(I) divide the Pool Two payments from paragraphs (3) and (4) of this subsection by the FMAP for the program year; and

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

(ii) For each Non-urban public hospital:

(I) divide the Pool Two payments from paragraphs (3) and (4) of this subsection by the FMAP for the program year; and

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

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

(B) HHSC will calculate the secondary payment from Pool Three for each transferring public hospital as follows.

(i) Sum the intergovernmental transfers made on behalf of all transferring public hospitals.

(ii) For each transferring public hospital, divide the intergovernmental transfer made on behalf of that hospital by the sum of the intergovernmental transfers made on behalf of all transferring public hospitals from clause (i) of this subparagraph.

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

(iv) Subtract the sum from clause (iii) of this subparagraph from the total value of Pool Three.

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) HHSC will determine an allocation percentage such that all rural public hospitals receive a uniform percentage of the costs covered to fully utilize the rural public all funds allocation. The per-

centage of cost covered will consider all previous DSH payments for the program year, including the funds for the non-state hospitals.

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

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

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

(8) Rural private hospital pool distribution and payment calculation.

(A) If any funds remain from the rural public pool described in paragraph (7) of this subsection, HHSC will allocate a percentage of the remaining funds to rural private hospitals.

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

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

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

(E) Each governmental entity that owns and operates a transferring public hospital is responsible for funding the non-federal share of the DSH payments from the rural private hospital pool to rural private hospitals. If an entity transfers less than the suggested amount, HHSC will reduce the rural private hospitals' payments to the level supported by the amount of the intergovernmental transfer.

(F) Any remaining funds from the percentage allocation described in subparagraph (A) of this paragraph and any undistributed funds from this pool will be redistributed back into the pool two secondary payment as described in paragraph (4) of this subsection.

(9) Pass Three - If any portion non-federal share of the available DSH funds is not fully funded, the remaining allocation will be available to non-urban public hospitals that met the funding requirements described in paragraph (2)(C)(iii)(I) of this subsection.

(A) For each non-urban public hospital that met the funding requirements described in paragraph (2)(C)(iii)(I) of this subsection, HHSC will determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with paragraphs (4) - (8) of this subsection, as appropriate.

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

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

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

(i) determine remaining available funds by subtracting payment amounts for all DSH hospitals calculated in paragraphs (4) - (8) of this subsection from the amount in subsection (g)(3) of this section;

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

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

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

(E) Non-urban public hospitals that do not meet the funding requirements of paragraph (2)(C)(iii)(I) of this subsection are not eligible for participation on Pass Three.

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

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

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

then the state owned IMD payments will be reduced on a pro-rata basis until they equal the federal IMD limit.

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

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

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

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

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

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

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

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

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

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

(k) Disproportionate share funds held in reserve.

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

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

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

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

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

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

(i) be sent to HHSC's Director of Hospital Finance, Provider Finance Department;

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

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

(B) The review is:

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

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

(iii) not conducted as an adversarial hearing.

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

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

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

(n) Voluntary withdrawal from the DSH program.

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

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

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

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

(o) Audit process.

(1) Independent certified audit. HHSC is required by the Social Security Act (Act) to annually complete an independent certified audit of each hospital participating in the DSH program in Texas.

Audits will comply with all applicable federal law and directives, including the Act, the Omnibus Budget and Reconciliation Act of 1993 (OBRA '93), the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), pertinent federal rules, and any amendments to such provisions.

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

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

(i) The Medicaid cost report;

(ii) Medicaid Management Information System data; and

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

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

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

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

(F) Review of preliminary audit finding of overpayment.

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

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

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

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

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

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

(iii) The review is:

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

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

(III) not an adversarial hearing.

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

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

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

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

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

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

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

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

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

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

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

(B) HHSC will make a first pass allocation by multiplying the weight described in subsection (p)(2)(A) of this section by the final remaining HSL calculated in the audit findings described in subsection (o) of this section. HHSC will divide the product by the total remaining HSLs for all non-state providers. HHSC will multiply the quotient by the total amount of recouped dollars available for redistribution described in subsection (p)(1) of this section.

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

(q) Advance Payments

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

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

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

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

(5) The amount of the advance payments:

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

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

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

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

(C) in DSH program year 2024, HHSC will run the application data for hospital applications through an updated DSH qualification and calculation file to determine advanced payment eligibility and amount to account for rule changes between program year 2023 and 2024 to prevent recoupments; and

(D) HHSC will determine the payment allocation for the advances for 2025 and subsequent years by calculating a percentage based on a hospital's payment in the preceding year divided by the sum of all other hospitals' payment in the preceding year that are eligible for an advance payment.

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

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

(b) Definitions.

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

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

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

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

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

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

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

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

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

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

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

(12) Hospital-specific limit--The maximum payment amount authorized by Section 1923(g) of the Social Security Act that a hospital may receive in reimbursement for the cost of providing

Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured for payments made during a prior program year. The amount is calculated as described in subsection (d) of this section using actual cost and payment data from that period. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who have third-party coverage; and costs associated with pharmacies, clinics, and physicians. The calculation of the hospital-specific limit must be consistent with federal law.

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) Total state and local subsidies--Total state and local subsidies is defined in §355.8065 of this division.

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

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

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

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

(1) Calculation of uninsured and Medicaid costs and payments.

(A) Uninsured charges and payments.

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

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

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

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

(B) Medicaid charges and payments.

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

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

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

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

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

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

(II) HHSC will exclude charges and payments for:

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Determining inpatient routine costs.

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

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

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

(iii) Determining inpatient and outpatient ancillary costs.

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

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

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

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

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

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

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

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

(3) Calculation of the Recoupment Prevention Payment Ceiling.

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

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

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

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

(4) State Payment Cap.

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

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

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

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

(d) Hospital-Specific Limit.

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

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

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

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

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

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

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

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

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

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

(e) Due date for DSH and UC Application.

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

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

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

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

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

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

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

(2) Request for review of data.

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

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

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

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

(3) HHSC's review.

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

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

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

(iii) solely a data review; and

(iv) not an adversarial hearing.

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

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

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

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

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

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

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

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on May 31, 2023.

TRD-202302015
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: June 20, 2023
Proposal publication date: April 14, 2023
For further information, please call: (737) 867-7813

♦ ♦ ♦

DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

1 TAC §355.8212

STATUTORY AUTHORITY

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

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

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

(b) Definitions.

(1) Allocation amount--The amount of funds approved by the Centers for Medicare & Medicaid Services for uncompensated-care payments for the demonstration year that is allocated to each uncompensated-care provider pool or individual hospital, as described in subsections (f)(2) and (g)(6) of this section.

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

(3) Charity care--Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2012). Charity care includes full or partial discounts given to uninsured patients who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

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

(5) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. This period corresponds to the Disproportionate Share Hospital (DSH) program year. Demonstration year one corresponded to the 2012 DSH program year, October 1, 2011, through September 30, 2012.

(6) Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program as defined in §355.8065 of this subchapter (relating to Disproportionate Share Hospital Reimbursement Methodology).

(7) Governmental entity--A state agency or a political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county, or state entity.

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

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

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

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

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

(13) Mid-Level Professional--Medical practitioners which include the following professions only:

(A) Certified Registered Nurse Anesthetists;

(B) Nurse Practitioners;

(C) Physician Assistants;

(D) Dentists;

(E) Certified Nurse Midwives;

(F) Clinical Social Workers;

(G) Clinical Psychologists; and

(H) Optometrists.

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

(15) Public funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

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

(17) Rural hospital--A hospital enrolled as a Medicaid provider that:

(A) is located in a county with 68,750 or fewer persons according to most recent decennial census U.S. Census; or

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

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

(D) meets all of the following:

(i) has 100 or fewer beds;

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

(iii) is located in an MSA.

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

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

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

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

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

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

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

(25) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in this subsection.

(26) Uninsured patient--An individual who has no health insurance or other source of third-party coverage for the services provided. The term includes an individual enrolled in Medicaid who received services that do not meet the definition of medical assistance in section 1905(a) of the Social Security Act (Medicaid services), if such inclusion is specified in the hospital's charity-care policy or financial assistance policy and the patient meets the hospital's policy criteria.

(27) Waiver--The Texas Healthcare Transformation and Quality Improvement Program Medicaid demonstration waiver under §1115 of the Social Security Act.

(c) Eligibility. A hospital that meets the requirements described in this subsection may receive payments under this section.

(1) Generally. To be eligible for any payment under this section:

(A) A hospital must be enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year.

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

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

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

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

(F) Beginning in demonstration year thirteen, all non-rural hospitals, except for state-owned hospitals, will be required to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in UC. This requirement does not apply to a program or component, as applicable, if:

(i) a hospital's estimated payment:

(I) is less than $25,000 from the entire program for a program without multiple components; or

(II) is less than $25,000 from a component for a program with multiple components; and

(ii) enrollment for the program concluded after the effective date of this requirement.

(2) Uncompensated-care payments. For a hospital to be eligible to receive uncompensated-care payments, in addition to the requirements in paragraph (1) of this subsection, the hospital must submit to HHSC an uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC.

(3) Changes that may affect eligibility for uncompensated-care payments.

(A) If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, or files bankruptcy before receiving all or a portion of the uncompensated-care payments for a demonstration year, HHSC will determine the hospital's eligibility to receive payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the demonstration year and whether it can satisfy the requirement to cooperate in the reconciliation process as described in subsection (i) of this section.

(B) A hospital must notify HHSC Provider Finance Department in writing within 30 days of the filing of bankruptcy or of changes in ownership, operation, licensure, or Medicare or Medicaid enrollment that may affect the hospital's continued eligibility for payments under this section.

(C) Merged Hospitals.

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

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

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

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

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

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

(f) Funding limitations.

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

(2) Uncompensated-care pools.

(A) HHSC will designate different pools for demonstration years as follows:

(i) for demonstration years nine and ten, a state-owned hospital pool, a non-state-owned hospital pool, a physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool;

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

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

(B) The state-owned hospital pool.

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

(ii) HHSC will determine the allocation for this pool at an amount less than or equal to the total annual maximum uncompensated-care payment amount for these hospitals as calculated in subsection (g)(2) of this section.

(C) The state-owned physician group practice pool.

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

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

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

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

(ii) A hospital will be deemed as having a high proportion of uncompensated care charges if its impecunious charge ratio is equal to or greater than 27.5 percent, calculated as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(g) Uncompensated-care payment amount.

(1) Application.

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

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

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

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

(2) Calculation.

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

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

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

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

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

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

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

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

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

(iv) For each transferring public hospital, the amount transferred to HHSC to that hospital and private hospitals to support DSH payments for the same demonstration year.

(B) A hospital also participating in the DSH program cannot receive total uncompensated-care payments under this section (relating to inpatient and outpatient hospital services provided to uninsured charity-care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's state payment cap for interim payments or DSH hospital-specific limit (HSL) in the UC reconciliation plus the unreimbursed costs of inpatient and outpatient services provided to uninsured charity-care patients not included in the state payment cap or HSL for the corresponding program year.

(3) Hospital charity-care costs.

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

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

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

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

(4) Other eligible costs.

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

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

(ii) certain pharmacy services.

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

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

(A) A hospital:

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

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

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

(i) Such supporting documentation must include:

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

(II) verifiable information from the hospital's general ledger, financial statements, patient accounting records or

other relevant sources that support the numbers used to calculate the adjustment; and

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

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

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

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

(A) Calculations in this paragraph will be applied to each of the uncompensated-care pools separately.

(B) HHSC will calculate the following data points.

(i) For each provider, prior period payments equal prior period uncompensated-care payments for the demonstration year, including advance payments described in paragraph (9) of this subsection, and payments allocated in preceding UC pools. For example, the HICH pool will consider UC payments allocated in the state-owned hospital and non-state-owned hospital pools.

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

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

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

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

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

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

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

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

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

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

(I) For rural hospitals, HHSC will:

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

(-b-) in demonstration year:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) Advance payments.

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

(B) The amount of the advance payments will:

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

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

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

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

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

(h) Payment methodology.

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

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

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

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to hospitals in each pool or sub-pool will be determined based on the amount of funds transferred by governmental entities as follows.

(A) If the governmental entities transfer the maximum amount referenced in paragraph (1) of this subsection, the hospitals in the pool or sub-pool will receive the full payment amount calculated for that payment period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1) of this subsection, each hospital in the pool or sub-pool will receive a portion of its payment amount for that period, based on the hospital's percentage of the total payment amounts for all providers in the pool or sub-pool.

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

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

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

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

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

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

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

(j) Recoupment.

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

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

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

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

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on May 31, 2023.

TRD-202302016
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: June 20, 2023
Proposal publication date: April 14, 2023
For further information, please call: (737) 867-7813

♦ ♦ ♦

TITLE 10. COMMUNITY DEVELOPMENT

PART 5. OFFICE OF THE GOVERNOR, ECONOMIC DEVELOPMENT AND TOURISM OFFICE

CHAPTER 200. TEXAS SMALL BUSINESS CREDIT INITIATIVE

The Office of the Governor, Economic Development and Tourism Office ("Office") adopts new Subchapter A, §§200.1 - 200.20, concerning the Texas Small Business Credit Initiative Capital Access Program, and new Subchapter B, §§200.101 - 200.117, concerning the Texas Small Business Credit Initiative Loan Guarantee Program. New §§200.1, 200.3 - 200.7, 200.9 - 200.20, 200.101, 200.103 - 200.105, 200.107 - 200.117 are adopted without changes to the proposed text as published in the March 10, 2023, issue of the *Texas Register* (48 TexReg 1381) and will not be republished. New §§200.2, 200.8, 200.102, 200.106 are adopted with changes to the proposed text as published in the March 10, 2023, issue of the *Texas Register* (48 TexReg 1381) and will be republished. The Office has made changes to §§200.2, 200.8, 200.102, 200.106 from the proposed text to clarify the losses that are eligible for reimbursement and that certain refinanced loans are eligible for enrollment in the Texas Small Business Credit Initiative ("TSCBI") Capital Access Program ("CAP") and Loan Guarantee Program ("LGP"). The revisions do not materially alter the issues addressed in the rules, address new subjects of regulation, affect no new individuals, and impose no additional requirements for compliance.

REASONED JUSTIFICATION

Subchapter A. Texas Small Business Credit Initiative Capital Access Program

Adopted new §200.1 specifies the authority and purpose of the TSBCI CAP.

Adopted new §200.2 establishes definitions the Bank intends to utilize in administering TSBCI CAP. After its initial publication, the Office updated §200.2(7) to clarify what losses are covered by the TSBCI CAP program. The word "original" was added before "principal amount," and the definition of "Loss" now reads: "Any original principal amount due and not paid and not more than the enrolled amount of the Qualified Loan plus reasonable out-of-pocket expenses. In the event only a portion of a Qualified Loan was enrolled, the Office limits reimbursement of out-of-pocket expenses to the ratio of the enrolled portion to the total loan amount."

Adopted new §200.3 establishes that a financial institution seeking to participate in TSBCI CAP must apply through the TSBCI portal, provide any additional information the Office determines is necessary to properly review the application, and sign a required participation agreement. The adopted rule also specifies that the Office has no obligation to allow a financial institution to participate.

Adopted new §200.4 specifies that the Office will develop an agreement and underscore that a financial institution must agree to the terms of that agreement to participate in the program.

Adopted new §200.5 establishes that a participating financial institution must establish a loan loss reserve account after it enters the participation agreement with the Office. The account must have a competitive interest rate. The new rule also specifies that the funds in the loan loss reserve account may be used to cover loan charge offs. Thus, if a borrower defaults on a loan, the financial institution may withdraw funds from the reserve to cover the principal it lost when it charged off the loan. Adopted new §200.6 establishes that the loan loss reserve account does not belong to the financial institution; rather, the account is property of the State of Texas. The state will collect all interest earned on the contributions to the account and periodically withdraw the earned interest. Section 200.6 also specifies that the Office may withdraw contributions the Office made to the account if the Office must unenroll a loan that was enrolled in error.

Adopted new §200.7 establishes the types of loans that qualify to be enrolled in TSBCI CAP and sets minimum and maximum loan amount thresholds.

Adopted new §200.8 specifies prohibited uses of funds from loans enrolled in the program. After its initial publication, the Office updated §200.8(b) to delete former paragraph (5), renumber the remaining provisions in the subsection, and add language to clarify that only loans already enrolled in non TSBCI related credit enhancement or credit insurance programs may not be refinanced. These changes clarify that certain refinanced loans or portions of refinanced loans may be enrolled in TSBCI CAP.

Adopted new §200.9 specifies the contributions that a borrower and financial institution must make to the loan loss reserve and establishes the circumstances in which a financial institution may seek the maximum contribution allowed under TSCBI CAP.

Adopted new §200.10 establishes that, after a financial institution deposits the required contribution to the loan loss reserve, the financial institution may request that the Office enroll the loan in TSBCI CAP. The adopted rule also lays out the loan-enrollment process. The rule also establishes that the Office must unenroll any loans it determines were in enrolled in error. Section 200.10 also establishes that no loan may be enrolled in TSBCI CAP for more than one hundred twenty months.

Adopted new §200.11 requires the Office to deposit into the loan loss reserve account an amount equal to the combined contribution from the borrower and the financial institution. For example, if the borrower and financial institution each contribute premiums equal to 3.5 percent of the loan principal a combined contribution equal to seven percent of the loan principal unless an exception applies, the Office will deposit an additional amount equal to seven percent of the loan principal into the loan loss reserve. New §200.11 also specifies the exceptions to the requirement that the Office match contributions dollar-for-dollar, such as if the TSBCI Fund does not contain money greater than or equal to the contribution.

Adopted new §200.12 details the process a financial institution must follow to make a claim for reimbursement on a loan the institution charged off. The rule also specifies the steps a financial institution must take before making a claim.

Adopted new §200.13 establishes how the Office will review claims and reimburse a financial institution when the institution makes a valid claim. The rule also details the circumstances in which the Office may reject a claim. New §200.13 also specifies that, if the loan loss reserve account does not have sufficient funds to cover the requested reimbursement, then the Office will pay an amount up to the available balance of the loan loss reserve account, less earned interest. Adopted new §200.14 requires financial institutions that recover on debts after the institutions have been reimbursed for a loss to promptly repay the loan loss reserve the amount recovered on the debt, up to the amount of the reimbursement.

Adopted new §200.15 details some of the circumstances in which the Office may terminate the enrollment of loans in TSBCI CAP, when the Office may terminate the participation agreement with a financial institution, and how a financial institution may withdraw from TSBCI CAP.

Adopted new §200.16 notifies financial institutions that, if an institution has an annual claims rate that exceeds six percent and the Office determines the institution's practices do not meet TSBCI CAP standards or it is using the program to offset costs of a high default rate, the Office may disallow that institution from enrolling future loans in the program. The new rule also details how claims rates are determined.

Adopted new §200.17 establishes that the Office may inspect a financial institution's files related to enrolled loans. New §200.18 specifies reporting requirements for program participants. New §200.19 notes the Office may recover actual and necessary administrative expenses accrued in operating TSBCI CAP from the TSBCI Fund.

Adopted new §200.20 details the circumstances in which a provision in Subchapter A may be waived.

Subchapter B. Texas Small Business Credit Initiative Loan Guarantee Program

Adopted new §200.101 specifies the authority and purpose of the TSBCI LGP.

Adopted new §200.102 establishes definitions the Bank intends to utilize in administering TSBCI LGP. After its initial publication, the Office updated §200.2(7) to clarify what losses are covered by the TSBCI LGP program. The word "original" was added before "principal amount," and the definition of "Loss" now reads: "Any original principal amount due and not paid and not in excess of the Guaranteed Amount of the Qualified Loan."

Adopted new §200.103 establishes that a financial institution seeking to participate in TSBCI LGP must apply through the TSBCI portal, provide any additional information the Office determines is necessary to properly review the application, and sign a required participation agreement. The adopted rule also specifies that the Office has no obligation to allow a financial institution to participate.

Adopted new §200.104 specifies that the Office will develop an agreement and underscore that a financial institution must agree to the terms of that agreement to participate in the program.

Adopted new §200.105 establishes the types of loans that qualify to be enrolled in TSBCI LGP and sets minimum and maximum loan amount thresholds.

Adopted new §200.106 specifies the purposes for which loan proceeds may and may not be used. After its initial publication, the Office updated §200.106(b) to delete former paragraph (5), renumber the remaining provisions in the subsection, and add language to clarify that only loans already enrolled in non TSBCI related credit enhancement or credit insurance programs may not be refinanced. These changes clarify that certain refinanced loans or portions of refinanced loans may be enrolled in TSBCI LGP.

Adopted new §200.107 specifies the maximum guarantees available under TSBCI LGP and establishes the circumstances in which a financial institution may seek the maximum guarantee allowed under TSCBI LGP. Adopted new §200.107 also establishes the process a financial institution must undertake to enroll a loan in TSBCP LGP. The rule also establishes that the Office must unenroll any loans it determines were in enrolled in error. Section 200.107 also establishes that no loan may be enrolled in TSBCI LGP for more than one hundred eight months.

Adopted new §200.108 requires the Office to encumber an amount up to the guaranteed amount in the TSBCI fund, and attribute that encumbrance to the enrolled loan. New §200.108 also specifies the exceptions to the requirement that the Office encumbers up to the guaranteed amount, such as if the TSBCI Fund does not contain an available balance greater than or equal to the encumbrance amount.

Adopted new §200.109 details the process a financial institution must follow to make a claim for reimbursement on a loan the institution charged off. The rule also specifies the steps a financial institution must take before making a claim.

Adopted new §200.110 establishes how the Office will review claims and remit funds to a financial institution when the institution makes a valid claim. The rule also details the circumstances in which the Office may reject a claim. New §200.110 also specifies that, if the TSBCI Fund does not have sufficient funds to cover the requested amount, then the Office will pay an amount up to the available balance of the TSBCI Fund allocated to the LGP. Adopted new §200.111 requires financial institutions that recover on debts after the institutions have recovered on a loss to promptly repay the Office for the amount recovered on the debt, up to the amount of the recovery.

Adopted new §200.112 details some of the circumstances in which the Office may terminate the enrollment of loans in TSBCI LGP, when the Office may terminate the participation agreement with a financial institution, and how a financial institution may withdraw from TSBCI LGP.

Adopted new §200.113 notifies financial institutions that, if an institution has an annual claims rate that exceeds six percent

and the Office determines the institution's practices to not meet TSBCI LGP standards or it is using the program to offset costs of a high default rate, the Office may disallow that institution from enrolling future loans in the program. The new rule also details how claims rates are determined.

Adopted new §200.114 establishes that the Office may inspect a financial institution's files related to enrolled loans. New §200.115 specifies reporting requirements for program participants. New §200.16 notes the Office may recover actual and necessary administrative expenses accrued in operating TSBCI LGP from the TSBCI Fund.

Adopted new §200.17 details the circumstances in which a provision established in Subchapter B may be waived.

SUMMARY OF COMMENTS AND AGENCY RESPONSES

The public comment period for these rules began on March 10, 2023, and continued for at least 30 days, as required by Chapter 2001, Texas Government Code. The OOG received six comments. The following provides summaries of the comments and the OOG's responses.

Comment 1: The commenter expressed support for Texas's implementation of the State Small Business Credit Initiative.

Response: The Office appreciates the commenter's support.

Comment 2: The commenter expressed support for Texas's implementation of the State Small Business Credit Initiative.

Response: The Office appreciates the commenter's support.

Comment 3: The commenter expressed support for Texas's implementation of the State Small Business Credit Initiative and suggested the following: (1) Regarding 10 T.A.C. §200.113, the commenter suggested increasing the threshold for when the Office may stop authorizing loan enrollments from 6 percent to 15 percent; (2) regarding 10 TAC §200.107, the commenter encouraged the Office to not "re-underwrite" loans submitted for enrollment; and (3) the commenter asked for loans to be enrolled in the Loan Guarantee Program before the loan is funded so the lender has assurance the loan will be supported. The commenter also suggested that, should any fees be charged by the Programs, they be less than those charged by other programs, such as the federal SBA program.

Response: The Office is grateful for the support for Texas's implementation of the State Small Business Credit Initiative and for the commenter's participation in the rulemaking process.

Regarding suggestion (1): Section VII.g of Treasury's SSBCI guidance pertaining to Capital Access Programs requires the Office to review lenders whose annual claims rate exceeds 6 percent. If lenders have an excessive claims rate, the Office "may" not "must" decline to enroll loans in the Capital Access Program if the Office determines the lender's practices do not meet program standards or is using the program to offset costs of high default rate lending. The Office has also independently determined the 6 percent threshold is an appropriate measure for increase oversight of a lender. For administrative alignment, the appropriateness of the threshold, and the discretionary nature of the requirement, the Office set a similar standard for TSBCI LGP. The Office will review each lender independently and will make determinations based on the facts before the Office. Accordingly, the Office declines to make such a change.

Regarding suggestion (2): The Office agrees with the commenter. The Office will perform due diligence and review to ensure lenders are appropriately underwriting loans; not engaging in fraud, waste, and abuse; and implement other controls required by law and Treasury guidance, but the Office will not "re-underwrite" loans.

Regarding suggestion (3): In TSBCI LGP, the Office requires a participating financial institution to apply through the Program Website on or before the 15th day after the loan documents were executed, but there is no restriction on how early an application can be submitted. This means that a lender may apply for the LGP before the loan is funded if the application is submitted on or before the 15th day after the loan documents are executed. The Office declines to make any changes in response to this suggestion.

Comment 4: The commenter suggested three modifications to the rulemaking related to TSBCI LGP: (1) increase the maximum guarantee amount for SEDI-owned or very small businesses from 80% to 100%; (2) include an additional item in the list of eligible uses of loan proceeds; and (3) increase the maximum guarantee for all borrowers from 50% to 80%.

Response: The Office is grateful for the commenter's suggestions and participation in the rulemaking process.

Regarding suggestion (1): The SSBCI controlling statutes and guidance require that lenders have "a meaningful amount of their own capital resources at risk." Providing a 100% maximum guarantee would mean a meaningful amount of lenders' capital would not be at risk, and would violate SSBCI program law and policy. Accordingly, the Office declines to make any changes in response to this suggestion.

Regarding suggestion (2): The list provided in §200.106(a) is a non-exhaustive list of "business purposes" and is only intended to give examples of expenditures that fall in the category. Accordingly, the Office declines to make any changes to the list, as the list is not intended to specify all purposes for which TSBCI-related funds may be used.

Regarding suggestion (3): In addition to requiring that lenders have a meaningful amount of capital at risk in their loans, SSBCI statutes and guidance encourage incentivizing lenders to provide access to capital to SEDI-owned and very small businesses. Accordingly, to encourage participating financial institutions to direct their efforts toward SEDI-owned businesses and very small businesses, the Office has provided a higher ceiling for guarantees associated with those types of businesses. Additionally, §200.107(g) provides a mechanism by which a lender may be approved to obtain the maximum guaranteed amount of 80%, regardless of the SEDI status of borrowers. Accordingly, the Office declines to make changes in response to this suggestion.

Comment 5: The commenter thanked the Office for its efforts on Texas's implementation of the SSBCI program and suggested two changes to the proposed rules "to foster the inclusion of [Community Development Financial Institutions (CDFIs)] and the communities they serve, particularly nonprofit CDFIs that serve the communities who lack access to capital from traditional financial institutions." The commenter expressed concern that the proposed rules may potentially omit CDFIs from participating in TSBCI programs and that language relating to the Office exercising its discretion in decision-making results in ambiguous guidance.

The commenter's first suggestion is for the definition of "Participating Financial Institution" or "PFI" to be updated to remove

the phrase "bankable loans." The commenter states that some nonprofit CDFIs work to help unbankable communities become bankable, and so the current language implies that such nonprofits may not participate in the programs.

The commenter's second suggestion is for the Office to remove uses in the proposed rules of the phrases "sole discretion," "due care and diligent efforts," and "consistently and actively undertaken activities." The commenter asserts these phrases are subjective and may lead to inconsistent decision-making and create an unpredictable and potentially unfair environment for program recipients.

Regarding suggestion (1): The Office will remove the word "bankable" from the definition of "Participating Financial Institutions" to clarify that that nonprofit CDFIs may participate in the TSBCI programs.

Regarding suggestion (2): To best use SSBCI funds and ensure proper program administration, the Office must retain its ability to act in its discretion. The Office notes the purposes of the TSBCI Programs are established in §§200.1 and 200.101 and will exercise its discretion only in accordance with these established principles and purposes and will not act arbitrarily and capriciously. Accordingly, the Office declines to make any changes in response to this suggestion.

Comment 6: The commenter expressed excitement about the TSBCI programs but also expressed concern about its success because she believes lenders will not be incentivized to participate. The commenter suggested changing the programs to allow for the recovery of expenses the lender undertook to collect on defaulted debts, as well as unpaid interest.

Response: The Office is grateful for the commenter's input and shares her excitement about Texas's implementation of the State Small Business Credit Initiative. The Office notes that, in addition to the original principal amount of the loan, "reasonable out-of-pocket expenses" are reimbursable losses under both TSBCI CAP and TSBCI LGP. Accordingly, participating financial institutions will be able to recover reasonable expenses incurred to collect on defaulted debts. Accordingly, the Office declines to make any changes with respect to the commenter's suggestions.

SUBCHAPTER A. TEXAS SMALL BUSINESS CREDIT INITIATIVE CAPITAL ACCESS PROGRAM

10 TAC §§200.1 - 200.20

STATUTORY AUTHORITY.

Section 481.021, Texas Government Code, authorizes the Office to adopt and enforce rules necessary to carry out the programs established in Chapter 481, Texas Government Code, including the TSBCI CAP, which the Office established, and the Bank will administer, pursuant to Section 481.403, Texas Government Code.

CROSS REFERENCE TO STATUTE

Chapter 200, Subchapter A. No other statutes, articles, or codes are affected by the adopted rules.

§200.2. Definitions.

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

(1) Agreement--A contract between a Financial Institution and the Office that authorizes the Financial Institution to participate in the Program and establishes, in accordance with §200.4 of this chapter (relating to Agreement), the terms required for the Financial Institution's participation.

(2) Borrower--A Qualified Business that has received a Qualified Loan from a Participating Financial Institution.

(3) Enrolled Loan--A Qualified Loan enrolled in the Program as described in §200.10 of this chapter (relating to Procedure for Enrollment of a Qualified Loan).

(4) Financial Institution--An insured depository institution, insured credit union, or Community Development Financial Institution, as each of those terms is defined in 12 U.S.C. § 4702.

(5) Fund--The Texas Small Business Credit Initiative Capital Access Fund.

(6) Loan Loss Reserve Account--An account established at a financial institution in which premiums are deposited to serve as insurance to reimburse a Participating Financial Institution for Losses on Enrolled Loans.

(7) Loss--Any original principal amount due and not paid and not more than the enrolled amount of the Qualified Loan plus reasonable out-of-pocket expenses. In the event only a portion of a Qualified Loan was enrolled, the Office limits reimbursement of out-of-pocket expenses to the ratio of the enrolled portion to the total loan amount.

(8) Office--The Economic Development and Tourism Office in the Office of the Governor.

(9) Participating Financial Institution or PFI--A Financial Institution authorized to conduct business in the State of Texas that has adequate capacity, as determined by the Office in its sole discretion, to underwrite and monitor loans and has executed an Agreement with the Office to participate in the Program.

(10) Principal of a Borrower--A person, other than an insured bank, that directly or indirectly, or acting through or in concert with one or more persons, owns, controls, or has the power to vote more than 10 percent of any class of voting securities of a member bank or company. Shares owned or controlled by a member of an individual's immediate family are considered to be held by the individual.

(11) Principal of a Lender--The principal of a lender is:

(A) If a sole proprietorship, the proprietor;

(B) If a partnership, each partner; and

(C) If a corporation, limited liability company, association or a development company, each director, each of the five most highly compensated executives, officers or employees of the entity, and each direct or indirect holder of twenty percent or more of the ownership stock or stock equivalent of the entity.

(12) Program--The Texas Small Business Credit Initiative Capital Access Program.

(13) Program Website--The dynamic web portal developed by the Office and located at https://tsbci.gov.texas.gov.

(14) Qualified Business--A Small Business authorized to conduct business in the State of Texas that meets the eligibility requirements of §200.7 of this chapter (relating Qualified Loan Eligibility and Approval).

(15) Qualified Loan--A loan or portion of a loan that is made by a PFI to a Qualified Business for a business purpose consistent

with §200.8 of this chapter (relating to Eligible and Restricted Uses of Texas Small Business Credit Initiative Capital Access Program Loan Proceeds), and not contrary to state or federal law or policy.

(16) Small Business--A corporation, partnership, sole proprietorship, or other legal entity that:

(A) is domiciled in this state or has at least 51 percent of its employees located in this state;

(B) is formed to make a profit;

(C) is independently owned and operated; and

(D) employs fewer than 500 employees.

(17) Socially and Economically Disadvantaged Individuals or SEDI--Individuals whose ability to compete in the free enterprise system has been impaired due to diminished capital and credit opportunities as compared to others in the same or similar line of business who are not socially disadvantaged.

(18) Treasury--The United States Department of Treasury.

(19) Very Small Business--A Small Business that employs fewer than 10 employees.

§200.8. Eligible and Restricted Uses of Texas Small Business Credit Initiative Capital Access Program Loan Proceeds.

(a) Borrowers must use loan proceeds for a business purpose. Business purposes include, but are not limited to:

(1) start-up costs;

(2) working capital;

(3) franchise fees; and

(4) acquisition of equipment, inventory, or services used in the production, manufacturing, or delivery of a business's goods or services, or in the purchase, construction, renovation, or tenant improvements of an eligible place of business that is not for passive real estate investment purposes.

(b) Loan proceeds shall not be used for:

(1) acquiring or holding passive investments in real estate;

(2) the purchase of owner-occupied residential housing;

(3) the construction, improvement, or purchase of residential housing that is owned or to be owned by the Borrower;

(4) the purchase of real property that is intended for resale or not used for the business operations of the Borrower;

(5) the purchase of securities;

(6) lobbying activities;

(7) the purchase of good will;

(8) inside bank transactions;

(9) repayment of delinquent federal or state income taxes unless the Borrower has a payment plan in place with the relevant taxing authority;

(10) repayment of taxes held in trust or escrow;

(11) reimbursement of funds owed to any owner, including any equity injection or injection of capital for the business' continuance;

(12) purchase of any portion of the ownership interest of any owner of the Borrower, such as the acquisition of shares of a company or the partnership interest of a partner when the proceeds of the Enrolled Loan will go to any existing owner or partner of the Borrower;

(13) refinance of any portion of a loan enrolled in another credit enhancement or credit insurance program not encompassed by 10 T.A.C. Chapter 200;

(14) a loan in which any Principal of a Borrower has been convicted of a sex offense against a minor as such terms are defined 34 U.S.C. 20911; or

(15) a loan that is contrary to federal or state law or policy.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2023.

TRD-202302060
Adriana Cruz
Executive Director
Office of the Governor, Economic Development and Tourism Office
Effective date: June 25, 2023
Proposal publication date: March 10, 2023
For further information, please call: (512) 463-2000

♦ ♦ ♦

SUBCHAPTER B. TEXAS SMALL BUSINESS CREDIT INITIATIVE LOAN GUARANTEE PROGRAM

10 TAC §§200.101 - 200.117

STATUTORY AUTHORITY.

Section 481.021, Texas Government Code, authorizes the Office to adopt and enforce rules necessary to carry out the programs established in Chapter 481, Texas Government Code, including the TSBCI LGP, which the Office established, and the Bank will administer, pursuant to Section 481.403, Texas Government Code.

CROSS REFERENCE TO STATUTE

Chapter 200, Subchapter B. No other statutes, articles, or codes are affected by the adopted rules.

§200.102. Definitions.

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

(1) Agreement--A contract between a Financial Institution and the Office that authorizes the Financial Institution to participate in the Program and establishes, in accordance with §200.104 of this chapter (relating to Agreement), the terms required for the Financial Institution's participation.

(2) Borrower--A Qualified Business that has received a Qualified Loan from a Participating Financial Institution.

(3) Enrolled Loan--A Qualified Loan enrolled in the Program as described in §200.107 of this chapter (relating to Loan Guarantee Maximums; Procedure for Enrollment of a Qualified Loan).

(4) Financial Institution--An insured depository institution, insured credit union, or Community Development Financial Institution, as each of those terms is defined in 12 U.S.C. § 4702.

(5) Fund--The Texas Small Business Credit Initiative Loan Guarantee Fund.

(6) Guaranteed Amount--The amount of principal of an Enrolled Loan that is guaranteed by the Office.

(7) Loss--Any original principal amount due and not paid and not in excess of the Guaranteed Amount of the Qualified Loan.

(8) Office--The Economic Development and Tourism Office in the Office of the Governor.

(9) Participating Financial Institution or PFI--A Financial Institution authorized to conduct business in the State of Texas that has adequate capacity, as determined by the Office in its sole discretion, to underwrite and monitor loans and has executed an Agreement with the Office to participate in the Program.

(10) Principal of a Borrower--A person, other than an insured bank, that directly or indirectly, or acting through or in concert with one or more persons, owns, controls, or has the power to vote more than 10 percent of any class of voting securities of a member bank or company. Shares owned or controlled by a member of an individual's immediate family are considered to be held by the individual.

(11) Principal of a Lender--The principal of a lender is:

(A) If a sole proprietorship, the proprietor;

(B) If a partnership, each partner; and

(C) If a corporation, limited liability company, association or a development company, each director, each of the five most highly compensated executives, officers or employees of the entity, and each direct or indirect holder of twenty percent or more of the ownership stock or stock equivalent of the entity.

(12) Program--The Texas Small Business Credit Initiative Loan Guarantee Program.

(13) Program Website--The dynamic web portal developed by the Office and located at https://tsbci.gov.texas.gov.

(14) Qualified Business--Any Small Business authorized to conduct business in the State of Texas that meets the eligibility requirements of §200.105 of this chapter (relating to Qualified Loan Eligibility and Approval).

(15) Qualified Loan--A loan or portion of a loan that is made by a PFI to a Qualified Business for a business purpose consistent with §200.106 of this chapter (relating to Eligible and Restricted Uses of Texas Small Business Credit Loan Guarantee Program Loan Proceeds), and not contrary to state or federal law or policy.

(16) Small Business--A corporation, partnership, sole proprietorship, or other legal entity that:

(A) is domiciled in this state or has at least 51 percent of its employees located in this state;

(B) is formed to make a profit;

(C) is independently owned and operated; and

(D) employs fewer than 500 employees.

(17) Socially and Economically Disadvantaged Individuals or SEDI--Individuals whose ability to compete in the free enterprise system has been impaired due to diminished capital and credit opportunities as compared to others in the same or similar line of business who are not socially disadvantaged.

(18) Treasury--The United States Department of Treasury.

(19) Very Small Business--A Small Business that employs fewer than 10 employees.

§200.106. Eligible and Restricted Uses of Texas Small Business Credit Loan Guarantee Program Loan Proceeds.

(a) Borrowers must use loan proceeds for a business purpose. Business purposes include, but are not limited to:

(1) start-up costs;

(2) working capital;

(3) franchise fees; and

(4) acquisition of equipment, inventory, or services used in the production, manufacturing, or delivery of a business's goods or services, or in the purchase, construction, renovation, or tenant improvements of an eligible place of business that is not for passive real estate investment purposes.

(b) Loan proceeds shall not be used for:

(1) acquiring or holding passive investments in real estate;

(2) the purchase of owner-occupied residential housing;

(3) the construction, improvement, or purchase of residential housing that is owned or to be owned by the Borrower;

(4) the purchase of real property that is intended for resale or not used for the business operations of the Borrower;

(5) the purchase of securities;

(6) lobbying activities;

(7) the purchase of good will;

(8) inside bank transactions;

(9) repayment of delinquent federal or state income taxes unless the Borrower has a payment plan in place with the relevant taxing authority;

(10) repayment of taxes held in trust or escrow;

(11) reimbursement of funds owed to any owner, including any equity injection or injection of capital for the business' continuance;

(12) purchase of any portion of the ownership interest of any owner of the Borrower, such as the acquisition of shares of a company or the partnership interest of a partner when the proceeds of the Enrolled Loan will go to any existing owner or partner of the Borrower;

(13) refinance of any portion of a loan enrolled in another credit enhancement or credit insurance program not encompassed by 10 T.A.C. Chapter 200;

(14) a loan in which any Principal of a Borrower has been convicted of a sex offense against a minor as such terms are defined 34 U.S.C. 20911; or

(15) a loan that is contrary to federal or state law or policy.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2023.

TRD-202302061
Adriana Cruz
Executive Director
Office of the Governor, Economic Development and Tourism Office
Effective date: June 25, 2023
Proposal publication date: March 10, 2023
For further information, please call: (512) 463-2000

♦ ♦ ♦

TITLE 13. CULTURAL RESOURCES

PART 1. TEXAS STATE LIBRARY AND ARCHIVES COMMISSION

CHAPTER 2. GENERAL POLICIES AND PROCEDURES

SUBCHAPTER A. PRINCIPLES AND PROCEDURES OF THE COMMISSION

13 TAC §§2.2, 2.70, 2.77

The Texas State Library and Archives Commission (commission) adopts amendments to 13 Texas Administrative Code §2.2, Responsibilities of the Commission and the Director and Librarian and §2.70, Vehicle Fleet Management, and new §2.77, Contract Approval Authority and Responsibilities. The commission adopts the amendments to §2.70 without changes to the proposed text as published in the March 3, 2023, issue of the *Texas Register* (48 TexReg 1197). This rule will not be republished. The commission adopts amendments to §2.2 and new §2.77 with changes to the proposed text as published in the March 3, 2023, issue of the *Texas Register* (48 TexReg 1197) and these rules will be republished.

The adopted amendment to §2.2 and adopted new §2.77 are necessary to update and streamline the commission's contract approval procedures. The amendment to §2.2(b)(3) removes the $100,000 threshold for contract approvals and adds a reference to new §2.77. New §2.77 requires the commission to approve contracts or amendments with a value, defined to mean the overall estimated dollar amount of the initial contract term plus all optional renewals and extensions, expected to exceed $1 million; amendments that result in the contract value exceeding $1 million; certain contracts related to key agency programs regardless of contract value; and any other contract deemed appropriate for commission approval as determined by the director and librarian in consultation with the commission chair. The rule delegates approval of all other contracts to the director and librarian and delegates authority to execute all contracts. Under the adopted rule, the agency will present a contract plan to the commission for information purposes each year with periodic updates by the director and librarian.

The adopted amendments to §2.70 are necessary to update a reference in the rule, remove unnecessary language, and improve readability and clarity.

Changes to §2.2 and §2.77 as proposed correct grammar and clarify the four instances when the commission will approve a contract. Proposed language in §2.77 inadvertently combined two of the subparagraphs. The adopted language separates the two scenarios into two subparagraphs as originally intended.

The commission did not receive any comments on the proposed amendments or new section.

STATUTORY AUTHORITY. The amendments and new rule are adopted under Government Code, §441.002, which authorizes the commission to assign duties to the director and librarian and which requires the commission to develop and implement policies that clearly separate the policy-making responsibilities of the commission and the management responsibilities of the director and librarian and staff of the commission; Government Code, §2261.254, which requires the commission to approve and sign contracts over $1 million, but authorizes the commission to delegate this authority to director and librarian or assistant state librarian; and Government Code, §2171.1045, which requires the commission to adopt rules relating to assignment and use of agency vehicles.

§2.2. Responsibilities of Commission and the Director and Librarian.

(a) General Powers and Responsibilities. The commission is a seven member citizen board appointed by the governor with the advice and consent of the senate. The commission is an agency within the executive branch, but functions independently within its statutory authority to serve the long-term public interest.

(b) Powers and Responsibilities of the Commission. The commission is responsible for establishing the policy framework through which the Texas State Library carries out its statutory responsibilities. The commission governs the library through the director and librarian. The staff of the library receive direction from the commission through the director and librarian. Specifically, the commission:

(1) adopts administrative rules that guide the staff in administering library programs;

(2) approves strategic and operating plans and requests for appropriations;

(3) approves all contracts as specified in §2.77 of this subchapter (relating to Contract Approval Authority and Responsibilities);

(4) approves all competitive grants, and all other grants of $100,000 or more, made by the library;

(5) acknowledges acceptance of gifts, grants, or donations of $500 or more that are in accord with the mission and purposes of the library;

(6) oversees operations of the library for integrity, effectiveness, and efficiency;

(7) acts as a final board of appeals for staff decisions or advisory board recommendations on grants, accreditation of libraries, certification of librarians, or other issues of concern to the public;

(8) selects the director and librarian and approves the selection of the assistant state librarian; and

(9) conducts a periodic performance review of the director and librarian.

(c) Powers and Responsibilities of the Director and Librarian. The director and librarian is responsible for the effective and efficient administration of the policies established by the commission. Specifically, the director and librarian:

(1) selects, organizes, and directs the staff of the library;

(2) establishes the operating budget for the library and allocates funds among strategies, programs, and projects within the limits of statutory authority and as set forth in the General Appropriations Acts of the legislature;

(3) approves expenditures of funds in accordance with law;

(4) represents the commission and reports on behalf of the commission to the governor, the legislature, the public, or other organized groups as required;

(5) reports in a timely manner all relevant information first to the chairman and subsequently to all members of the commission, endeavoring to report to members of the commission in such a manner that the members are equally well informed on matters that concern the commission; and

(6) delegates his/her responsibilities to the assistant state librarian or other agency staff as appropriate.

§2.77. Contract Approval Authority and Responsibilities.

(a) Purpose. The purpose of this rule is to establish the approval authority and responsibilities for executing contracts required by the agency.

(b) Applicability. This rule applies to all contracts entered into by the agency.

(c) Definitions. As used in this section, the following terms shall have the following meanings, unless the context clearly indicates otherwise.

(1) Agency--means Texas State Library and Archives Commission as an agency of the state of Texas, including the staff, collections, archives, operations, programs, and property of the Texas State Library and Archives Commission.

(2) Commission--means the seven-member governing body of the Texas State Library and Archives Commission.

(3) Contract--means a written agreement between the agency and a contractor for goods or services. As used in this section, "contract" includes the following: interagency contracts with other government entities; interlocal agreements with other government entities; and other documents in which funds or services allocated to the agency are exchanged for the delivery of other goods or services.

(4) Value--means the estimated dollar amount the agency may be obligated to pay pursuant to the contract and all executed and proposed amendments, extensions, and renewals of the contract. The agency shall base its determination of the proposed length of and compensation during the original term and renewal periods of the contract on best business practices, state fiscal standards, and applicable law, procedures, and regulations. The agency's determination of contract value reflects the definition set forth in the State of Texas Contract Management Guide as developed by the comptroller under Government Code, §2262.051.

(d) Approval Authority.

(1) Commission Approval. The director and librarian or designee shall present certain contracts to the commission for approval. The commission shall consider for approval:

(A) any contract or amendment with a value expected to exceed $1 million;

(B) any amendment to a contract that results in the contract value exceeding $1 million;

(C) any contract or amendment to a contract that relates to the TexShare Library Consortium regardless of overall contract value; and

(D) any other contract deemed appropriate for commission approval as determined by the director and librarian in consultation with the chair of the commission.

(2) Agency Approval.

(A) The commission delegates authority to the director and librarian or designee to approve all contracts not listed in paragraph (1) of this subsection;

(B) The commission delegates authority to the director and librarian or designee to approve contracts with an overall contract value that exceeds $1 million as approved by commission order; and

(C) The commission delegates authority to the director and librarian to approve a purchase request or contract listed in paragraph (1) of this subsection for an emergency as defined in 34 TAC §20.25 (relating to Definitions), or to avoid undue material additional cost to the state. The director and librarian shall report any purchase requests or contracts executed by the director and librarian under this authority to the commission chair prior to execution of any such purchase requests or contracts.

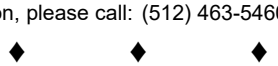
(e) Authority to Execute Contracts. The commission delegates authority to the director and librarian to execute all contracts for the agency. This authority may be delegated by the director and librarian to the assistant state librarian or other designee.

(f) Contract Planning. The agency will present to the commission for information a contract plan for the next fiscal year that outlines the agency's anticipated contracting actions that exceed $500,000. The director and librarian or designee will present updates to the contract plan to the commission for information periodically throughout the fiscal year.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2023.

TRD-202302063
Sarah Swanson
General Counsel
Texas State Library and Archives Commission
Effective date: June 25, 2023
Proposal publication date: March 3, 2023
For further information, please call: (512) 463-5460



SUBCHAPTER C. GRANT POLICIES
DIVISION 1. GENERAL GRANT GUIDELINES

13 TAC §2.112, §2.116

The Texas State Library and Archives Commission (commission) adopts amendments to 13 Texas Administrative Code §2.112, Eligible and Ineligible Expenses, and §2.116, Uniform Grants Management Standards (UGMS). The commission adopts the amendments without changes to the proposed text as published in the March 3, 2023, issue of the *Texas Register* (48 TexReg 1199). The rules will not be republished.

The adopted amendments are necessary to bring the commission's rules up to date with current standards. The amendments to §2.116 update a reference in both the rule text and title and delete a reference to repealed rules. The amendments to §2.112 update the reference to §2.116 as amended.

The commission did not receive any comments on the proposed amendments.

STATUTORY AUTHORITY. The amendments are adopted under Government Code, §441.009, which authorizes the commission to adopt a state plan for improving library services consistent with federal goals, and, more generally, §441.006(b)(3), which authorizes the commission to accept, receive, and administer federal funds made available by grant or loan to improve the public libraries of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2023.

TRD-202302064
Sarah Swanson
General Counsel
Texas State Library and Archives Commission
Effective date: June 25, 2023
Proposal publication date: March 3, 2023
For further information, please call: (512) 463-5460

♦ ♦ ♦

TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 102. EDUCATIONAL PROGRAMS
SUBCHAPTER JJ. COMMISSIONER'S RULES CONCERNING INNOVATION DISTRICT

19 TAC §102.1303, §102.1313

The Texas Education Agency adopts amendments to §102.1303 and §102.1313, concerning innovation districts. The amendments are adopted without changes to the proposed text as published in the March 31, 2023 issue of the *Texas Register* (48 TexReg 1697) and will not be republished. The adopted amendments modify the requirements for renewal of a local innovation plan.

REASONED JUSTIFICATION: Chapter 102, Subchapter JJ, establishes provisions relating to the applicable processes and procedures for innovation districts.

The adopted amendment to §102.1303(a) clarifies that it is the district's final and most recent academic performance rating that must be at least acceptable performance in order to be eligible for designation as an innovation district.

The adopted amendment to §102.1313(a)(3) specifies that the district is not required to notify the commissioner of education of the board's intention to vote on the adoption of the renewal of a local innovation plan.

Adopted new §102.1313(a)(3)(A) requires the district to meet eligibility requirements under §102.1303 in order to be eligible to renew a local innovation plan. Adopted new §102.1313(a)(3)(B) allows a district that chooses to renew its local innovation plan to do so in the six months subsequent to the plan's expiration date to maintain a continuous designation as a district of innovation.

Adopted new §102.1313(a)(3)(B)(i) clarifies that the term of a renewed plan may not begin prior to the date on which it is adopted by the board of trustees unless the plan is adopted as renewed within the six months following its expiration date. Adopted new §102.1313(a)(3)(B)(ii) clarifies that the term of a plan renewed during the six months subsequent to the plan's expiration date begins on the date of expiration of the prior term and may not exceed five years. Adopted new §102.1313(a)(3)(B)(iii) clarifies that any changes made to the plan during the renewal process are not effective prior to the date of adoption of the renewed plan, and adopted new §102.1313(a)(3)(B)(iv) requires the district to indicate the date of adoption next to any changes made to the plan during the renewal process in order to denote the earliest date the changes may take effect. Adopted new §102.1313(a)(3)(B)(v) clarifies that a district whose plan is not renewed during the six months subsequent to the plan's expiration date shall comply with all previously adopted exemptions upon the plan's expiration date and begin the initial adoption process over again in its entirety should the district wish to pursue designation as an innovation district in the future.

SUMMARY OF COMMENTS AND AGENCY RESPONSES: The public comment period on the proposal began March 31, 2023, and ended May 1, 2023. Following is a summary of the public comment received and the agency response.

Comment: The Texas Classroom Teachers Association (TCTA) commented that it behooves the public to be able to know which districts choose to exempt themselves from sections of the Texas Education Code (TEC) per a locally adopted district of innovation (DOI) plan and asserted that the main mechanisms to do so are by the requirement in TEC, §12A.005, that a district notify the commissioner of the board's intention to vote on the adoption of a proposed plan as well as the requirement in TEC, §12A.0071(b) that a district provide a copy of the current local innovation plan to the agency not later than the 15th day after the date on which the board of trustees takes action to adopt, amend, or renew a plan. TCTA further commented that it objects to the proposed changes to §102.1313(a)(3) in which a board's intention to vote on renewal of a local innovation plan is not required because TCTA believes that the agency will not be able to effectively carry out its statutory duty to ensure that the district sends the adopted renewed plan to the agency for posting on the agency's internet website within 15 days of adopting the renewed plan.

Response: The agency agrees that the public has a vested interest in the actions of their school district and school board. The agency disagrees with the assertion that the main mechanism by which the public is made aware of local actions related to DOI is via a district's notice of its intent to renew a locally adopted plan or the timeline to which the district must adhere when notifying the agency of a DOI plan adoption, amendment, or renewal. The DOI designation is accomplished via a locally adopted plan that receives approval by the TEC, Chapter 11, district-level committee and adoption by a district's elected board of trustees at a public meeting. The plan is also posted for the duration of the designation on the district's website. It is the agency's assertion that it is through the local actions of these bodies and the local web posting by which the public is primarily made aware from which sections of the TEC a district is claiming exemption. As plans are locally adopted, the onus to fulfill the timeline requirement under TEC, §12A.0071(b), lies with the district rather than agency, which does not have the authority to approve or reject plans. Whether or not a district adheres to this requirement does not impede the agency's statutory obligation to post current local innovation plans on its website, which is not required within 15 days but rather "promptly" after which the district's notification is received.

STATUTORY AUTHORITY. The amendments are adopted under Texas Education Code, §12A.009, which authorizes the commissioner of education to adopt rules to implement districts of innovation.

CROSS REFERENCE TO STATUTE. The amendments implement Texas Education Code, §12A.009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on May 31, 2023.

TRD-202301991

Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: June 20, 2023
Proposal publication date: March 31, 2023
For further information, please call: (512) 475-1497

♦ ♦ ♦

TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 133. HOSPITAL LICENSING
SUBCHAPTER J. HOSPITAL LEVEL OF CARE DESIGNATIONS FOR NEONATAL CARE

25 TAC §§133.181 - 133.191

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), adopts amendments to §133.181, concerning Purpose; §133.182, concerning Definitions; §133.183, concerning General Requirements; §133.184, concerning the Designation Process; §133.185, concerning Program Requirements; §133.186, concerning Neonatal Designation Level I; §133.187, concerning Neonatal Designation Level II; §133.188, concerning Neonatal Designation Level III; §133.189, concerning Neonatal Designation Level IV; §133.190, concerning the Survey Team; and new §133.191, concerning the Perinatal Care Regions (PCRs). The amendments to §§133.182 - 133.190 are adopted with changes to the proposed text as published in the January 13, 2023, issue of the *Texas Register* (48 TexReg 83) and the sections will be republished. The amendment to §133.181 and new §133.191 are adopted without changes and will not be republished.

BACKGROUND AND JUSTIFICATION

The adoption updates the content and processes with the advances and practices since these rules were adopted in 2016. Senate Bill (S.B.) 749, 86th Legislature, Regular Session, 2019, amended the Texas Health and Safety Code, Chapter 241. S.B. 749 requires language specific to waiver agreements, a three-person appeal panel for designation reviews, and language specific to telemedicine and telehealth be integrated into the neonatal rules.

In addition, the Perinatal Advisory Council (PAC) provided DSHS with rule language recommendations designed to clarify specific subsections of the rules. The recommendations include the use of prearranged consultative agreements using telemedicine technology, and consideration of a waiver agreement for facilities that cannot meet a specific designation requirement. The recommendations further define the process for the three-person appeal panel, clarify that pediatric echocardiography with pediatric cardiology interpretation and consultation to be completed in a time period consistent with standards of professional practice, and include national accredited organizations providing resuscitation courses.

The PAC formed a workgroup to collaborate with DSHS staff to review the public comments received and determine the most appropriate language to ensure the health and safety of neonatal patients and prevent any undue burden on the facilities providing neonatal care.

COMMENTS

During the 31-day comment period, DSHS received comments from 35 commenters, including the American Academy of Pediatrics (AAP); Baylor Scott & White Health (BSWH); Children's Hospital Association of Texas (CHAT); Children's Hospital of San Antonio (CHoSA); CHRISTUS Health; CHRISTUS Southeast Texas Health System; CHRISTUS St. Michael Health System; East Texas Gulf Coast Regional Advisory Council; Harris Health System; HCA Houston Healthcare Southeast; Medical City Healthcare; Methodist Children's Hospital; Methodist Hospital Stone Oak; Metropolitan Methodist Hospital; Parkland Health; Teaching Hospitals of Texas (THOT); Tenet Healthcare; Texas Association of Nurse Anesthetists (TxANA); Texas EMS, Trauma and Acute Care Foundation (TETAF)/Texas Perinatal Services; Texas Health Presbyterian Hospital Dallas; Texas Hospital Association (THA); Texas Medical Association (TMA) representing three additional physician organizations; and 13 individuals. A summary of comments relating to the rules and DSHS's responses follows.

Comment: One commenter requested DSHS allow stakeholders to review and submit comments on the DSHS survey guidelines that are not in the proposed neonatal rules.

Response: DSHS acknowledges the comment. DSHS is coordinating multiple training updates and opportunities to review the guidelines before the January 1, 2024, implementation date.

Comment: One commenter appreciated the PAC ad hoc workgroup serving as a resource to review the comments on the neonatal proposed rules and provide recommendations to DSHS for revisions.

Response: DSHS appreciates the comment, and no change is necessary to the rules.

Comment: One commenter requested clarification in the rules regarding the terms medical staff, personnel, and advanced practice providers.

Response: DSHS acknowledges the comment and declines to revise the rules. The standard dictionary and medical dictionary definitions are sufficient.

Comment: One commenter requested that DSHS include rule language to address adequate nurse staffing.

Response: DSHS disagrees and declines to revise the language without national standards to define required staff.

Comment: §133.182(4) and (6): Three commenters requested the definitions for "CAP" and "contingent probationary designation" to include DSHS operations expectations.

Response: DSHS acknowledges the comments and declines to revise the rule language in response to these comments. The definition for "contingent probationary designation" was removed from the rules. DSHS operations for the CAP--Corrective Action Plan are implemented by DSHS policy.

Comment: §133.182(5) and (6): Nine commenters recommended the definitions for "contingent designation" and "contingent probationary designation" be removed from the rule language to be consistent with the maternal rules or for DSHS to provide further clarification.

Response: DSHS agrees to remove both definitions, therefore clarification is not needed. The remaining paragraphs are renumbered in §133.182 due to the removal of these definitions.

Comment: §133.182(9): One commenter suggested adding "outside of a medical facility" for clarity to the "Emergency Medical Services (EMS)" definition.

Response: DSHS acknowledges the comment and declines to revise the rule language. The language is consistent with the EMS definition in §157.2 of this title, relating to Emergency Medical Care.

Comment: §133.182(13): Two commenters recommended removing "or near" from the definition of "immediately."

Response: DSHS agrees and modifies the language in renumbered §133.182(11).

Comment: §133.182(13): One commenter requested clarification of a time frame for "Immediately."

Response: DSHS acknowledges the comment and finds the rule language is sufficient. DSHS declines to revise the rule language.

Comment: §133.182(13) and (19): One commenter supports the new definitions for "immediately" and "Neonatal Program Oversight."

Response: DSHS appreciates the comment, and no change is necessary to the rules.

Comment: §133.182(19): Three commenters recommended further clarification of the definition "Neonatal Program Oversight."

Response: DSHS acknowledges the comments and declines to revise the rule. Language is consistent with the definition of the Maternal Program Oversight in §133.202(19) of this title, relating to Hospital Level of Care Designations for Maternal Care.

Comment: §133.183(c): One commenter requested the current language regarding free-standing children's hospitals be retained.

Response: DSHS agrees and replaces the stand-alone children's facility language allowing exemptions from obstetrical requirements.

Comment: §133.183(f)(3)(C): One commenter suggested removing "specific to the patient population served" from the continuing education language.

Response: DSHS acknowledges the comment and declines to revise the rule language. The language allows facilities to identify their specific neonatal populations and ensure education appropriate for patient conditions and care are provided.

Comment: §133.183(f)(3)(D) and §133.183(f)(4)(D): One commenter recommended adding language, to facilitate neonatal transports, in the Level II requirements.

Response: DSHS acknowledges the comment and declines to revise the rule language. The additional role of facilitating transports will remain with the higher-level facilities.

Comment: §§133.183(f)(3)(E), 133.183(f)(4)(E), 133.188(a)(5), and 133.189(a)(5): Two commenters stated the proposed language limits outreach education to only findings in the Quality Assessment and Performance Improvement (QAPI) Plan and process.

Response: DSHS agrees and revises the language to provide additional opportunities for outreach education.

Comment: §§133.183(f)(3)(E), 133.183(f)(4)(E), 133.188(a)(5), and 133.189(a)(5): Two commenters requested to include same and higher-level designated facilities to be included in rule language.

Response: DSHS acknowledges the comments and declines to revise the language in response to these comments. The requirement does not exclude facilities from providing outreach education to same or higher-level care facilities.

Comment: §§133.183(f)(3)(E), 133.183(f)(4)(E), 133.188(a)(5), and 133.189(a)(5): One commenter stated that providing outreach to non-designated facilities and lay birthing centers is a liability for the facilities.

Response: DSHS acknowledges the comment and declines to revise the rules in response to this comment because the facility provides education that is appropriate and applicable.

Comment: §§133.183(f)(1)(B), 133.183(f)(2)(C), 133.183(f)(3)(C), and 133.183(f)(4)(C): Two commenters suggested removing "annual" from the continuing education requirements.

Response: DSHS acknowledges the comment and declines to change the rule language. The language is consistent with §133.203 of this title.

Comment: §133.183(f)(3)(B) and §133.188(a)(2): Two commenters stated concerns regarding the availability and response times for pediatric subspecialists.

Response: DSHS acknowledges the comments and declines to revise the rules. The language requires access to consultation only and does not require a response time for the pediatric subspecialists.

Comment: §133.183(f)(4)(B) and §133.189(a)(2): Seven commenters stated concerns regarding the availability and response times for pediatric subspecialists.

Response: DSHS acknowledges the comments and declines to revise the rules. The language requires subspecialists to be available to arrive on-site at a facility which provides care for the most critical and complex neonatal patients. The language does not include response times for the pediatric subspecialist.

Comment: §133.183(g): Two commenters inquired about who determines if a facility may schedule a virtual or on-site survey.

Response: DSHS acknowledges the comments, and no change is necessary. DSHS Designation Virtual Survey Guidelines are available on the website to guide facilities in determining the method of survey.

Comment: §133.183(g)(4) and (h): Two commenters recommended modifying the language that facilities must not accept surveyors with any "known" conflict of interest.

Response: DSHS agrees and modifies the language.

Comment: §133.183(h)(1), and §133.190(b): Three commenters recommended removing the language related to surveyors not being from the same Perinatal Care Region (PCR) or Trauma Service Area (TSA) or a contiguous region of the facility's location. The concern is that the requirement will have a negative impact on the Texas hospitals and state-based survey organizations.

Response: DSHS acknowledges the comment and declines to revise the rules. DSHS is establishing requirements to limit surveyor conflicts of interest with the facility undergoing the survey. Language is consistent with §133.203(h)(1) of this title.

Comment: §133.183(h): One commenter recommended removing any responsibility from the hospital for identifying surveyor conflicts and suggested that responsibility be left solely to the survey organization.

Response: DSHS acknowledges the comment and declines to revise the rule. This language is consistent with §133.203(h) of this title.

Comment: §§133.184(a)(1)(B), 133.184(d), and 133.184(k): Seven commenters recommended DSHS extend the 90 days for a facility to implement a sustainable change in the program.

Response: DSHS appreciates the comments and declines to revise the rules. The proposed published language is: "documented evidence that the Plan of Correction (POC) was implemented within 90 days of the designation survey," replacing "demonstrated improvement." This language is consistent with §133.204(a)(1)(C) of this title.

Comment: §133.184(a)(1)(C): One commenter supported the ability for the facilities to develop and implement a plan of correction in 90 days for requirements not met.

Response: DSHS appreciates the comment, and no change is necessary to the rule.

Comment: §133.184(c): Two commenters recommended removing the language related to a change of ownership or change in physical location requirement.

Response: DSHS disagrees and declines to revise the rule. Re-designating ensures the commitment and the requirements for designation continue to be met.

Comment: §133.184(g): Two commenters requested clarification on how the designation application packet is included in the Quality Assurance and Performance Improvement (QAPI) Plan.

Response: DSHS acknowledges the comments and declines to revise the rule. Neonatal designation documents are an element of the QAPI Plan to ensure confidentiality of the information.

Comment: §133.184(j)(1): Two commenters suggested allowing facilities to post the neonatal designation status on their facility website and not post it in a public area in the facility.

Response: DSHS disagrees and declines to revise the rule. A certificate posted in the facility allows staff, patients, and visitors to view the document. Facility designation may be posted on the facility website, in addition to posting in the facility.

Comment: §133.184(p)(1) and (2): One commenter recommends DSHS develop a standard process for facility notifications.

Response: DSHS acknowledges the comment and declines to revise the rule. Regional Advisory Councils (RACs) utilize different methods of notifying healthcare entities in their region of significant changes impacting neonatal patient care.

Comment: §133.184(p)(2)(C): Three commenters shared concerns that the waiver language is not reflective of the S.B. 749 language. It is recommended to use statute language in the rule.

Response: DSHS agrees and revises the rule language to reflect the S.B. 749 language in renumbered §133.184(r)(2)(C).

Comment: §133.184(t): Twelve commenters identified concerns regarding access to peer review information by DSHS and survey organizations due to statutory confidentiality.

Response: DSHS agrees and removes the language in renumbered §133.184(v).

Comment: §133.184(u) and §133.190(f): One commenter recommended survey organizations be included in the language regarding complying with all relevant law related to the confidentiality of all facility information reviewed.

Response: DSHS agrees and revises the language in renumbered §133.184(w) and §133.190(f).

Comment: §133.185(b)(2)(A): Two commenters requested clarification that policies, procedures, and guidelines may be referenced in the Neonatal Program Plan.

Response: DSHS acknowledges the comments and declines to revise the rule. The policies, procedures, and guidelines may be referenced in the Neonatal Program Plan.

Comment: §133.185(b)(2)(D)(ii): Eight commenters stated concerns regarding the monitoring of informed consent for telemedicine and recommends removing the language.

Response: DSHS acknowledges the comments and declines to amend the language in response to these comments. Inpatient neonatal care is continuously evaluated and monitored for appropriateness and variances, for both virtual and in-person encounters, through a collaborative, multidisciplinary process.

Comment: §133.185(b)(2)(E) and §133.188(d)(19): Two commenters requested clarification related to discharge follow-up care.

Response: DSHS acknowledges the comments, and no revision is needed to the rule language. The requirements are before and during patient discharge from the facility.

Comment: §133.185(b)(2)(F): Three commenters requested the evaluation of a facility's disaster preparedness and evacuation plan be limited to the Neonatal Intensive Care Unit (NICU) or the patients directly in their care.

Response: DSHS acknowledges the comments and declines to revise the rule in response to these comments. The neonatal designation program is inclusive of all-facility inpatient neonatal care.

Comment: §133.185(b)(2)(F): One commenter requested clarification allowing the disaster response and evacuation plan to be referenced in the Neonatal Program Plan.

Response: DSHS acknowledges the comment and declines to revise the language in response to this comment, as it is sufficient. The disaster response and evacuation plan may be referenced in the Neonatal Program Plan.

Comment: §133.185(b)(2)(G): One commenter requested clarification on this requirement and if it relieves the Neonatal Medical Director (NMD) from the responsibility of reviewing credentials for medical staff and respiratory therapists.

Response: DSHS acknowledges the comment and declines to revise the rule. The NMD responsibilities are further outlined in §133.185(d) and require review of credentials.

Comment: §133.185(b)(2)(K): Two commenters requested clarification of the expected response times related to this rule.

Response: DSHS acknowledges the comments and declines to revise the rule in response to this comment. The facility defines the expected response times in their guidelines.

Comment: §133.185(b)(3)(A): Two commenters recommended removing the requirement for the Chief Executive Officer, Chief Medical Officer, and Chief Nursing Officer to implement a culture of safety.

Response: DSHS disagrees and declines to revise the rule language in response to these comments. The commitment of facility administration is required for the success of a designation program and patient safety.

Comment: §133.185(b)(3)(D): Two commenters stated concerns regarding participation in benchmarking.

Response: DSHS acknowledges the comments and declines to revise the rule in response to these comments. Benchmarking is essential for Level III and IV neonatal facilities providing care for the most critical and complex neonates.

Comment: §133.185(b)(3)(G): One commenter stated that not all facilities use telehealth.

Response: DSHS agrees and modifies the language to include "if utilized."

Comment: §133.185(c): Seven commenters stated concerns over including the medical staff bylaws.

Response: DSHS agrees and removes "bylaws" from the language.

Comment: §133.185(c)(2): Two commenters requested clarification of the participants in the team-based education and training.

Response: DSHS acknowledges the comments and declines to revise the rule. Participants include all healthcare disciplines that participate in the care of neonates. The language is consistent with the rules in this title, relating to Hospital Level of Care Designations for Maternal Care.

Comment: §133.185(d)(1): One commenter recommended adding language that allows the identified Neonatal Medical Director to delegate responsibilities to a designee.

Response: DSHS disagrees and declines to revise the rule. The facility Neonatal Medical Director responsibilities cannot be delegated.

Comment: §133.185(d)(1)(I): One commenter recommended revising language to be consistent with §133.205(d)(7) of this title, regarding leading the neonatal QAPI meetings.

Response: DSHS agrees and revises the language to "frequently lead the neonatal QAPI meetings with the NPM and participate in Neonatal Program Oversight and other neonatal meetings, as appropriate."

Comment: §133.185(e)(1): One commenter suggested additional requirements of perinatal experience for the NPM requirements.

Response: DSHS agrees and adds "experience" to the present language "for neonatal care applicable to the level of care being provided."

Comment: §133.185(e)(1): One commenter requested additional clarification for the NPM education.

Response: DSHS acknowledges the comment and declines to revise the rule in response to this comment. The NPM has requirements to both obtain education and to provide education.

Comment: §133.185(e)(3)(B): One commenter requested clarification of the NPM participation in staff and team-based training.

Response: DSHS acknowledges the comment and declines to revise the rule. The standard dictionary definition of "participation" is sufficient.

Comment: §133.185(e)(3)(E): Four commenters requested NPM exclusion from regular and active participation in neonatal care at the facility.

Response: DSHS acknowledges the comments and declines to revise the rule. The NPM must be engaged and active in neonatal care at the facility to effectively perform the duties of the position.

Comment: §§133.186(c)(3), 133.187(c)(3), 133.187(c)(12), 133.188(d)(3), and 133.189(d)(3): Three commenters stated concerns related to the NMD approval of providers. One of the commenters requested to retain "reviewed" only in the language.

Response: DSHS acknowledges the comments and modifies the language to remove "and approved."

Comment: §§133.186(c)(4)(A), 133.187(c)(11)(E), 133.188(d)(10)(F), and 133.189(d)(10)(F): Three commenters requested clarification for the preliminary and final radiology readings.

Response: DSHS acknowledges the comments and declines to revise the rules. If a preliminary reading is completed by the attending or treating physician, the final reading will be completed by a radiologist qualified to read the image.

Comment: §§133.186(c)(5), 133.187(c)(9), 133.188(d)(9), and 133.189(d)(9): One commenter suggested that immediate supervision of a pharmacy technician compounding medications for neonates may be performed virtually.

Response: DSHS acknowledges the comment and declines to revise the rules. The rule language is sufficient.

Comment: §133.187(a)(2): One commenter requested clarification for Level II subspeciality services and retaining neonatal patients.

Response: DSHS acknowledges the comment and declines to revise the rule. Medical decisions are made by the treating physician in the best interest of the patient.

Comment: §§133.187(c)(6), 133.188(d)(6), and 133.189(d)(6): Eight commenters stated concerns that a dietitian has to be available at all times, due to the "available" definition, which is unnecessary.

Response: DSHS agrees with the comments and revises the language by removing "available."

Comment: §133.187(c)(10) and §133.188(d)(12): Three commenters stated concerns regarding the requirements for speech, occupational, and physical therapists participating in neonatal care.

Response: DSHS acknowledges the comments and agrees to remove "available," which is defined as "at all times." The rule language allows the facility to define the availability and exper-

tise or qualifications of the therapists, based on the needs of the neonatal population served.

Comment: §133.187(c)(14): One commenter requested clarification if the perinatal educator has to be separate from the NPM.

Response: DSHS acknowledges the comment and declines to revise the rule. The rule language is sufficient.

Comment: §133.188(a)(4): One commenter requested to define "facilitate."

Response: DSHS acknowledges the comment and declines to revise the rule. The standard dictionary definition is sufficient.

Comment: §133.188(d)(3)(C) - (D): Eight commenters stated that interpretation of the current rule requiring additional neonatology back-up coverage would be burdensome to the facilities.

Response: DSHS acknowledges the comments and modifies the wording to clarify back-up is required when a neonatologist is covering more than one facility.

Comment: §133.188(d)(4): One commenter suggested a language revision for Level III facilities that do not perform neonatal surgery.

Response: DSHS acknowledges the comment and declines to revise the rule. The rule language is sufficient.

Comment: §133.188(d)(4) and §133.189(d)(5): Eleven commenters requested revising the pediatric surgeons' 30-minute onsite response time for urgent requests.

Response: DSHS agrees and revises the language to "within a time period consistent with current standards of professional practice and neonatal care" and included that the response times must be reviewed and monitored in the neonatal QAPI Plan.

Comment: §133.188(d)(5) and §133.189(d)(4): One commenter appreciates revisions to the current rule that required anesthesiologists to "directly provide" care to neonates.

Response: DSHS appreciates the comment, and no change is necessary to the rule language.

Comment: §133.188(d)(7)(C): One commenter recommended to remove the requirement for pathology in the operative suite for Level III facilities.

Response: DSHS acknowledges the comment and declines to revise the language. Pathology services are at the request of the operating surgeon requiring timely results during the operative procedures. Level III facilities performing applicable operative procedures must meet the requirement.

Comment: §133.188(d)(7)(B) and (C) and §133.189(d)(7)(B) and (C): Four commenters stated concerns regarding neonatal pathology and the availability of the pathologist for neonatal cases as requested.

Response: DSHS acknowledges the comments and agrees to remove "neonatal" in §133.188(d)(7)(B) and (C) and §133.189(d)(7)(B) and (C), leaving "pediatric" only to describe pathology services available. DSHS disagrees with the comments referring to a pathologist, as the rule language only states "pathology services." DSHS adds "or intra-operative frozen section" to §133.188(d)(7)(C) and §133.189(d)(7)(C), pediatric pathology services at the request of the surgeon requirement.

Comment: §133.188(d)(10)(B) and §133.189(d)(10)(B): Five commenters recommended to revise the personnel response time for urgent requests and to remove magnetic resonance imaging language.

Response: DSHS agrees with the comment and removes "magnetic resonance imaging." The language is revised to "within a time period consistent with current standards of professional practice."

Comment: §133.188(d)(10)(C) and §133.189(d)(10)(C): Three commenters requested to have "at all times" removed from the language.

Response: DSHS acknowledges the comments and declines to revise the language.

Comment: §133.188(d)(10)(E) and §133.189(d)(10)(E): Seven commenters recommended to revise the radiologist interpretation time for urgent studies.

Response: DSHS agrees and revises the language to "images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the neonatal QAPI Plan and process." The facility may define the method of communication from the radiologist.

Comment: §133.188(d)(10)(F) and §133.189(d)(10)(F): One commenter suggested adding language from Level I to clarify if a preliminary reading is performed.

Response: DSHS agrees and adds a new paragraph (F) for §133.188(d)(10) and §133.189(d)(10) that states "preliminary findings documented in the medical record, if preliminary reading of imaging studies pending formal interpretation is performed." The remaining paragraph is renumbered to paragraph (G).

Comment: §133.188(d)(10)(F) and §133.189(d)(10)(F): Two commenters requested revision to the QAPI language for preliminary and final readings.

Response: DSHS acknowledges the comments and declines to revise the rules. Monitoring of variances in imaging interpretations is essential for patient care.

Comment: §133.188(d)(13): Two commenters requested clarification on the "approval" of respiratory therapists by the NMD.

Response: DSHS acknowledges the comments and revises the language by removing "and approved."

Comment: §133.188(d)(18) and §133.189(d)(18): Five commenters proposed changes in the availability and staffing of lactation consultants.

Response: DSHS acknowledges the comments and declines to revise the rules. The language is consistent with §133.208(d)(28) and §133.209(d)(27) of this title.

Comment: §133.189(d)(5): Four commenters recommended revising the 30-minute response time for pediatric subspecialists.

Response: DSHS agrees and revises the language to "a time period consistent with current standards of professional practice and neonatal care," including that surgeon response times must be reviewed and monitored through the neonatal QAPI Plan.

Comment: §133.189(d)(10)(D) and (E): Three commenters requested clarification for pediatric expertise for radiologists.

Response: DSHS acknowledges the comments and declines to revise the rule in response to this comment. Pediatric expertise is determined by the neonatal program and facility, which may

include education, training, experience, and ongoing physician performance evaluations.

Comment: §133.189(d)(17): Five commenters stated concerns that the retinopathy of prematurity (ROP) follow-up includes post discharge care.

Response: DSHS acknowledges the comments and declines to revise the rule. The ROP follow up care includes inpatient treatment and discharge planning to ensure optimal patient outcomes.

Comment: §133.190(c)(1) and (2): One commenter suggested removing "collaborated with a key member of the facility's leadership" from the conflict of interest requirements.

Response: DSHS acknowledges the comment and declines to revise the language. DSHS is establishing requirements to limit surveyor conflicts of interest with the facility undergoing the survey. This language is consistent with §133.210(c)(1) of this title.

Comment: §133.191(a): Two commenters recommended removing the Perinatal Care Regions rule from the facility levels of care requirements.

Response: DSHS acknowledges the comments and declines to revise the rule. DSHS is required by Texas Health and Safety Code §241.183 to develop and adopt rules dividing the state into neonatal and maternal care regions and for facilitating transfer agreements through regional coordination.

DSHS revises §133.183(c) to replace the word "determines" with "approves." The word "facility's" is changed to "location's" for consistency within the section. The word "requirements" is replaced with "criteria" for consistency with §133.203(c) of this title.

DSHS revises §133.183(d) to "must meet department-approved requirements validated by a department-approved survey organization" and removes "demonstrate compliance with" and "have the compliance."

DSHS revises §133.183(e) and §133.185(b)(2)(I), with the word "meeting" for "compliance with." The language is revised to remove "compliance," which is a regulatory term.

DSHS revises §§133.183(f)(1)(A), 133.183(f)(2)(A), 133.186(a)(1), and 133.187(a)(1) replacing the symbol "≥" with "more than or equal to" for public communication with plain language.

DSHS revises §§133.183(f)(1)(C), (f)(3)(E), and (f)(4)(E); 133.183(g)(5); 133.185(b)(2)(D)(i); 133.185(b)(3), (b)(3)(A) and (b)(3)(D); 133.185(d)(1)(C) and (d)(1)(H); 133.185(e) and (e)(3)(F); 133.186(a)(3); 133.186(b)(3); 133.186(c)(6) and (c)(6)(D); 133.187(a)(1)(B) and (a)(2)(B); 133.187(b)(2)(C); 133.187(c)(13), (c)(13)(D), and (c)(16); 133.188(a)(5); 133.188(d)(14), (d)(14)(D), and (d)(17); 133.189(d)(14) and (d)(17) adding neonatal to QAPI plan to clarify the QAPI plan is specific to neonatal services provided in the facility.

DSHS revises §§133.183(f)(1)(C), 133.186(a)(3), 133.186(c)(6), and 133.187(a)(1)(A) and (B) replacing the symbol "≥" with "less than" for public communication with plain language.

DSHS revises §133.183(f)(2) to remove "The" to be consistent with the other Level language in §133.183(f)(1), (3), and (4).

DSHS revises the language in §133.183(g)(1) - (5) with additions of "must," "are responsible for scheduling," and "are responsible" to clarify language and for consistency with §133.203(g)(1) - (5) of this title.

DSHS revises §133.183(h) to include "had a previous working relationship with the facility or facility leaders" for consistency with §133.203(h) of this title. The time period "in the past four years" is moved to the end of the requirement and grammar is corrected to be consistent with the §133.203(h) of this title.

DSHS revises §133.183(h)(2) to state "Designation site survey summary and medical record reviews performed by a surveyor with an identified conflict of interest may not be accepted by the department" for consistency with §133.203(h)(2) of this title.

DSHS revises §133.184(a)(1) to state "the completed application packet includes:" to be consistent with §133.204(a)(1) of this title.

DSHS revises §133.184(a)(1)(A) adding "an accurate and complete" application to align with §133.204(a)(1)(A) of this title.

DSHS revises §133.184(a)(1)(B) to add "a completed" neonatal attestation for consistency with §133.204(a)(1)(B) of this title. The language "includes the requirement compliance findings" is replaced with "validates the department requirements are met." The language is revised to remove "compliance findings," which is a regulatory term.

DSHS revises the language in §133.184(a)(1)(C) to clarify if a facility has three or more department-approved designation requirements defined as "not met," the facility must contact the department within 10 business days to discuss the Plan of Correction (POC). This language is consistent with the §133.204(a)(1)(C) of this title.

DSHS adds "if required by the department" to §133.184(a)(1)(D) to clarify that the POC is not required for every application packet.

DSHS revises §133.184(a)(1)(D)(v) to state "how the corrective actions will be monitored" remove " a statement on" and change "action" to "actions" for consistent language with §133.204(a)(1)(D)(v) of this title.

DSHS revises §133.184(a)(2)(A)(i) to replace the symbol "≤" with "less than or equal to" for public communication with plain language.

DSHS revises §133.184(a)(2)(A)(ii) to replace the symbol ">" with "more than" for public communication with plain language.

DSHS revises §133.184(c) adding "The neonatal designation renewal process, or a request" to replace "A facility requesting." The word "experiencing" was removed and replaced with "or" and "require the facility to" is added to replace "must." The language is consistent with §133.204(c) of this title.

DSHS revises §133.184(d) to replace "renewal designations" with "designation renewals" to be consistent with §133.204(d) of this title.

DSHS revises §133.184(e) removing "being approved for" and replacing it with "a" and replacing "by the department" with "approval" to be consistent with §133.204(e) of this title.

DSHS adds §133.184(f) with "The facility must seek neonatal designation renewal to maintain continual designation and prevent an interruption in designation" for consistent language with §133.204(f) of this title. The remaining subsections for this section are renumbered due to this addition.

DSHS revises renumbered §133.184(g) to remove "timely and" to be consistent with §133.204(g) of this title.

DSHS revises renumbered §133.184(h) to remove "and all relevant laws related to the confidentiality of such records" to be consistent with §133.204(h) of this title.

DSHS revises renumbered §133.184(j) adding "and this designation" to replace "which" to be consistent with §133.204(j) of this title.

DSHS revises renumbered §133.184(l) moving "required documents" and "to continue the designation process" together. Words "and" and "with the" are added to be consistent with §133.204(l) of this title. DSHS revises the language in renumbered §133.184(m) adding "will approve" in place of "reviews and approves" and corrected the tense of "demonstrated" to "demonstrates" to be consistent with §133.204(m) of this title.

DSHS revises the language in renumbered §133.184(n) with "the designation requirement for that level of care designation" to be consistent with §133.204(n) of this title.

DSHS adds §133.184(o) with "If a facility does not meet the designation requirement for the level of designation requested, the department will designate the facility at the highest level for which designation requirements are met," for consistent language with §133.204(o) of this title.

DSHS revises renumbered §133.184(p) adding "designation" before requirements, changing "notify" to "provide written notification" and adding "provide a Corrective Action Plan (CAP) to assist the facility in meeting the designation requirements. The CAP may include requiring the facility to have a focused survey or a complete re-survey." The language revisions are consistent with §133.204(p) of this title.

DSHS revises the language in renumbered §133.184(q) to replace the word "determined" with "awarded." The language "recommends" and "panel will recommend" is added to §133.184(q)(2) and (3). The word "decision" is replaced with "recommendation" in §133.184(q)(2) and (4). The word "decision" was removed in §133.184(q)(5). The language revisions are consistent with §133.204(q), (q)(2), (q)(3), (q)(4), and (q)(5) of this title.

DSHS revises renumbered §133.184(r)(2)(C) language to remove "may" and add "facility meets all other designation requirements for the level of care designation and the," for consistent language with §133.204(r)(2)(C) of this title.

DSHS removes §133.184(r)(2)(C)(iv) and relocates and revises this requirement to §133.184(r)(2)(C) to be consistent with §133.204(r)(2)(C) of this title.

DSHS revises §133.185(b)(1) to add "and approval" to be consistent with the §133.205(b) of this title.

DSHS revises §§133.185(b)(2)(D)(ii), 133.185(d)(1)(F)(i), 133.185(d)(2)(A) and 133.185(e)(3)(D)(i) by replacing the word "compliance" with "variances." The language was revised to remove "compliance," which is a regulatory term.

DSHS revises §133.185(b)(2)(E) to written guidelines for "follow-through planning, discharge instructions." The language was revised to remove "compliance" which is a regulatory term.

DSHS revises §133.185(b)(2)(F) to change "hospital's" to "hospital" and adds "and this process" to replace "which" to align with §133.205(b)(2)(G) of this title.

DSHS revises §§133.185(b)(2)(H) and 133.185(d)(1)(B) changing "competency" to "competencies" for consistency in the rule language.

DSHS revises §133.185(b)(2)(I) adding "meeting" to replace "compliance with." The language was revised to remove "compliance," which is a regulatory term.

DSHS revises §133.185(b)(2)(K) to include "support" personnel and "lactation" to align with §133.206 and §133.207 of this title.

DSHS revises §133.185(b)(3)(A) changing "available" to "allocated" to align with §133.205(b)(3)(A) of this title.

DSHS revises §133.185(b)(3)(B) to replace "and monitor until the needed change is sustained" to "An action plan will track and analyze data through resolution or correction of the identified variance" to be consistent with §133.205(b)(3)(B) of this title.

DSHS revises §133.185(b)(3)(D) to add "All neonatal facilities must participate in a neonatal data initiative." The language is added to support the stakeholders request for state-wide data to support PAC decisions.

DSHS revises §133.185(b)(3)(F) moving "QAPI" between "regional" and "initiatives" to define the QAPI is for regional initiatives.

DSHS revises §133.185(b)(3)(G) adding "reviewed and reported by Neonatal Program Oversight" that monitor "and ensure the provision of services or procedures through" telehealth and telemedicine, "if utilized, is in accordance with the" standards of care "applicable to the provision of the same service or procedure in an in-person setting" to align with §133.205(b)(3)(G) of this title.

DSHS revises §133.185(d)(1)(C) adding "stabilization, operative intervention(s) if applicable, through discharge and review variances in care" to be consistent with §133.205(d)(3) of this title.

DSHS revises §133.185(d)(1)(F)(iv) to include "medical staff, advanced practice providers, and personnel competencies" to further clarify which staff are included for competencies, education, and training.

DSHS revises §133.185(d)(1)(I) to "frequently lead the neonatal QAPI meetings with the NPM and participate in the Neonatal Program Oversight and other neonatal meetings as appropriate" to be consistent with §133.205(d)(7) of this title.

DSHS revises §133.185(d)(1)(K) and §133.185(e)(3)(H) adding "develop and." The language was revised to maintain the action of developing relationships due to personnel changes in the MMD and MPM roles for designation.

DSHS revises §133.185(e)(1) to add "and experience" to the language to align with §133.205(e)(1) of this title.

DSHS revises §133.185(e)(3)(C) to replace "track" with "monitor." The language is revised to be consistent with §133.205(b)(2)(E)(i) and (ii) of this title, related to telehealth and telemedicine.

DSHS revises §133.185(e)(3)(G) to "frequently lead the neonatal QAPI meetings and participate in Neonatal Program Oversight and other neonatal meetings as appropriate" to be consistent with §133.205(e)(5) of this title.

DSHS revises §133.186(b)(1) adding "and with privileges in neonatal care" to be consistent with §133.206(b)(1) of this title, which includes "privileges in maternal care."

DSHS revises §133.186(b)(3) and §133.187(b)(2)(C) adding "demonstrates" to replace "maintains" to be consistent with §§133.206(b)(2) and §133.207(b)(2) of this title.

DSHS revises §133.186(b)(4) and §133.187(b)(2)(E) replacing "annually" with "annual" and "must complete annual" to be consistent with §133.206(b)(4) and §133.207(b)(3) of this title.

DSHS revises §§133.186(c)(3), 133.187(c)(3), and 133.188(d)(3) moving "must" to the additional list of requirements to clarify the grammar.

DSHS adds "The facility must have" to §133.186(c)(4) to correct grammar.

DSHS revises §§133.186(c)(6)(D), 133.187(c)(13)(D) 133.188(d)(14)(D), and 133.189(d)(14)(D) adding "Variances from these standards are monitored through the neonatal QAPI Plan and process" to replace "Compliance to this staffing requirement is monitored through the QAPI Plan." The language was revised to remove "compliance," which is a regulatory term.

DSHS revises §§133.187(c)(6) language to "Dietitian or nutritionist with appropriate training and experience in neonatal nutrition provides services for the population served" to be consistent with the §133.207 of this title.

DSHS revises §§133.187(c)(18), 133.188(d)(19), and 133.189(d)(19) to replace "follow-up" with "follow-through" because the standard definition for "follow-through" is more accurate for the requirement.

DSHS revises §133.188(d)(6) language to "Dietitian or nutritionist with appropriate training and experience in neonatal nutrition, plans diets that meet the needs of the neonate/infant and provides services for the population served" to be consistent with the §133.208 of this title.

DSHS revises §133.188(d)(12)(A) and §133.189(d)(12)(A) replacing "manage" with "recommend management of" and adding "as appropriate for the patient's condition" to align with the neonatal clinical practices for the population served by the facility.

DSHS revises §133.189(d)(3)(A) - (C) adding "must" and replacing "annually" with "annual" in (B) to be consistent with §133.209 of this title.

DSHS adds "must ensure the facility has a back-up neonatal provider if the neonatologist is not immediately available" as §133.189(d)(3)(C). The addition for Level IV is consistent with Level I, II, and III requirements to ensure a back-up for the primary neonatologist if they are unavailable.

DSHS revises §133.189(d)(6) language to "Dietitian or nutritionist with appropriate training and experience in neonatal nutrition, plans diets that meet the needs of the neonate/infant and critically ill neonatal patient and provides services for the population served" to be consistent with the §133.209 of this title.

DSHS revises §133.189(d)(12) to add "infant" and remove "be available to" to align language with §133.188(d)(12).

DSHS revises §133.190(a)(2)(A) - (D), (a)(3)(A) - (D) and (a)(4)(A) - (D) to correct grammar by changing "has" to "have," "is" to "are" and "meets" to "meet."

DSHS adds "in the facility" in §133.190(a)(3) to clarify that a pediatric surgeon is included in the Level III survey team if the facility performs neonatal surgery.

DSHS adds "or this subchapter" in §133.190(f) to ensure all information and materials required in the Neonatal Levels of Care rule, for review by DSHS or a survey organization, are considered confidential under applicable laws to be consistent with the §133.210 of this title.

STATUTORY AUTHORITY

The amendments and new rule are authorized by Texas Health and Safety Code, Chapter 241, which provides DSHS with the authority to adopt rules establishing the levels of care for neonatal care, establish a process of assignment or amendment of the levels of care to hospitals, divide the state into Perinatal Care Regions, and facilitate transfer agreements through regional coordination; and by Texas Government Code §531.0055, and Texas Health and Safety Code, §1001.075, which authorizes the Executive Commissioner of HHSC to adopt rules and policies necessary for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code, Chapter 1001.

§133.182. Definitions.

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

(1) Attestation--A written statement, signed by the chief executive officer of the facility, verifying the results of a self-survey represent a complete and accurate assessment of the facility's capabilities required in this subchapter.

(2) Available--Relating to staff who can be contacted for consultation at all times without delay.

(3) Birth weight--The weight of the neonate recorded at time of birth.

(A) Low birth weight--Birth weight less than 2500 grams (5 lbs., 8 oz.);

(B) Very low birth weight (VLBW)--Birth weight less than 1500 grams (3 lbs., 5 oz.); and

(C) Extremely low birth weight (ELBW)--Birth weight less than 1000 grams (2 lbs., 3 oz.).

(4) CAP--Corrective Action Plan. A plan for the facility developed by the department that describes the actions required of the facility to correct identified deficiencies to ensure the applicable designation requirements are met.

(5) Department--The Texas Department of State Health Services.

(6) Designation--A formal recognition by the department of a facility's neonatal care capabilities and commitment for a period of three years.

(7) EMS--Emergency medical services. Services used to respond to an individual's perceived need for immediate medical care.

(8) Focused survey--A department-defined, modified facility survey by a department-approved survey organization or the department. The specific goal of this survey is to review designation requirements identified as not met to resolve a contingent designation or requirement deficiencies.

(9) Gestational age--The age of a fetus or embryo determined by the amount of time that has elapsed since the first day of the mother's last menstrual period or the corresponding age of the gestation as estimated by a physician through a more accurate method.

(10) High-risk infant--A newborn that has a greater chance of complications because of conditions that occur during fetal development, pregnancy conditions of the mother, or problems that may occur during labor or birth.

(11) Immediately--Able to respond without delay, commonly referred to as STAT.

(12) Infant--A child from birth to one year of age.

(13) Inter-facility transport--Transfer of a patient from one health care facility to another health care facility.

(14) Lactation consultant--A health care professional who specializes in the clinical management of breastfeeding.

(15) Maternal--Pertaining to the mother.

(16) NCPAP--Nasal continuous positive airway pressure.

(17) Neonatal Program Oversight--A multidisciplinary process responsible for the administrative oversight of the neonatal program and having the authority for approving the defined neonatal program's policies, procedures, and guidelines for all phases of neonatal care provided by the facility, to include defining the necessary staff competencies, monitoring to ensure neonatal designation requirements are met, and the aggregate review of the neonatal Quality Assessment and Performance Improvement (QAPI) initiatives and outcomes. Neonatal Program Oversight may be performed through the neonatal program's performance improvement committee, multidisciplinary oversight committee, or other structured means.

(18) Neonate--An infant from birth through 28 completed days.

(19) NMD--Neonatal Medical Director.

(20) NPM--Neonatal Program Manager.

(21) NRP--Neonatal Resuscitation Program. A resuscitation course developed and administered jointly by the American Heart Association and the American Academy of Pediatrics.

(22) On-site--At the facility and able to arrive at the patient bedside for urgent requests.

(23) PCR--Perinatal Care Region. The PCRs are established for descriptive and regional planning purposes. The PCRs are geographically divided by counties and are integrated into the existing 22 Trauma Service Areas (TSAs) and the applicable Regional Advisory Council (RAC) of the TSA provided in §157.122 of this title (relating to Trauma Services Areas) and §157.123 of this title (relating to Regional Emergency Medical Services/Trauma Systems).

(24) Perinatal--Of, relating to, or being the period around childbirth, especially the five months before and one month after birth.

(25) POC--Plan of Correction. A report submitted to the department by the facility detailing how the facility will correct any deficiencies cited in the neonatal designation site survey summary or documented in the self-attestation.

(26) Premature/prematurity--Birth at less than 37 weeks of gestation.

(27) QAPI Plan--Quality Assessment and Performance Improvement Plan. QAPI is a data-driven and proactive approach to quality improvement. It combines two approaches - Quality Assessment (QA) and Performance Improvement (PI). QA is a process used to ensure services are meeting quality standards and assuring care reaches a defined level. PI is the continuous study and improvement process designed to improve system and patient outcomes.

(28) RAC--Regional Advisory Council as described in §157.123 of this title.

(29) Supervision--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity.

(30) Telehealth service--A health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology as defined in Texas Occupations Code §111.001.

(31) Telemedicine medical service--A health care service delivered by a physician licensed in this state, or health professional acting under the delegation and supervision of a physician licensed in this state and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or technology as defined in Texas Occupations Code §111.001.

(32) TSA--Trauma Service Area as described in §157.122 of this title.

(33) Urgent--Requiring action or attention within 30 minutes of notification.

§133.183. General Requirements.

(a) The department reviews the applicant documents and approves the appropriate level of facility designation.

(b) A facility is defined under this subchapter as a single location where inpatients receive hospital services; or each location, if there are multiple buildings where inpatients receive hospital services and are covered under a single hospital license.

(c) Each location must be considered separately for designation and the department approves the designation level for each location based on the location's ability to demonstrate designation criteria are met. A stand-alone children's facility that does not provide obstetrical services is exempt from obstetrical requirements.

(d) The department determines requirements for the levels of neonatal designation. Facilities seeking Levels II, III, and IV neonatal designation must meet department-approved requirements validated by a department-approved survey organization.

(e) Facilities seeking Level I neonatal designation must submit a self-survey and attest to meeting department-approved requirements.

(f) The four levels of neonatal designation are:

(1) Level I (Well Care). The Level I neonatal designated facility must:

(A) provide care for mothers and their infants of generally more than or equal to 35 weeks gestational age who have routine, transient perinatal problems;

(B) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served; and

(C) provide the same level of care that the neonate would receive at a higher-level designated neonatal facility and complete an in-depth critical review and assessment of the care provided to these infants through the neonatal QAPI Plan and process if an infant less than 35 weeks gestational age is retained.

(2) Level II (Special Care). The Level II neonatal designated facility must:

(A) provide care for mothers and their infants of generally more than or equal to 32 weeks gestational age and birth weight

more than or equal to 1500 grams who have physiologic immaturity or problems that are expected to resolve rapidly and are not anticipated to require subspecialty services on an urgent basis;

(B) provide care, either by including assisted endotracheal ventilation for less than 24 hours or nasal continuous positive airway pressure (NCPAP) until the infant's condition improves, or arrange for appropriate transfer to a higher-level designated facility; and

(C) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served.

(3) Level III (Neonatal Intensive Care). The Level III neonatal designated facility must:

(A) provide care for mothers and comprehensive care for their infants of all gestational ages with mild to critical illnesses or requiring sustained life support;

(B) ensure access to consultation to a full range of pediatric medical subspecialists and pediatric surgical specialists, and the capability to perform major pediatric surgery on-site or at another appropriate neonatal designated facility;

(C) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served;

(D) facilitate neonatal transports; and

(E) provide outreach education related to trends identified through the neonatal QAPI Plan, specific requests, and system needs to lower-level neonatal designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(4) Level IV (Advanced Neonatal Intensive Care). The Level IV neonatal designated facility must:

(A) provide care for mothers and comprehensive care for their infants of all gestational ages with the most complex and critical medical and surgical conditions or requiring sustained life support;

(B) ensure access to a comprehensive range of pediatric medical subspecialists and pediatric surgical subspecialists available to arrive on-site, in person for consultation and care, and the capability to perform major pediatric surgery, including the surgical repair of complex conditions on-site;

(C) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served;

(D) facilitate neonatal transports; and

(E) provide outreach education related to trends identified through the neonatal QAPI Plan, specific requests, and system needs to lower-level neonatal designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(g) Facilities seeking neonatal designation must undergo an on-site or virtual survey as outlined in this section and:

(1) are responsible for scheduling a neonatal designation survey through a department-approved survey organization;

(2) must notify the department of the neonatal designation survey date;

(3) are responsible for expenses associated with the neonatal designation survey;

(4) must not accept surveyors with any known conflict of interest; and

(5) must provide the survey team access to records and documentation regarding the neonatal QAPI Plan and process related to neonatal patients. The department may determine that failure by a facility to provide access to these records does not meet the requirements of this subchapter.

(h) If a known conflict of interest is present for the facility seeking neonatal designation, the facility must decline the assigned surveyor through the surveying organization. A conflict of interest exists when a surveyor has a direct or indirect financial, personal, or other interest which would limit or could reasonably be perceived as limiting the surveyor's ability to serve in the best interest of the public. The conflict of interest may include a surveyor who personally trained a key member of the facility's leadership in residency or fellowship, collaborated with a key member of the facility's leadership team professionally, participated in a designation consultation with the facility, had a previous working relationship with the facility or facility leaders, or conducted a designation survey for the facility within the past four years.

(1) Surveyors cannot be from the same PCR or TSA region or a contiguous region of the facility's location.

(2) Designation site survey summary and medical record reviews performed by a surveyor with an identified conflict of interest may not be accepted by the department.

(i) The department, at its sole discretion, may appoint an observer to accompany the survey team with the observer costs borne by the department.

(j) The survey team evaluates the facility's evidence that department-approved designation requirements are met and documents all requirements that are not met in the neonatal designation site survey summary and medical record reviews.

§133.184. Designation Process.

(a) A facility seeking neonatal designation or renewal of designation must submit a completed application packet.

(1) The completed application packet includes:

(A) an accurate and complete neonatal designation application for the requested level of designation;

(B) a completed neonatal attestation and self-survey report for Level I applicants, or the documented neonatal designation site survey summary that validates the department requirements are met and the medical record reviews for Levels II, III and IV applicants, submitted to the department no later than 90 days after the neonatal designation site survey date;

(C) if the facility has three or more department-approved designation requirements that are defined as not met in the neonatal designation site survey summary, the facility must contact the department's designation unit within 10 business days to discuss the Plan of Correction (POC);

(D) the POC, if required by the department, which must include:

(i) a statement of the cited designation requirement not met;

(ii) a statement describing the corrective action taken by the facility seeking neonatal designation to meet the requirement;

(iii) the title of the individuals responsible for ensuring the corrective actions are implemented;

(iv) the date the corrective actions were implemented;

(v) how the corrective actions will be monitored; and

(vi) documented evidence that the POC was implemented within 90 days of the designation survey;

(E) written evidence of annual participation in the applicable PCRs; and

(F) any subsequent documents submitted by the date requested by the department.

(2) The application includes full payment of the non-refundable, non-transferrable designation fee listed:

(A) Level I neonatal facility applicants, the fees are as follows:

(i) less than or equal to 100 licensed beds, the fee is $250.00; or

(ii) more than 100 licensed beds, the fee is $750.00.

(B) Level II neonatal facility applicants, the fee is $1,500.00.

(C) Level III neonatal facility applicants, the fee is $2,000.00.

(D) Level IV neonatal facility applicants, the fee is $2,500.00.

(b) The application will not be processed if a facility seeking neonatal designation fails to submit the required application documents and total designation fee.

(c) The neonatal designation renewal process, or a request to designate at a different level of care, or a change in ownership, or a change in physical address require the facility to notify the department and submit a complete designation application packet outlined in subsection (a)(1) and (2) of this section.

(d) The facility must submit the required documents described in subsection (a)(1) and (2) of this section to the department no later than 90 days before the facility's current neonatal designation expiration date for all designation renewals.

(e) The facility has the right to withdraw its application for neonatal designation any time before a designation approval.

(f) The facility must seek neonatal designation renewal to maintain continual designation and prevent an interruption in designation.

(g) The facility's neonatal designation will expire if the facility fails to provide a complete neonatal designation application packet to the department.

(h) The neonatal designation application packet in its entirety, including any recommendations or follow-up from the department, and any opportunities for improvement, must be a written element of the facility's neonatal QAPI Plan and must be reviewed through this process, which is all subject to confidentiality as described in Texas Health and Safety Code, §241.184, Confidentiality; Privilege.

(i) The department reviews the application packet to determine and approve the facility's level of neonatal designation.

(j) The department defines the final neonatal designation level awarded to the facility, and this designation may be different than the level requested based on the neonatal designation site survey summary.

(k) If the department determines the facility meets the requirements for neonatal designation, the department provides the facility with a designation award letter and a designation certificate.

(1) The facility must display its neonatal designation certificate in a public area of the licensed premises that is readily visible to patients, employees, and visitors.

(2) The facility must not alter the neonatal designation certificate. Any alteration voids neonatal designation for the remainder of that designation period.

(l) The survey organization must provide the facility with a written, signed neonatal designation site survey summary, including medical record reviews, regarding their evaluation and validation of the facility's demonstration that neonatal designation requirements are met. The neonatal designation site survey summary must be forwarded to the facility no later than 30 days after the completion date of the survey. The facility is responsible for submitting a copy of the neonatal designation site survey summary and medical record reviews to the department, with the required documents to continue the designation process, within 90 days of completion of the site survey.

(m) The department will approve designation of a facility that demonstrates the requirements are met.

(n) A neonatal level of care designation must not be denied to a facility that meets the designation requirements for that level of care designation.

(o) If a facility does not meet the designation requirements for the level of designation requested, the department will designate the facility at the highest level for which designation requirements are met.

(p) If the department determines a facility does not meet the designation requirements for the level of designation requested, the department must provide written notification to the facility of the designation requirements not met and provide a Corrective Action Plan (CAP) to assist the facility in meeting the designation requirements. The CAP may include requiring the facility to have a focused survey or a complete re-survey.

(1) The facility must submit to the department reports as required and outlined in the CAP. The department may require a second survey to ensure they meet the designation requirements. The cost of the second survey will be at the expense of the facility.

(2) If the department substantiates actions taken by the facility demonstrating documented evidence that designation requirements are met, the department removes the contingencies.

(q) If a facility disagrees with the designation level awarded by the department, it may request an appeal in writing to the EMS/Trauma Systems Section Director not later than 30 days after the designation award. The written appeal must be from the facility's Chief Executive Officer, Chief Medical Officer, or Chief Nursing Officer with documented evidence of how the facility meets the requirements for the requested designation level.

(1) The EMS/Trauma Systems Section will establish a three-person appeal panel and follow approved appeal panel guidelines to assess the facility's designation appeal as referenced in Texas Health and Safety Code §241.1836.

(2) If the designation appeal panel recommends the original determination, the EMS/Trauma Systems Section Director will give

written notice of such to the facility not later than 30 days after the appeal panel's recommendation.

(3) If the designation appeal panel disagrees with the department's original designation determination, the panel will recommend the appropriate level of neonatal designation to the department.

(4) If a facility disagrees with the designation appeal panel's recommendation regarding its designation level, the facility can request a second appeal review with the department's Associate Commissioner for Consumer Protection Division. If the Associate Commissioner upholds the designation appeal panel's recommendation, the designation status will remain the same. If the Associate Commissioner disagrees with the designation appeal panel's recommendation, the Associate Commissioner will define the appropriate level and award designation. The department will send a notification letter of the second appeal decision within 30 days of receiving the second appeal request.

(5) If the facility continues to disagree with the second level of appeal, the facility has a right to a hearing in the manner referenced in §133.121 of this title (relating to Enforcement Action).

(r) Exceptions and Notifications

(1) A designated neonatal facility must provide written or electronic notification of any significant change to the neonatal program impacting patient care. The notification must be provided to the following:

(A) all emergency medical services (EMS) providers that transfer neonatal patients to or from the designated neonatal facility;

(B) the hospitals to which it customarily transfers out or transfers in neonatal patients;

(C) applicable PCRs and RACs; and

(D) the department.

(2) If the designated neonatal facility is unable to meet the requirements to maintain its current designation, it must submit to the department a POC as described in subsection (a)(1)(D) of this section, and a request for a temporary exception to the designation requirements. Any request for an exception must be submitted in writing from the facility's Chief Executive Officer and define the facility's timeline to meet the designation requirements. The department reviews the request and the POC, and either grants the exception with a specific timeline based on the public interest, geographic maternal care capabilities, and access to care, or denies the exception. If the facility is not granted an exception or it does not meet the designation requirements at the end of the exception period, the department will elect one of the following:

(A) re-designate the facility at the level appropriate to its revised capabilities;

(B) outline an agreement with the facility to satisfy all designation requirements for the level of care designation within a time specified under the agreement, which may not exceed the first anniversary of the effective date of the agreement; or

(C) waive one specific designation requirement for a level of care designation if the facility meets all other designation requirements for the level of care designation and the department determines the waiver is justified considering:

(i) the expected impact on accessibility of neonatal care in the geographic area served by the facility if the waiver is not granted and the expected impact on the quality of care and patient safety; or

(ii) whether these services can be met by other facilities in the area or with telehealth/telemedicine services.

(3) Waivers expire with the expiration of the current designation but may be renewed. The department may specify any conditions for ongoing reporting during this time.

(4) The department maintains a current list on its internet website of facilities that have contingency agreements or an approved waiver with the department and an aggregated list of the designation requirements conditionally met or waived.

(5) Facilities that have contingency agreements or an approved waiver with the department must post on the facility's internet website the nature and general terms of the agreement.

(s) An application for a higher or lower level of neonatal designation may be submitted to the department at any time.

(1) A designated neonatal facility that is increasing its neonatal capabilities may choose to apply for a higher-level of designation at any time. The facility must follow the designation process as described in subsection (a)(1) and (2) of this section to apply for the higher-level.

(2) A designated neonatal facility that is unable to maintain the facility's current level of neonatal designation may choose to apply for a lower level of designation at any time.

(t) If the facility is relinquishing its neonatal designation, the facility must provide 30 days written, advance notice of the relinquishment to the department, the applicable PCRs/RACs, EMS providers, and facilities it customarily transfers out or transfers in neonatal patients. The facility is responsible for continuing to provide neonatal care services or ensuring a plan for neonatal care continuity for the 30 days following the written notice of relinquishing its neonatal designation.

(u) A hospital providing neonatal services must not use the terms "designated neonatal facility" or similar terminology in its signs, advertisements, facility internet website, social media, or in the printed materials and information it provides to the public, unless the facility is currently designated at that level of neonatal care.

(v) During a virtual, on-site, or focused designation review, conducted by the department or survey organization, the department or surveyor has the right to review and evaluate neonatal patient records, neonatal multidisciplinary QAPI Plan documents, and any action specific to improving neonatal care and outcomes, as well as any other documents relevant to neonatal care in a designated neonatal facility or facility seeking neonatal designation to validate designation requirements are met.

(w) The department and survey organization will comply with all relevant laws related to the confidentiality of records.

(x) The department may deny, suspend, or revoke designation if a designated neonatal facility ceases to provide services to meet or maintain the designation requirements of this section.

§133.185. Program Requirements.

(a) Neonatal Program Philosophy. Designated facilities must have a family-centered philosophy. Parents must have reasonable access to their infants at all times and be encouraged to participate in the care of their infants. The facility environment for perinatal care must meet the physiologic and psychosocial needs of the mothers, infants, and families.

(b) Neonatal Program Plan. The facility must develop a written neonatal operational plan for the neonatal program that includes a detailed description of the scope of services and clinical resources

available for all neonatal patients, mothers, and families. The plan must define the neonatal patient population evaluated, treated, transferred, or transported by the facility consistent with clinical guidelines based on current standards of neonatal practice ensuring the health and safety of patients.

(1) The written Neonatal Program Plan must be reviewed and approved by Neonatal Program Oversight and be submitted to the facility's governing body for review and approval. The governing body must ensure the requirements of this section are implemented and enforced.

(2) The written Neonatal Program Plan must include, at a minimum:

(A) clinical guidelines based on current standards of neonatal practice, and policies and procedures that are adopted, implemented, and enforced by the neonatal program;

(B) a process to ensure and validate these clinical guidelines based on current standards of neonatal practice, policies, and procedures, are reviewed and revised a minimum of every three years;

(C) written triage, stabilization, and transfer guidelines for neonatal patients that include consultation and transport services;

(D) the role and scope of telehealth/telemedicine practices, if utilized, including:

(i) documented and approved written policies and procedures that outline the use of telehealth/telemedicine for inpatient hospital care or for consultation, including appropriate situations, scope of care, and documentation that is monitored through the neonatal QAPI Plan and process; and

(ii) written and approved procedures to gain informed consent from the patient or designee for the use of telehealth/telemedicine, if utilized, that are monitored for variances;

(E) written guidelines for discharge planning instructions and appropriate follow-up appointments for all neonates/infants;

(F) written guidelines for the hospital disaster response, including a defined neonatal evacuation plan and process to relocate mothers and infants to appropriate levels of care with identified resources, and this process must be evaluated annually to ensure neonatal care can be sustained and adequate resources are available;

(G) written minimal education and credentialing requirements for all staff participating in the care of neonatal patients, which are documented and monitored by the managers who have oversight of staff;

(H) written requirements for providing continuing staff education, including annual competencies and skills assessment that is appropriate for the patient population served, which are documented and monitored by the managers who have oversight of staff;

(I) documentation of meeting the requirement for a perinatal staff registered nurse to serve as a representative on the nurse staffing committee under §133.41 of this title (relating to Hospital Functions and Services);

(J) measures to monitor the availability of all necessary equipment and services required to provide the appropriate level of care and support for the patient population served; and

(K) documented guidelines for consulting support personnel with knowledge and skills in breastfeeding and lactation, which includes expected response times, defined roles, responsibilities, and expectations.

(3) The facility must have a documented and approved neonatal QAPI Plan.

(A) The Chief Executive Officer, Chief Medical Officer, and Chief Nursing Officer must implement a culture of safety for the facility and ensure adequate resources are allocated to support a concurrent, data-driven neonatal QAPI Plan.

(B) The facility must demonstrate that the neonatal QAPI Plan consistently assesses the provision of neonatal care provided. The assessment must identify variances in care, the impact to the patient, and the appropriate levels of review. This process must identify opportunities for improvement and develop a plan of correction to address the variances in care or the system response. An action plan will track and analyze data through resolution or correction of the identified variance.

(C) The neonatal program must measure, analyze, and track performance through defined quality indicators, core performance measures, and other aspects of performance that the facility adopts or develops to evaluate processes of care and patient outcomes. Summary reports of these findings are reported through the Neonatal Program Oversight.

(D) All neonatal facilities must participate in a neonatal data initiative. Level III and IV neonatal facilities must participate in benchmarking programs to assess their outcomes as an element of the neonatal QAPI Plan.

(E) The Neonatal Medical Director (NMD) must have the authority to make referrals for peer review, receive feedback from the peer review process, and ensure neonatal physician representation in the peer review process for neonatal cases.

(F) The NMD and Neonatal Program Manager (NPM) must participate in PCR meetings, regional QAPI initiatives, and regional collaboratives, and submit requested data to assist with data analysis to evaluate regional outcomes as an element of the facility's neonatal QAPI Plan.

(G) The facility must have documented evidence of neonatal QAPI summary reports reviewed and reported by Neonatal Program Oversight that monitor and ensure the provision of services or procedures through telehealth and telemedicine, if utilized, is in accordance with the standards of care applicable to the provision of the same service or procedure in an in-person setting.

(H) The facility must have documented evidence of neonatal QAPI summary reports to support that aggregate neonatal data are consistently reviewed to identify developing trends, opportunities for improvement, and necessary corrective actions. Summary reports must be provided through the Neonatal Program Oversight, available for site surveyors, and submitted to the department as requested.

(c) Medical Staff. The facility must have an organized, effective neonatal program that is recognized by the facility's medical staff and approved by the facility's governing body.

(1) The credentialing of the neonatal medical staff must include a process for the delineation of privileges for neonatal care.

(2) The neonatal medical staff must participate in ongoing staff and team-based education and training in the care of the neonatal patient.

(d) Medical Director. There must be an identified NMD and an identified Transport Medical Director (TMD) if the facility has its own transport program. The NMD and TMD must be credentialed by the facility for treatment of neonatal patients and have their responsi-

bilities and authority defined in a job description. The NMD and TMD must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course.

(1) The NMD is responsible for the provision of neonatal care services and must:

(A) examine qualifications of medical staff and advanced practice providers requesting privileges to participate in neonatal/infant care, and make recommendations to the appropriate committee for such privileges;

(B) ensure neonatal medical staff and advanced practice provider competencies in managing neonatal emergencies, complications, and resuscitation techniques;

(C) monitor neonatal patient care from transport, to admission, stabilization, and operative intervention(s), as applicable, through discharge, and review variances in care through the neonatal QAPI Plan;

(D) participate in ongoing neonatal staff and team-based education and training in the care of the neonatal patient;

(E) oversee the inter-facility neonatal transport as appropriate;

(F) collaborate with the NPM, maternal teams, consulting physicians, and nursing leaders and units providing neonatal care to include developing, implementing, or revising:

(i) written policies, procedures, and guidelines for neonatal care that are implemented and monitored for variances;

(ii) the neonatal QAPI Plan, specific reviews, and data initiatives;

(iii) criteria for transfer, consultation, or higher-level of care; and

(iv) medical staff, advanced practice providers, and personnel competencies, education, and training;

(G) participate as a clinically active and practicing physician in neonatal care at the facility where medical director services are provided;

(H) ensure that the neonatal QAPI Plan is specific to neonatal/infant care, is ongoing, data driven, and outcome based;

(I) frequently lead the neonatal QAPI meetings with the NPM and participate in the Neonatal Program Oversight and other neonatal meetings, as appropriate;

(J) maintain active staff privileges as defined in the facility's medical staff bylaws; and

(K) develop and maintain collaborative relationships with other NMDs of designated neonatal facilities within the applicable PCR.

(2) The TMD is responsible for the facility neonatal transport program and must:

(A) collaborate with the transport team to develop, revise, and implement written policies, procedures, and guidelines, for neonatal care that are implemented and monitored for variances;

(B) participate in ongoing transport staff competencies, education, and training;

(C) review and evaluate transports from initial activation of the transport team through delivery of patient, resources, quality of patient care provided, and patient outcomes; and

(D) integrate review findings into the overall neonatal QAPI Plan and process.

(3) The NMD may also serve as the TMD.

(e) NPM. The facility must identify an NPM who has the authority and oversight responsibilities written in his or her job description, for the provision of neonatal services through all phases of care, including discharge, and identifying variances in care for inclusion in the neonatal QAPI Plan.

(1) The NPM must be a registered nurse with defined education, credentials, and experience for neonatal care applicable to the level of care being provided.

(2) The NPM must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course.

(3) The NPM must:

(A) ensure staff competency in resuscitation techniques;

(B) participate in ongoing staff and team-based education and training in the care of the neonatal patient;

(C) monitor utilization of telehealth/telemedicine, if used;

(D) collaborate with the NMD, maternal program, consulting physicians, and nursing leaders and units providing neonatal care to include developing, implementing, or revising:

(i) written policies, procedures, and guidelines for neonatal care that are implemented and monitored for variances;

(ii) the neonatal QAPI Plan, specific reviews, and data initiatives;

(iii) criteria for transfer, consultation, or higher-level of care; and

(iv) staff competencies, education, and training;

(E) regularly and actively participate in neonatal care at the facility where program manager services are provided;

(F) consistently review the neonatal care provided and ensure the neonatal QAPI Plan is specific to neonatal/infant care, data driven, and outcome-based;

(G) frequently lead the meetings and participate in Neonatal Program Oversight and other neonatal meetings as appropriate; and

(H) develop and maintain collaborative relationships with other NPMs of designated neonatal facilities within the applicable PCR.

§133.186. Neonatal Designation Level I.

(a) Level I (Well Care). The Level I neonatal designated facility must:

(1) provide care for mothers and their infants of generally more than or equal to 35 weeks gestational age who have routine, transient perinatal problems;

(2) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served; and

(3) provide the same level of care that the neonate would receive at a higher-level designated neonatal facility and complete an in-depth critical review and assessment of the care provided to these infants through the neonatal QAPI Plan and process if an infant less than 35 weeks gestational age is retained.

(b) Neonatal Medical Director (NMD). The NMD must be a physician who:

(1) is a currently practicing pediatrician, family medicine physician, or physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care;

(2) maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course;

(3) demonstrates effective administrative skills and oversight of the neonatal QAPI Plan; and

(4) completes annual continuing medical education specific to the care of neonates.

(c) Program Functions and Services.

(1) The neonatal program must collaborate with the maternal program, consulting physicians, and nursing leadership to ensure pregnant mothers who are at high risk of delivering a neonate that requires a higher-level of care are transferred to a higher-level facility before delivery unless the transfer would be unsafe.

(2) The facility provides appropriate, supportive, and emergency care delivered by trained personnel for unanticipated maternal-fetal or neonatal problems that occur during labor and delivery through the disposition of the patient.

(3) The on-call physician, advanced practice nurse, or physician assistant must have documented special competence in the care of neonates, privileges and credentials to participate in neonatal/infant care reviewed by the NMD, and:

(A) must maintain a current status of successful completion of the NRP or a department-approved equivalent course;

(B) must complete annual continuing education specific to the care of neonates;

(C) must arrive at the patient bedside within 30 minutes of an urgent request;

(D) if not immediately available to respond or is covering more than one facility, must ensure appropriate back-up coverage is available, back-up call providers are documented in the neonatal on-call schedule and must be readily available to respond to the facility staff; and

(E) the back-up call physician, advanced practice nurse, or physician assistant must arrive at the patient bedside within 30 minutes of an urgent request.

(4) The facility must have written guidelines defining the availability of appropriate anesthesia, laboratory, radiology, respiratory, ultrasonography, and blood bank services on a 24-hour basis as described in §133.41 of this title (relating to Hospital Functions and Services).

(A) If preliminary reading of imaging studies pending formal interpretation is performed, the preliminary findings must be documented in the medical record.

(B) The facility must ensure regular monitoring and comparison of the preliminary and final readings through the radiology QAPI Plan. Summary reports of activities must be presented at the Neonatal Program Oversight.

(5) Pharmacy services must be in compliance with the requirements in §133.41 of this title and must have a pharmacist available at all times.

(A) If medication compounding is done by a pharmacy technician for neonates/infants, a pharmacist must provide immediate supervision of the compounding process.

(B) When medication compounding is done for neonates/infants, the pharmacist must implement guidelines to ensure the accuracy of the compounded final product and ensure:

(i) the process is monitored through the pharmacy QAPI Plan; and

(ii) summary reports of activities are presented to the Neonatal Program Oversight.

(6) The facility must have personnel with appropriate training for managing neonates/infants, written policies, procedures, and guidelines specific to the facility for the stabilization and resuscitation of neonates based on current standards of professional practice. The facility must ensure the availability of personnel who can stabilize distressed neonates, including those less than 35 weeks gestation until they are transferred to a higher-level facility. Variances from these standards are monitored through the neonatal QAPI Plan and process.

(A) Each birth must be attended by at least one person who maintains a current status of successful completion of the NRP or a department-equivalent course, whose primary focus is management of the neonate and initiating resuscitation.

(B) At least one person must be immediately available on-site with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications.

(C) Additional personnel with current status of successful completion of the NRP, or a department-equivalent course, must be on-site and immediately available upon request for the following:

(i) multiple birth deliveries, to care for each neonate;

(ii) deliveries with unanticipated maternal-fetal problems that occur during labor and delivery; and

(iii) deliveries determined or suspected to be high-risk for the pregnant patient or neonate.

(D) Variances from these standards are monitored through the neonatal QAPI Plan and process and reported at the Neonatal Program Oversight.

(E) Neonatal resuscitative equipment, supplies, and medications must be immediately available for trained personnel to perform resuscitation and stabilization on any neonate/infant.

(7) A registered nurse with experience in neonatal or perinatal care must provide supervision and coordination of staff education.

(8) The neonatal program ensures the availability of support personnel with knowledge and skills in breastfeeding and lactation to assist and counsel mothers.

(9) Social services, supportive spiritual care, and counseling must be provided as appropriate to meet the needs of the patient population served.

§133.187. Neonatal Designation Level II.

(a) Level II (Special Care). The Level II neonatal designated facility must:

(1) provide care for mothers and their infants of generally more than or equal to 32 weeks gestational age and birth weight more than or equal to 1500 grams who have physiologic immaturity or problems that are expected to resolve rapidly and are not anticipated to require subspecialty services on an urgent basis; and

(A) if a facility is located more than 75 miles from the nearest Level III or IV designated neonatal facility and retains a neonate less than 32 weeks of gestation or having a birth weight of less than 1500 grams, the facility must provide the same level of care that the neonate would receive at a higher-level designated neonatal facility; and

(B) any facility that retains a neonate less than 32 weeks of gestation or a birth weight less than 1500 grams, must, through the neonatal QAPI Plan, complete an in-depth critical review and assessment of the care provided;

(2) provide care, either by including assisted endotracheal ventilation for less than 24 hours or nasal continuous positive airway pressure (NCPAP) until the infant's condition improves or arrange for appropriate transfer to a higher-level designated facility; and

(A) if the facility performs neonatal surgery, it must provide the same level of care that the neonate would receive at a higher-level designated facility; and

(B) the neonatal surgical procedure and follow-up must be reviewed through the neonatal QAPI Plan; and

(3) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served.

(b) Neonatal Medical Director (NMD). The NMD must be a physician who:

(1) is a board-eligible/certified neonatologist, with experience in the care of neonates/infants and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course; or

(2) is a pediatrician or neonatologist by the effective date of this section who:

(A) continuously provided neonatal care for the last consecutive two years and has experience and training in the care of neonates/infants, including assisted endotracheal ventilation and NCPAP management;

(B) maintains a consultative relationship with a board-eligible/certified neonatologist;

(C) demonstrates effective administrative skills and oversight of the neonatal QAPI Plan;

(D) maintains a current status of successful completion of the NRP or a department-approved equivalent course; and

(E) must complete annual continuing medical education specific to the care of neonates.

(c) Program Functions and Services.

(1) The neonatal program must collaborate with the maternal program, consulting physicians, and nursing leadership to ensure pregnant patients who are at high risk of delivering a neonate that requires a higher-level of care are transferred to a higher-level facility before delivery unless the transfer would be unsafe.

(2) The facility provides appropriate, supportive, and emergency care delivered by trained personnel, for unanticipated maternal-fetal or neonatal problems that occur during labor and delivery through the disposition of the patient.

(3) The on-call physician, advanced practice nurse, or physician assistant must have documented special competence in the care of neonates, privileges and credentials to participate in neonatal/infant care reviewed by the NMD, and:

(A) must maintain a current status of successful completion of the NRP or a department-approved equivalent course;

(B) must complete annual continuing education specific to the care of neonates;

(C) must arrive at the patient bedside within 30 minutes of an urgent request;

(D) if not immediately available to respond or is covering more than one facility, must ensure appropriate back-up coverage is available, back-up call providers are documented in the neonatal on-call schedule and must be readily available to respond to the facility staff;

(i) the back-up call physician, advanced practice nurse, or physician assistant must arrive at the patient bedside within 30 minutes of an urgent request; and

(ii) the on-call staff must be on-site to provide ongoing care and to respond to emergencies when a neonate/infant is maintained on endotracheal ventilation.

(4) The neonatal program ensures if surgeries are performed for neonates/infants, a surgeon privileged and credentialed to perform surgery on a neonate/infant is on-call and must arrive at the patient bedside within a time period consistent with current standards of professional practice and neonatal care. Surgeon response times must be reviewed and monitored through the neonatal QAPI Plan.

(5) Anesthesia providers with pediatric experience and competence must provide services in compliance with the requirements in §133.41 of this title (relating to Hospital Functions and Services).

(6) Dietitian or nutritionist with appropriate training and experience in neonatal nutrition provides services for the population served in compliance with the requirements in §133.41 of this title.

(7) Laboratory services must be in compliance with the requirements in §133.41 of this title and must have:

(A) personnel on-site at all times as defined by written management guidelines, which may include when a neonate/infant is maintained on endotracheal ventilation; and

(B) a blood bank capable of providing blood and blood component therapy within the timelines defined in approved blood transfusion guidelines.

(8) The facility must provide neonatal/infant blood gas monitoring capabilities.

(9) Pharmacy services must be in compliance with the requirements in §133.41 of this title and must have a pharmacist with experience in neonatal/pediatric pharmacology available at all times.

(A) If medication compounding is done by a pharmacy technician for neonates/infants, a pharmacist must provide immediate supervision of the compounding process.

(B) When medication compounding is done for neonates/infants, the pharmacist must implement guidelines to ensure the accuracy of the compounded final product and ensure:

(i) the process is monitored through the pharmacy QAPI Plan; and

(ii) summary reports of activities are presented at the Neonatal Program Oversight.

(C) Total parenteral nutrition appropriate for neonates/infants must be available, if requested.

(10) A speech, occupational, or physical therapist with sufficient neonatal expertise must provide therapy services to meet the needs of the population served.

(11) Radiology services must be in compliance with the requirements in §133.41 of this title, incorporate the "As Low as Reasonably Achievable" principle when obtaining imaging in neonatal patients, and must have:

(A) personnel appropriately trained in the use of x-ray and ultrasound equipment;

(B) personnel at the bedside within 30 minutes of an urgent request;

(C) personnel appropriately trained, available on-site to provide ongoing care and to respond to emergencies when an infant is maintained on endotracheal ventilation;

(D) interpretation capability of neonatal and perinatal x-rays and ultrasound studies are available at all times;

(E) if preliminary reading of imaging studies pending formal interpretation is performed, the preliminary findings must be documented in the medical record; and

(F) regular monitoring and comparison of preliminary and final readings through the radiology QAPI Plan and provide summary reports of activities at the Neonatal Program Oversight.

(12) A respiratory therapist, with experience and specialized training in the respiratory support of neonates/infants, whose credentials have been reviewed by the NMD, must be immediately available on-site when:

(A) a neonate/infant is on a respiratory ventilator to provide ongoing care and to respond to emergencies; or

(B) a neonate/infant is on a Continuous Positive Airway Pressure (CPAP) apparatus.

(13) The facility must have staff with appropriate training for managing neonates/infants, written policies, procedures, and guidelines specific to the facility for the stabilization and resuscitation of neonates based on current standards of professional practice. Variances from these standards are monitored through the neonatal QAPI Plan.

(A) Each birth must be attended by at least one person who maintains a current status of successful completion of the NRP or a department-approved equivalent course, whose primary focus is management of the neonate and initiating resuscitation.

(B) At least one person must be immediately available on-site with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications.

(C) Additional personnel who maintain a current status of successful completion of the NRP or a department-approved equivalent course must be on-site and immediately available upon request for the following:

(i) multiple birth deliveries, to care for each neonate;

(ii) deliveries with unanticipated maternal-fetal problems that occur during labor and delivery; and

(iii) deliveries determined or suspected to be high-risk for the pregnant patient or neonate.

(D) Variances from these standards are monitored through the neonatal QAPI Plan and process and reported at the Neonatal Program Oversight.

(E) Neonatal resuscitative equipment, supplies, and medications must be immediately available for trained staff to perform resuscitation and stabilization on any neonate/infant.

(14) A registered nurse with experience in neonatal care, including special care, or perinatal care must provide supervision and coordination of staff education.

(15) Social services, supportive spiritual care, and counseling must be provided as appropriate to meet the needs of the patient population served.

(16) Written and implemented policies and procedures to ensure the timely evaluation of retinopathy of prematurity, documented referral for treatment, and follow-up of an at-risk infant, which must be monitored through the neonatal QAPI Plan.

(17) The neonatal program ensures the availability of support personnel with knowledge and expertise in breastfeeding and lactation to assist and counsel mothers.

(18) The neonatal program ensures provisions for follow-through care at discharge for infants at high risk for neurodevelopmental, medical, or psychosocial complications.

§133.188. Neonatal Designation Level III.

(a) Level III (Neonatal Intensive Care). The Level III neonatal designated facility must:

(1) provide care for mothers and comprehensive care for their infants of all gestational ages with mild to critical illnesses or requiring sustained life support;

(2) ensure access to consultation to a full range of pediatric medical subspecialists and pediatric surgical specialists, and the capability to perform major pediatric surgery on-site or at another appropriate neonatal designated facility;

(3) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served;

(4) facilitate neonatal transports; and

(5) provide outreach education related to trends identified through the neonatal QAPI Plan, specific requests, and system needs to lower-level neonatal designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(b) Neonatal Medical Director (NMD). The NMD must be a physician who is a board-eligible/certified neonatologist with experience in the care of neonates/infants and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course.

(c) If the facility has its own transport program, there must be an identified Transport Medical Director (TMD). The TMD or Trans-

port Medical Co-Director must be a physician who is a board-eligible/certified neonatologist or pediatrician with expertise and experience in neonatal/infant transport.

(d) Program Functions and Services.

(1) The neonatal program must collaborate with the maternal program, consulting physicians, and nursing leadership to ensure pregnant patients who are at high risk of delivering a neonate that requires a higher-level of care are transferred to a higher-level facility before delivery unless the transfer would be unsafe.

(2) The facility provides appropriate, supportive, and emergency care delivered by trained personnel for unanticipated maternal-fetal or neonatal problems that occur during labor and delivery through the disposition of the patient.

(3) At least one of the following neonatal providers must be on-site and available at all times: pediatric hospitalists, neonatologists, neonatal nurse practitioners, or neonatal physician assistants, as appropriate, who must have documented competence in the management of severely ill neonates/infants, and privileges and credentials to participate in neonatal/infant care reviewed by the NMD and:

(A) must maintain a current status of successful completion of the NRP or a department-approved equivalent course;

(B) must complete annual continuing education specific to the care of neonates;

(C) must have a neonatologist available for consultation at all times that arrives on-site within 30 minutes of an urgent request, if the on-site provider is not a neonatologist; and

(D) if the neonatologist is covering more than one facility, must ensure the facility has a back-up neonatologist available, the back-up neonatologist is documented in the neonatal on-call schedule, and readily available to respond to the facility staff and arrive at the patient bedside within 30 minutes of an urgent request.

(4) The neonatal program that performs surgeries for neonates/infants must have a surgeon privileged and credentialed to perform surgery on a neonate/infant on-call. The surgeon on-call must be available to arrive at the patient bedside within a time period consistent with current standards of professional practice and neonatal care. Surgeon response times must be reviewed and monitored through the neonatal QAPI Plan.

(5) Anesthesiologists with pediatric expertise and competence must direct and evaluate anesthesia care provided to neonates in compliance with the requirements in §133.41 of this title.

(6) Dietitian or nutritionist with appropriate training and experience in neonatal nutrition, plans diets that meet the needs of the neonate/infant and provides services for the population served, in compliance with the requirements in §133.41 of this title.

(7) Laboratory services must be in compliance with the requirements in §133.41 of this title and must have:

(A) laboratory personnel on-site at all times;

(B) pediatric pathology services available for the population served;

(C) pediatric surgical or intra-operative frozen section pathology services available in the operative suite at the request of the operating surgeon; and

(D) a blood bank capable of providing blood and blood component therapy within the timelines defined in approved blood transfusion guidelines.

(8) The facility must provide neonatal/infant blood gas monitoring capabilities.

(9) Pharmacy services must be in compliance with the requirements in §133.41 of this title and must have a pharmacist with experience in neonatal/pediatric pharmacology available at all times.

(A) If medication compounding is done by a pharmacy technician for neonates/infants, a pharmacist must provide immediate supervision of the compounding process;

(B) When medication compounding is done for neonates/infants, the pharmacist must implement guidelines to ensure the accuracy of the compounded final product and ensure:

(i) the process is monitored through the pharmacy QAPI Plan; and

(ii) summary reports of activities are presented at the Neonatal Program Oversight.

(C) Total parenteral nutrition appropriate for neonates/infants must be available.

(10) Radiology services must be in compliance with the requirements in §133.41 of this title, incorporate the "As Low as Reasonably Achievable" principle when obtaining imaging in neonatal patients, and must have:

(A) personnel appropriately trained in the use of x-ray equipment on-site and available at all times;

(B) personnel appropriately trained in ultrasound, computed tomography, and cranial ultrasound equipment available on-site within a time period consistent with current standards of professional practice;

(C) fluoroscopy available at all times;

(D) neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret the neonatal diagnostic imaging studies, available at all times;

(E) a radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the neonatal QAPI Plan and process;

(F) preliminary findings documented in the medical record, if preliminary reading of imaging studies pending formal interpretation is performed; and

(G) regular monitoring and comparison of the preliminary and final readings through the radiology QAPI Plan and provide summary reports of activities at the Neonatal Program Oversight.

(11) Pediatric echocardiography with pediatric cardiology interpretation and consultation completed within a time period consistent with current standards of professional practice.

(12) Speech, occupational, or physical therapists with neonatal/infant expertise and experience must:

(A) evaluate and recommend management of feeding or swallowing disorders as appropriate for the patient's condition; and

(B) provide therapy services to meet the needs of the population served.

(13) A respiratory therapist, with experience and specialized training in the respiratory support of neonates/infants, whose credentials have been reviewed by the NMD, must be on-site and immediately available.

(14) The facility must have staff with appropriate training for managing neonates/infants and written policies, procedures, and guidelines specific to the facility for the stabilization and resuscitation of neonates based on current standards of professional practice. Variances from these standards are monitored through the neonatal QAPI Plan.

(A) Each birth must be attended by at least one person who maintains a current status of successful completion of the NRP or a department-approved equivalent course, and whose primary focus is management of the neonate and initiating resuscitation.

(B) At least one person must be immediately available on-site with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications.

(C) Additional personnel who maintain a current status of successful completion of the NRP or a department-approved equivalent course must be on-site and immediately available upon request for the following:

(i) multiple birth deliveries, to care for each neonate;

(ii) deliveries with unanticipated maternal-fetal problems that occur during labor and delivery; and

(iii) deliveries determined or suspected to be high-risk for the pregnant patient or neonate.

(D) Variances from these standards are monitored through the neonatal QAPI Plan and process and reported at the Neonatal Program Oversight.

(E) Neonatal resuscitative equipment, supplies, and medications must be immediately available for trained staff to perform complete resuscitation and stabilization for each neonate/infant.

(15) A registered nurse with experience in neonatal care, including neonatal intensive care, must provide supervision and coordination of staff education.

(16) Social services, supportive spiritual care, and counseling must be provided as appropriate to meet the needs of the patient population served.

(17) Written and implemented policies and procedures to ensure timely evaluation of retinopathy of prematurity, documented referral for treatment and follow-up of an at-risk infant, which must be monitored through the neonatal QAPI Plan.

(18) The neonatal program ensures a certified lactation consultant must be available at all times to assist and counsel mothers.

(19) The neonatal program ensures provisions for follow-through care at discharge for infants at high risk for neurodevelopmental, medical, or psychosocial complications.

§133.189. Neonatal Designation Level IV.

(a) Level IV (Advanced Neonatal Intensive Care). The Level IV neonatal designated facility must:

(1) provide care for the mothers and comprehensive care for their infants of all gestational ages with the most complex and critical medical and surgical conditions or requiring sustained life support;

(2) ensure access to a comprehensive range of pediatric medical subspecialists and pediatric surgical subspecialists are available to arrive on-site in person for consultation and care, and the capability to perform major pediatric surgery including the surgical repair of complex conditions on-site;

(3) have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served;

(4) facilitate neonatal transports; and

(5) provide outreach education related to trends identified through the neonatal QAPI Plan, specific requests, and system needs to lower-level neonatal designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(b) Neonatal Medical Director (NMD). The NMD must be a physician who is a board-eligible/certified neonatologist and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course.

(c) If the facility has its own transport program, there must be an identified Transport Medical Director (TMD). The TMD or Transport Medical Co-Director must be a physician who is a board-eligible/certified neonatologist with expertise and experience in neonatal/infant transport.

(d) Program Functions and Services.

(1) The neonatal program must collaborate with the maternal program, consulting physicians, and nursing leadership to ensure pregnant patients who are at high risk of delivering a neonate that requires specialized care are transferred to a facility with specialized care capabilities before delivery unless the transfer would be unsafe.

(2) The facility provides appropriate, supportive, and emergency care delivered by trained personnel for unanticipated maternal-fetal or neonatal problems that occur during labor and delivery, through the disposition of the patient.

(3) A board-eligible/certified neonatologist, with documented competence in the management of the most complex and critically ill neonates/infants, with neonatal privileges and credentials reviewed by the NMD, must be on-site and immediately available at the neonate/infant bedside as requested. The neonatologist:

(A) must maintain a current status of successful completion of the NRP or a department-approved equivalent course;

(B) must complete annual continuing education specific to the care of neonates; and

(C) must ensure the facility has a back-up neonatal provider if the neonatologist is not immediately available.

(4) Pediatric anesthesiologists must direct and evaluate anesthesia care provided to neonates in compliance with the requirements in §133.41 of this title (relating to Hospital Functions and Services).

(5) A comprehensive range of pediatric medical subspecialists and pediatric surgical subspecialists privileged and credentialed to participate in neonatal/infant care must be available to arrive on-site for in-person consultation and care within a time period consistent with current standards of professional practice and neonatal care. The pediatric medical and pediatric surgical subspecialists' response times must be reviewed and monitored through the neonatal QAPI Plan.

(6) Dietitian or nutritionist with appropriate training and experience in neonatal nutrition, plans diets that meet the needs of the neonate/infant and critically ill neonatal patient and provides services for the population served, in compliance with the requirements in §133.41 of this title.

(7) Laboratory services must be in compliance with the requirements in §133.41 of this title and must have:

(A) appropriately trained and qualified laboratory personnel on-site at all times;

(B) pediatric pathology services available for the population served;

(C) pediatric surgical or intra-operative frozen section pathology services available in the operative suite at the request of the operating surgeon; and

(D) a blood bank capable of providing blood and blood component therapy within the timelines defined in approved blood transfusion guidelines.

(8) The facility must provide neonatal/infant blood gas monitoring capabilities.

(9) Pharmacy services must be in compliance with the requirements in §133.41 of this title and must have a pharmacist with experience in neonatal/pediatric pharmacology available on-site at all times.

(A) If medication compounding is done by a pharmacy technician for neonates/infants, a pharmacist must provide immediate supervision of the compounding process.

(B) When medication compounding is done for neonates/infants, the pharmacist must implement guidelines to ensure the accuracy of the compounded final product and must ensure:

(i) the process is monitored through the pharmacy QAPI plan; and

(ii) summary reports of activities are presented at the Neonatal Program Oversight.

(C) Total parenteral nutrition appropriate for neonates/infants must be available.

(10) Radiology services must be in compliance with the requirements in §133.41 of this title, incorporate the "As Low as Reasonably Achievable" principle when obtaining imaging in neonatal patients, and must have:

(A) personnel appropriately trained in the use of x-ray equipment on-site and available at all times;

(B) personnel appropriately trained in ultrasound, computed tomography, and cranial ultrasound equipment be on-site within a time period consistent with current standards of professional practice;

(C) fluoroscopy be available at all times;

(D) neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret neonatal diagnostic imaging studies, available at all times;

(E) a radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the neonatal QAPI Plan and process;

(F) preliminary findings documented in the medical record, if preliminary reading of imaging studies pending formal interpretation is performed; and

(G) regular monitoring and comparison of the preliminary and final readings through the radiology QAPI Plan and provide a summary report of activities at the Neonatal Program Oversight.

(11) Pediatric echocardiography with pediatric cardiology interpretation and consultation completed within a time period consistent with current standards of professional practice.

(12) Speech, occupational, or physical therapists with neonatal/infant expertise and experience must:

(A) evaluate and recommend management of feeding and swallowing disorders as appropriate for the patient's condition; and

(B) provide therapy services to meet the needs of the population served.

(13) A respiratory therapist, with experience and specialized training in the respiratory support of neonates/infants, whose credentials have been reviewed and approved by the Neonatal Medical Director, must be on-site and immediately available.

(14) The facility must have staff with appropriate training for managing neonates/infants, written policies, procedures, and guidelines specific to the facility for the stabilization and resuscitation of neonates/infants based on current standards of professional practice. Variances from these standards are monitored through the neonatal QAPI Plan.

(A) Each birth must be attended by at least one person who maintains a current status of successful completion of the NRP or a department-approved equivalent course and whose primary focus is management of the neonate and initiating resuscitation.

(B) At least one person must be immediately available on-site with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access and administration of medications.

(C) Additional personnel who maintain a current status of successful completion of the NRP or a department-approved equivalent course must be on-site and immediately available upon request for the following:

(i) multiple birth deliveries, to care for each neonate;

(ii) deliveries with unanticipated maternal-fetal problems that occur during labor and delivery; and

(iii) deliveries determined or suspected to be high-risk for the pregnant patient or neonate.

(D) Variances from these standards are monitored through the neonatal QAPI Plan and process and reported at the Neonatal Program Oversight.

(E) Neonatal resuscitative equipment, supplies, and medications must be immediately available for trained staff to perform complete resuscitation and stabilization for each neonate/infant.

(15) A registered nurse with experience in neonatal care, including advanced neonatal intensive care, must provide supervision and coordination of staff education.

(16) Social services, supportive spiritual care, and counseling must be provided as appropriate to meet the needs of the patient population served.

(17) Written and implemented policies and procedures to ensure timely evaluation and treatment of retinopathy of prematurity on-site by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity of an at-risk infant. Patient follow-up of retinopathy of prematurity must be documented and monitored through the neonatal QAPI Plan.

(18) The neonatal program ensures a certified lactation consultant must be available at all times to assist and counsel mothers.

(19) The neonatal program ensures provisions for follow-through care at discharge for infants at high risk for neurodevelopmental, medical, or psychosocial complications.

§133.190. Survey Team.

(a) The survey team composition must be as follows:

(1) Level I facilities neonatal program staff must conduct a self-survey, documenting the findings on the approved department survey form. The department may periodically require validation of the survey findings by an on-site review conducted by department staff.

(2) Level II facilities must be surveyed by a multidisciplinary team that includes, at a minimum, one neonatologist and one neonatal nurse who:

(A) have completed a department survey training course;

(B) have observed a minimum of one neonatal survey;

(C) are currently active in the management of neonatal patients and active in the neonatal QAPI Plan and process at a facility providing the same or a higher-level of neonatal care; and

(D) meet the criteria outlined in the department survey guidelines.

(3) Level III facilities must be surveyed by a multidisciplinary team that includes, at a minimum, one neonatologist, one neonatal nurse, and a pediatric surgeon when neonatal surgery is performed in the facility, who:

(A) have completed a survey training course;

(B) have observed a minimum of one neonatal survey;

(C) are currently active in the management of neonatal patients and active in the neonatal QAPI Plan and process at a facility providing the same or a higher-level of neonatal care; and

(D) meet the criteria outlined in the department survey guidelines.

(4) Level IV facilities must be surveyed by a multidisciplinary team that includes, at a minimum, one neonatologist, one neonatal nurse, and one pediatric surgeon, who:

(A) have completed a survey training course;

(B) have observed a minimum of one neonatal survey;

(C) are currently active in the management of neonatal patients and active in the neonatal QAPI Plan and process at a facility providing the same level of neonatal care; and

(D) meet the criteria outlined in the department survey guidelines.

(b) All members of the survey team, except department staff, must come from a PCR outside the facility's region or a contiguous region.

(c) Survey team members cannot have a conflict of interest:

(1) A conflict of interest exists when a surveyor has a direct or indirect financial, personal, or other interest which would limit or could reasonably be perceived as limiting the surveyor's ability to serve in the best interest of the public. The conflict of interest may include a surveyor who, within the past four years, has personally trained a key member of the facility's leadership in residency or fellowship, collaborated with a key member of the facility's leadership professionally, participated in a designation consultation with the facility, or conducted a designation survey for the facility.

(2) If a designation survey occurs with a surveyor who has a conflict of interest, the department, in its sole discretion, may refuse to accept the neonatal designation site survey summary conducted by a surveyor with a conflict of interest.

(d) The survey team must follow the department survey guidelines to evaluate and validate that the facility demonstrates the designation requirements are met.

(e) The survey team must evaluate appropriate use of telehealth/telemedicine utilization for neonatal care.

(f) All information and materials submitted by a facility to the department and a survey organization under Texas Health and Safety Code, §241.183(d) or this subchapter, are subject to confidentiality as articulated in Texas Health and Safety Code, §241.184, Confidentiality; Privilege, and are not subject to disclosure under Texas Government Code, Chapter 552, or discovery, subpoena, or other means of legal compulsion for release to any person.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2023.

TRD-202302037
Cynthia Hernandez
General Counsel
Department of State Health Services
Effective date: June 22, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 535-8538

♦ ♦ ♦

TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 565. HOME AND COMMUNITY-BASED (HCS) PROGRAM AND COMMUNITY FIRST CHOICE (CFC) CERTIFICATION STANDARDS

The Executive Commissioner of Health and Human Services Commission (HHSC) adopts in Texas Administrative Code (TAC) Title 26, Part 1, Chapter 565, Home and Community-based Program (HCS) Certification Standards, new §§565.2, 565.3, 565.5, 565.7, 565.9, 565.11, 565.13, 565.15, 565.17, 565.19, 565.21, 565.23, 565.25, 565.27, 565.29, 565.31, 565.33, 565.35, 565.37, 565.39, 565.41, 565.43, 565.47, and 565.49.

New §§565.3, 565.5, 565.9, 565.11, 565.13, 565.15, 565.17, 565.19, 565.21, 565.23, 565.25, 565.27, 565.31, 565.35, 565.37, and 565.49 are adopted with changes to the proposed text as published in the February 17, 2023, issue of the *Texas Register* (48 TexReg 789). These rules will be republished. These rules contain references to §565.45, Administrative Penalties, which is being administratively transferred from 40 TAC §9.181, effective the same day these rules are adopted.

New §§565.2, 565.7, 565.29, 565.33, 565.39, 565.41, 565.43, and 565.47 are adopted without changes to the proposed text as published in the February 17, 2023, issue of the *Texas Register* (48 TexReg 789). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The new sections are necessary to describe the regulatory certification standards for HCS Medicaid waiver program providers.

The rules describe certification standards regarding service delivery; rights of individuals; requirements related to abuse, neglect, and exploitation; staff member and service provider requirements; and quality assurance. The rules also include requirements from the program's residential checklist along with new requirements for emergency preparedness, fire drills, and evacuation drills in all residential types in the HCS program. The rules set forth recommendations for increased oversight of HCS host home/companion care homes, clarify restraint and seclusion requirements, and add language for restricting the use of enclosed beds. The rules also modify HHSC surveyor requirements to allow for survey flexibility as the HCS waiver program evolves.

COMMENTS

The 31-day comment period ended March 20, 2023. During this period, HHSC received 57 comments regarding the proposed rules from three commenters: Every Child, Inc., Private Provider's Alliance of Texas, and Provider's Alliance for Community Services of Texas. A summary of comments and HHSC's responses follows.

Comment: A commenter recommended removing the term "emotional well-being" from the definition of "actual harm" because the term is subjective, not defined, and has been used broadly to establish harm.

Response: The concept of an individual's emotional well-being as it relates to harm is consistently used across Long-Term Care Regulation programs, including similar community settings for individuals diagnosed with intellectual disabilities or related conditions. Therefore, HHSC declines to make changes to this definition without further dialogue with stakeholders, advocates, and providers.

Comment: A commenter said it is unclear why there is "emotional injury" in the definition of neglect in §565.3(76) but not in the definition of neglect in the Texas Department of Family and Protective Services (DFPS) rules. The commenter asked what the definition of emotional injury is and stated that the definition of neglect should match that of DFPS's definition and include DFPS's definition for emotional harm, which is "a highly unpleasant mental reaction with obvious signs of distress, such as anguish, grief, fright, humiliation, or fury." The commenter added that emotional harm is innate in living and associating with other people, whether a roommate or direct care staff, but does not constitute neglect or abuse. The commenter recommended, at a minimum, adding a definition for "emotional harm," and that the outcome must be tied to abuse or neglect.

Response: HHSC declines to make changes in response to these comments because the language "emotional injury" is used in the HHSC definition of neglect located in 26 TAC §711.19, How is neglect defined? HHSC is the investigative authority for HCS abuse, neglect, and exploitation allegations, and as such, this term is consistent for the definition of neglect in both HCS and investigative rules.

Comment: A commenter stated that the definition of relative in §565.3(99) is different from what HHSC is using for "relative host home."

Response: HHSC declines to make changes in response to this comment because proposed §565.3(99) is used in context with HHSC Billing Requirements.

Comment: A commenter recommended deleting §565.7(c)(1)(B) unless there is a statutory or policy requirement that this web-based training be completed. Behavioral support services must be provided by a behavior therapist; therefore, it is unclear to the commenter what HHSC's web-based training would offer that a trained professional did not already gain from educational and hands-on experience.

Response: HHSC declines to make changes in response to these comments because proposed §565.7(c)(1)(B) is, in part, a federal Medicaid requirement as outlined in the CMS HCS waiver application.

Comment: A commenter stated that §565.9(b)(5), under Program Provider Requirements, may be the appropriate place to add a requirement that providers ensure the licenses of their licensed contractors are in good standing.

Response: HHSC declines to make changes in response to this comment. Proposed §565.7(c)(2)(A), under Staff Member and Service Provider Requirements, is specific to licensed contractors and requires a program provider to develop and implement policy and procedures to ensure a service provider continues to be licensed and in good standing with its licensing board during the provision of services to an individual.

Comment: Regarding §565.9(c), a commenter stated that licensure checks of service providers should be made upon employment (and upon expiration of the license) and that automobile insurance should only be required for the period of the policy, because it is unclear what an "ongoing verification process" would be other than requiring staff to inform providers if their insurance is canceled or changes, or if their license is revoked.

Response: HHSC agrees with the commenter and revised proposed §565.9(c) to require a program provider to develop and implement policy and procedures to ensure only staff members and service providers with a valid driver's license and insurance transport individuals.

Comment: A commenter recommended adding "unless" to the beginning of §565.9(e)(2).

Response: Changing the language of proposed §565.9(e)(2) in response to the requestor's suggestion would change the meaning of the rule so that the rule would no longer align with HHSC's intent. Therefore, HHSC declines to make the commenter's proposed change. However, proposed §565.9(e)(2) was revised to clarify the intent of the subsection.

Comment: A commenter recommended the following revision to §565.9(g)(2)(B) related to financial impropriety toward an individual: "unauthorized purchase of goods not requested for the individual and cannot be used by the individual or not intended for the individual's use." The commenter stated that it is subjective for regulators to independently determine what an individual can or cannot use and that this regulation does not require consideration of the intent of the purchase.

Response: HHSC agrees with the commenter and revised proposed §565.9(g)(2)(B) to clarify that financial impropriety toward an individual includes "any purchase of goods that are not requested for the individual, cannot be used by the individual, or are not intended for the individual's use."

Comment: A commenter stated, "After an approved individual plan of care (IPC) has been signed and shared with the provider, and unless the person has chosen a group home and the provider does not have a group home vacancy, or the

provider cannot ensure the health and safety of the individual. Providers may offer vacancies in other contract areas to satisfy this requirement."

Response: In accordance with the federal CMS HCS waiver application, the program provider must accommodate the individual's preference regarding where to live. HHSC declines to make changes in response to this comment because the requested revision is inconsistent with the federal HCS waiver application and would require additional analysis and a change to the federal HCS waiver application.

Comment: In reference to §565.11(a)(4), a commenter recommended changing the wording to, "facilitate modifications to a service plan if requested by the individual and maintain service plans to be responsive to individual's personal goals, conditions, abilities, and needs as identified by the service planning team and identified in the person directed plan."

Response: HHSC declines to make changes in response to these comments. To ensure an individual has access to services in a timely manner, the service provider is responsible for maintaining a system of delivering services that is responsive to the individual's personal goals, condition, abilities, and needs as identified by the service planning team, in accordance with proposed §565.11(a)(4).

Comment: A commenter stated that §565.11(a)(6) requires providers go through the process of obtaining a behavior plan to restrict an individual's rights. The commentor would like to have a separate process in rule for restricting an individual's right, when applicable, since not all restrictions of rights are linked to an undesirable behavior, and creating a behavior plan involves multiple entities, not just the program provider.

Response: An individual receiving HCS services has all the same rights and responsibilities exercised by people without disabilities unless otherwise justified. The federal CMS HCS waiver application requires that providers justify any restriction of rights and that those restrictions only occur with adequate discussion and documentation through the person-centered planning process. Therefore, HHSC declines to make changes in response to this without further dialogue with stakeholders, advocates, and providers.

Comment: A commenter expressed concerns regarding §565.11(a)(10), which requires providers to initiate an individual plan of care (IPC) renewal although they have no control over local intellectual and developmental disability authority availability, HHSC timeliness, or the families of the individuals. The commenter stated that providers already go without payment if the renewal deadline is missed. The commenter argued that if failure to meet this renewal requirement could result in an administrative penalty, the requirement should not also be a part of HHSC Billing Requirement nor a contract requirement under Medicaid and Children's Health Insurance Program.

Response: The IPC document provides information related to the care and needs of the individual. This document must be up to date to ensure the health and safety of the individual. Medicaid program rules located in 26 TAC §263.302 provide a 60-day window for renewals, which gives program providers sufficient time to initiate IPC renewals. Therefore, HHSC declines to makes changes in response to these comments because an accurate IPC is essential to the health and safety of the individual.

Comment: A commenter stated that since §565.11(a)(12) is already in the billing requirements, it should not also be in rule.

Response: HHSC declines to make changes in response to this comment because proposed §565.11(a)(12) is a different requirement than that of the HCS billing requirement. Billing requirements provide the documentation that is necessary for reimbursement. The proposed rules describe what the program provider must do to document the individual's progress or lack of progress towards goals and objectives.

Comment: In reference to §565.11(a)(14), a commenter stated that, "The state has specified that individuals can no longer receive paid work as part of a habilitation service so it is unclear whether individuals will still have access to sub-minimum wage, however, HHSC should not dictate the options available to individuals that are not covered by Medicaid."

Response: Proposed §565.11(a)(14) ensures that individuals who produce marketable goods and services in habilitation training programs are paid at a wage level commensurate with that paid to persons who are without disabilities and who would otherwise perform that work. Compensation is based on requirements contained in the Fair Labor Standards Act. This rule applies to HCS program providers and what they must do for individuals who receive HCS waiver program services. Therefore, HHSC declines to make changes in response to this comment.

Comment: A commenter stated that the language in §565.11(a)(20) is already outlined in licensure requirements for Individualized Skills and Socialization as well as the program service rules. Additionally, the commenter asserted that additional efforts are needed to set reasonable expectations for service providers who are contracting services with licensed providers that are expected to meet this standard under their license (and separately regulated by HHSC).

Response: HHSC made changes to this rule language and removed the program description language from the rule. The revised language requires the HCS program provider to ensure delivery of contracted services in accordance with the individual's person-directed plan (PDP), IPC, implementation plan, and Appendix C of the CMS federal HCS waiver application, but it does not require the HCS program provider to abide by the licensing requirements in the Individualized Skills and Socialization licensure rules.

Comment: The commenter recommended adding "including an electronic copy" to §565.11(a)(42)(B).

Response: HHSC agrees with the commenter and revised proposed §565.11(a)(42)(B) to include service by an electronic copy.

Comment: A commenter stated that the language about CFC ERS in §565.19 is not in the HCS Billing Requirements or as a service with a rate in the HCS rate tables.

Response: HHSC declines to make changes in response to this comment. Proposed §565.19 requires the program provider to deliver CFC ERS services as required by the federal CMS HCS waiver application. The rule ensures that an individual receives the appropriate services as indicated in the HCS waiver application and for the health and safety of the individual.

Comment: In reference to §565.19(1), a commenter asked why CFC ERS would not be approved for a person who is receiving host home companion care.

Response: HHSC declines to make changes in response to this comment because this comment is outside the scope of this rule project.

Comment: A commenter suggested adding "program providers should have policies and procedures to ensure:" to §565.23(b).

Response: HHSC declines to make changes in response to this comment because a program provider is directly responsible for the condition of an HCS residence rather than creating policies and procedures for selecting and maintaining HCS residences.

Comment: A commenter asked HHSC to explain how a neighborhood or community in §565.23(b)(1) can ensure the health, safety, and well-being of the individual.

Response: HHSC declines to make changes in response to this comment because the requestor was asking HHSC to provide examples of how a neighborhood could ensure the health, safety, and well-being of the individual rather than make changes to the rule language. A program provider may consider whether the neighborhood or community is adjacent to resources the individual may require, such as community engagement opportunities or medical resources.

Comment: A commenter recommended adding "including documentation of identified broken equipment and order date" to §565.23(b)(3). The commenter added that equipment breaks and may not be available for a time if the break is unexpected.

Response: HHSC agrees with this comment and revised proposed §565.23(b)(3) to clarify how a service provider will identify adaptive equipment that is not functional.

Comment: A commenter suggested adding "provided by the provider" to §565.23(b)(5). The commenter stated that host homes may have furnishings not in good repair, but that this should not necessarily be held against them, particularly if they are the parents of the individual and have limited income and resources.

Response: HHSC agrees with the commenter and revised proposed §565.23(b)(5) to include a requirement that furnishings must be safe and fit for use.

Comment: A commenter stated that the rules in §565.23(b)(7) should allow for a process for identifying and treating possible infestations and should not be penalized if the provider is treating a potential infestation and keeping individuals safe.

Response: HHSC declines to make changes in response to this comment because proposed §565.23(b)(7) only requires the home to be free of infestations including bugs, rodents, and other pests. The rule enables the provider to determine how to identify and treat infestations within the home.

Commenter: To ensure consistency with the Home and Community-based Services settings requirements located in 26 TAC §263.502, a commenter requested that the following be added to the end of §565.23(b)(14)(C): "Unless the LAR is the individual's host home provider."

Response: Under §263.502(b)(4), a lock is installed on the individual's bedroom door at no cost to the individual. The requirement for a lock to be installed on an individual's bedroom door at no cost to the individual or the individual's LAR, as proposed in rule §565.23(b)(14)(C), is consistent with §263.502 of this title. Therefore, HHSC declines to make changes in response to this comment.

Comment: In §565.23(b)(14)(C), a commenter asked to clarify in LTCR rule whether a family can purchase a different lock if they do not like the lock installed by the provider as long as it meets requirements.

Response: HHSC declines to make changes in response to this comment because proposed §565.23(b)(13) only requires that the program provider ensure a lock is on the individual's bedroom door.

Comment: A commenter asked HHSC to clarify the settings and frequency of fire drills in §565.23(e)(1).

Response: HHSC agrees with the commenter and made changes to §565.23 for clarity.

Comment: A commenter suggested that §565.23(e)(4) and (5) be consolidated into one statement, "Providers should retrain or revise emergency plans based upon assessment of staff and individual performance of the fire drill."

Response: HHSC declines to make changes in response to this comment because the requirement in each rule serves a different purpose in the service provider's emergency plan. Proposed §565.23(e)(4) relates to staff execution of a fire drill. Proposed §565.23(e)(5) involves actions the service provider takes at any time in response to an identified shortcoming in the emergency plan.

Comment: A commenter suggested adding language to §555.23(b)(e)(5) regarding fire drills and whether a person must evacuate in a home rated impractical with sprinklers.

Response: HHSC declines to make changes in response to this comment because proposed §565.23(f) requires the program provider to create and maintain an emergency plan to address fire drills and ensure the individual can exit the residence safely. The rule enables the HCS provider to create a plan based on the needs of the individual and adjust as necessary.

Comment: A commenter recommended adding text in quotes at the end of §565.25(d): "or electronically if available."

Response: HHSC agrees with the commenter and revised proposed §565.25(d) to include an option for electronic delivery of records, reports or other information requested by HHSC.

Comment: A commenter asked if providers could charge a deposit in accordance with the Texas Property Code in §565.27(a)(5)(A).

Response: Under 42 CFR 441.301(c)(4)(vi)(A), for a provider-owned or controlled residential setting, the individual receiving services has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. As such, the program provider or service provider of host home/companion care and the individual or LAR agree that the residential agreement is a "lease," as defined in Texas Property Code Chapter 92, and that they are subject to state law governing residential tenancies, including Texas Property Code Chapters 24, 91, and 92 and Texas Rules of Civil Procedure Rule 510, in accordance with §263.503(c)(7)(A) of this title. Therefore, HHSC declines to make changes in response to this comment because the terms of a residential lease agreement would be controlled by the Texas Property Code.

Comment: A commenter stated that §565.27(c) is duplicative with financial impropriety provisions in §565.9(g)(2).

Response: HHSC declines to make changes in response to this comment because proposed §565.9(g)(2) is the prohibition against financial impropriety whereas proposed §565.27(c) requires written approval for all charges assessed by the program provider against the individual's personal funds.

Comment: A commenter requested to add, "have policies and procedures" to §565.31(a), Requirements Related to Abuse, Neglect, and Exploitation.

Response: HHSC declines to make changes in response to this comment because proposed §565.31(a) outlines the regulatory requirements to ensure compliance with the service provider's responsibility to inform the individual, the individual's LAR, and staff on the procedures to report abuse, neglect, and exploitation and to ensure staff is adequately trained. An additional regulatory requirement for the service provider to develop policies and procedures would require further discussion with stakeholders, advocates, and service providers.

Comment: A commenter requested adding the language "have policies and procedures" in §565.31(a)(2) so that it requires the provider to have policies and procedures for training staff on abuse, neglect, and exploitation and document the training.

Response: HHSC declines to make changes in response to this comment because proposed §565.31(a)(2) outlines the regulatory requirements to ensure compliance with the service provider's responsibility to ensure staff is adequately trained. An additional regulatory requirement for the service provider to develop policies and procedures would require further discussion with stakeholders, advocates, and service providers.

Comment: A commenter stated that it does not make sense that a provider must send Form 8494, Notification Regarding an Investigation of Abuse, Neglect or Exploitation, required in §565.31(f)(4) to HHSC because HHSC is the one who issues the outcome of the investigation; therefore, the commenter argues, HHSC is aware of the outcome before the provider. The commenter also stated that in some cases, HHSC has shown up with citations written for violations of this subsection when the provider never received the report of the investigation.

Response: HHSC declines to make changes in response to this comment because the purpose of Form 8494 is for the service provider to document any actions taken as a result of the outcome of the investigation.

Comment: A commenter questioned why HHSC continues to require that at least one person in a four-person residence must receive residential support. The commenter stated that the rates are the same for residential support and supervised living regardless of whether a person lives in a three or four-bedroom home; the designation of "residential support" requires 24-hour awake staff.

Response: HHSC declines to make changes in response to this comment because the federal CMS HCS waiver application requires one person receive residential support in a four-person residence. Making a change to this rule would conflict with the federal CMS HCS waiver application.

Comment: A commenter stated that the rules use the term "Billing Guidelines" when the terminology should be "Billing Requirements."

Response: HHSC agrees with the commenter and revised proposed §§565.3(89), (90), (99), (102), and §565.17(1)(A) to replace "Billing Guidelines" with "Billing Requirements."

Comment: A commenter stated that rules that allow individuals to choose any group home and rules that specify that individuals should have input on their roommates should be reconciled. The commenter argued that if providers allow an individual to move into any room he or she chooses, this could violate the rights of other individuals living in the home and their input on regarding perspective roommates.

Response: The commenter does not identify the rules that require reconciliation. Therefore, HHSC is unable to respond to these comments.

Comment: Regarding §565.11(a)(4), a commenter stated that a provider should be responsive to an individual's change in condition or specific request for services; however, a provider should not face "regulatory action when regulatory disagrees with the service plan." Rather, the commenter asserted that concerns should be referred back to the service planning team for consideration.

Response: As part of the provider's service delivery, the provider must maintain a system of delivering HCS Program and CFC services that is continuously responsive to changes in the individual's personal goals, condition, abilities, and needs as identified by the service planning team. It is unclear what the commenter means by references to a regulatory action when regulatory disagrees with the service plan. Proposed §565.11(a)(4) relates to a provider's response to an individual's change in condition or a specific request for services. Therefore, HHSC declines to make changes in response to this comment.

Comment: A commenter stated that not every rights restriction requires a behavior support plan and that providers have an extensive process that they must undergo with the service planning team to justify any rights restriction and documentation in the PDP. This may or may not include a recommendation for a behavior support plan. Therefore, the commenter stated, §565.11(a)(6) should be modified.

Response: As part of the provider's service delivery, the provider must ensure that an individual's rights are not violated unless contraindications are documented with justification in a behavior support plan. The requirement of a behavior support plan to restrict an individual's rights ensures there is an identified need for the restriction, which is documented, and that lesser restrictive options are considered. Therefore, HHSC declines to make changes in response to this comment.

Comment: A commenter had concerns regarding the full impact of including the residential review checklist in this rule because previously providers were given the opportunity to correct any concerns without penalty unless there was a hazard to health and safety or serious concerns that would constitute the need for an interim survey. The commenter stated that these rules and program changes may change this practice and lead to essentially licensing every three or four-bedroom group home in HCS, as well as the program as a whole.

Response: HHSC declines to make changes in response to this comment because program providers have an opportunity to correct any identified non-compliance in accordance with proposed §565.49, Program Provider Compliance and Corrective Action.

Comment: Two commenters had concerns with putting an end date on the use of enclosed beds. One stated that if HHSC is going to prohibit the use of enclosure beds in §565.35(a), enclosed beds should not be prohibited until the date the rule becomes effective, rather than January 1, 2023.

Response: HHSC agrees with the commenter and revised proposed §565.35(a) to change the effective date from January 1, 2023, to June 19, 2023, matching the effective date of the rules.

Comment: Two commenters expressed concern with the prohibition on enclosed beds, stating that there are unique circumstances where an individual may need a more restrictive bed or where an enclosed bed is the safest option, and asserted that they should be allowed with proper documentation and discussion.

Response: Under proposed §565.35(a), the program provider may allow the use of an enclosed bed in a residence if the enclosed bed is purchased, obtained, and complies with §565.35(c) prior to June 19, 2023. Under proposed §565.35(b), an enclosed bed is prohibited in a residence if it is purchased or obtained on or after June 19, 2023. Under proposed §565.35(e), all enclosed beds are prohibited after June 19, 2028, for health and safety of the individual. Therefore, HHSC declines to continue the use of enclosed beds after June 19, 2028, without further dialogue with stakeholders, advocates, and providers.

Comment: In reference to §565.35(c)(3)(B), a commenter suggested that producing a receipt for an enclosed bed for HHSC may not be feasible in all cases as families may not still have a receipt for the bed.

Response: HHSC declines to make changes in response to this comment because a receipt from a durable medical equipment company for the enclosed bed ensures the purchased bed meets industry standards for an enclosed bed.

Comment: A commenter reported that there is some inconsistency in the use of the term "enclosed beds" throughout §565.35(c), and stated that the description of the assessment, documentation, and review of enclosed bed usage in HCS settings other than the participant's own home or family home is somewhat duplicative and confusing.

Response: The commenter does not identify the inconsistencies in the use of the term "enclosed bed" or what is duplicative and confusing in proposed §565.35(c). Therefore, HHSC is unable to respond to these comments.

Comment: A commenter stated that the requirements in §565.35, Enclosed Beds, must be consistent with §565.37, Protective Devices, given that the definition of an enclosed bed identifies it as a protective device.

Response: HHSC agrees with the commenter and revised proposed §565.37 to state that if the protective device is an enclosed bed, providers should follow proposed §565.35.

Comment: A commenter was concerned that the requirements in §565.35(c)(3)(C) may cause a misunderstanding with other requirements and asked that the rule language be simplified for clarity.

Response: The commenter does not identify the other requirements that could cause a misunderstanding with proposed §565.35(c)(3)(C). Therefore, HHSC is unable to respond to these comments.

Comment: A commenter was concerned that highlighting the requirements in §565.35(e) that an enclosed bed must be commercially produced may cause a misunderstanding with the other requirements that are needed to meet the definition of enclosed bed located in §565.5(34).

Response: HHSC agrees with this comment and removed subsection(e) from §565.35 for clarity as this requirement was already listed in the definition section at §565.5(34).

Comment: A commenter expressed concerns about removal of language in existing rules at 40 TAC §9.172(4) requiring program providers to, "encourage involvement of the LAR or family members and friends in all aspects of the individual's life and provide as much assistance and support as is possible and constructive."

Response: The program provider must develop and implement policies to ensure the individual's family members and LAR are involved in the individual's services, as proposed in §565.5(b)(39). Therefore, HHSC declines to make changes in response to this comment.

Comment: A commenter expressed concerns about removal of language in existing rules at 40 TAC §9.174(a)(9) requiring program providers to, "allow the individual's family members and friends access to an individual without arbitrary restrictions unless exceptional conditions are justified by the individual's service planning team and documented in the PDP."

Response: HHSC declines to make changes in response to this comment because proposed §565.5(b) requires the program provider to develop and implement policies to ensure the individual can receive visitors without prior notice, have privacy in visitation with family and others, and communicate, associate, and meet privately with any person of the individual's choice.

Comment: A commenter expressed concerns about removal of language in existing rules at 40 TAC §9.174(a)(11) requiring program providers to, "ensure that the individual who is living outside the family home is living in a residence that maximizes opportunities for interaction with community members to the greatest extent possible."

Response: HHSC declines to make changes in response to this comment because proposed §565.5(b) requires the service provider develop and implement policies to ensure the individual's right to interaction within the community is not violated.

Comment: A commenter expressed concerns about removal of language in existing rules at 40 TAC §9.174(a)(15) requiring program providers to, "ensure that each individual has opportunities to develop relationships with peers with and without disabilities and receives support if the individual chooses to develop such relationships."

Response: HHSC declines to make changes in response to this comment because proposed §565.5(b) requires the service provider to develop and implement policies to ensure an individual has the opportunity to develop relationships with peers, who may or may not have disabilities.

Comment: A commenter expressed concerns about removal of language in existing rules at 40 TAC §9.174(a)(19) requiring program providers to, "unless contraindications are documented with justification by the service planning team, ensure that an individual's routine provides opportunities for leisure time activities, vacation periods, religious observances, holidays, and days off, consistent with the individual's choice and routines of other members of the community."

Response: HHSC declines to make changes in response to this comment because proposed §565.5(b) requires the service provider to develop and implement policies to ensure an individual has opportunities for leisure time activities, vacation periods, religious observances, holidays, and days off, consistent with the individual's choice and routines of other members of the community. Further, proposed §565.11(a)(6) would allow for restriction of an individual's right, under §565.5, if there was a documented

justification for the restriction in the individual's behavior support plan.

Comment: A commenter expressed concerns about removal of language in existing rules at 40 TAC §9.174(a)(21) requiring program providers to, "unless contraindications are documented with justification by the service planning team, ensure that each individual is offered choices and opportunities for accessing and participating in community activities and experiences available to peers without disabilities."

Response: HHSC declines to make changes in response to this comment because proposed §565.5(b) requires the service provider to develop and implement policies to ensure an individual has an opportunity to participate in social, recreational, and community group activities. Further, proposed §565.11(a)(6) would allow for restriction of an individual's right, under §565.5, if there was a documented justification for the restriction in the individual's behavior support plan.

Comment: A commenter expressed concerns about removal of language in existing rules at 40 TAC §9.174(a)(22) requiring program providers to, "assist the individual to meet as many of the individual's needs as possible by using generic community services and resources in the same way and during the same hours as these generic services are used by the community at-large."

Response: HHSC declines to make changes in response to this comment as because proposed §565.5(b) requires the service provider develop and implement policies to ensure the individual's right to interaction within in the community is not violated.

Comment: A commenter expressed concerns about the removal of language in existing rules at 40 TAC §9.174(a)(51) requiring program providers to, "ensure that appropriate staff members, service providers, and the service coordinator are informed of a circumstance or event that occurs in an individual's life or a change to an individual's condition that may affect the provision of services to the individual."

Response: HHSC declines to make changes in response to this comment because proposed §565.11(a)(8) requires a program provider to inform appropriate staff members, service providers, and the service coordinator when a circumstance or even occurs in an individual's life or a change to an individual's condition affects the provision of services to the individual.

Comment: A commenter stated that while some individual rights remain in the proposed rules and the proposed rules require a program provider to inform and, in some cases, protect and promote the rights of an individual the rules do not require the provider to support the individual to exercise his or her rights. The commenter stated that this distinction is subtle, but important.

Response: HHSC declines to make changes in response to this comment because proposed §565.5(b) requires a program provider to develop and implement policies to ensure the individual can exercise the rights, enumerated under proposed §565.5, without interference, coercion, discrimination, or retaliation by the program provider. Further, the individual has a right to be informed that the individual may make a complaint with the Intellectual and Developmental Disability Ombudsman.

Comment: A commenter recommended adding "level of need (LON)" to §565.11(a)(2) so it reads that a program provider must serve an eligible individual without regard to age, sex, race, disability, or level of need.

Response: Level of need is an assignment given by HHSC to an individual upon which reimbursement for host home/companion care, supervised living, residential support, and Individualized Skills and Socialization is based. Proposed §565.11(a)(2) requires a program provider to serve an eligible applicant level of disability. Therefore, HHSC declines to make changes in response to this comment.

Comment: A commenter recommended adding the following "language currently at 40 TAC §9.174(a)(23)(E) requiring program providers to ensure: "unless contraindications are documented with justification by the service planning team, the individual lives near family and friends and needed or desired community resources consistent with the individual's choice, if possible."

Response: HHSC declines to make any changes in response to this comment as proposed §565.5(b)(27) requires program providers to promote the individual's right to participate in decisions regarding their living environment. Additionally, proposed §565.5(b)(18) outlines the right of the individual to live where the individual is within proximity of and can access treatment and services that are best suited to meet the individual's needs and abilities and that enhance that individual's strengths.

HHSC made minor changes to rule language as a result of internal feedback. Revisions include:

- clarifying expectations for the frequency of fire drills;

- changing the terminology "HHSC Provider User Guide" to "HHSC guidance";

- adding a reference to the Medicaid rules regarding prohibited settings, to clarify appropriate settings for respite;

- clarifying language regarding the individual's right to receive visitors without prior notice, to align with Medicaid program rules;

- clarifying the program provider's role in reporting abuse, neglect, and exploitation when a contracted service provider is involved, to align with Individualized Skills and Socialization rules; and

- updating TAC references related to new Medicaid HCS program rules.

SUBCHAPTER B. OVERVIEW

26 TAC §565.2, §565.3

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§565.3. Definitions.

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

(1) Abuse--Considered to be:

(A) physical abuse;

(B) sexual abuse; or

(C) verbal or emotional abuse.

(2) Actively involved--Significant, ongoing, and supportive involvement with an applicant or individual by a person, as determined by the applicant's or individual's service planning team or program provider, based on the person's:

(A) interactions with the applicant or individual;

(B) availability to the applicant or individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the applicant's or individual's needs, preferences, values, and beliefs.

(3) Activities of daily living (ADL)--Basic personal everyday activities, including tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(4) Actual harm--A negative outcome that compromises an individual's physical, mental, or emotional well-being but does not constitute an immediate threat.

(5) Alarm call--A signal transmitted from an individual's Community First Choice (CFC) emergency response services (ERS) equipment to the CFC ERS response center indicating that the individual needs immediate assistance.

(6) Alleged perpetrator--A person alleged to have committed an act of abuse, neglect, or exploitation of an individual.

(7) Applicant--A Texas resident seeking services in the Home and Community-based Services (HCS) Program.

(8) Behavioral emergency--A situation in which an individual's severely aggressive, destructive, violent, or self-injurious behavior:

(A) poses a substantial risk of imminent probable death of, or substantial bodily harm to, the individual or others;

(B) has not abated in response to preventive de-escalatory or redirection techniques;

(C) is not addressed in a written behavior support plan; and

(D) does not occur during a medical or dental procedure.

(9) Business day--Any day except a Saturday, Sunday, or national or state holiday listed in Texas Government Code §662.003(a) or (b).

(10) Calendar day--Any day, including weekends and holidays.

(11) Centers for Medicare and Medicaid Services (CMS)--The federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

(12) Certification standard--A minimum standard for a program provider used by the Texas Health and Human Services Commission (HHSC) during a survey to ensure health and safety of an individual. Violations of a certification principle or standard are subject to administrative penalties.

(13) CFC--Community First Choice.

(14) CFC emergency response services (CFC ERS)--Backup systems and supports used to ensure continuity of services and supports. CFC ERS includes electronic devices and an array of available technology, personal emergency response systems, and other mobile communication devices.

(15) CFC ERS provider--The entity directly providing CFC ERS to an individual, which may be the program provider or a contractor of the program provider.

(16) CFC Financial management services (CFC FMS)--The term used for FMS on the individual plan of care (IPC) of an applicant or individual if the applicant or individual receives only CFC personal assistance services/habilitation (PAS/HAB) through the CDS option.

(17) CFC personal assistance services/habilitation (CFC PAS/HAB). A service that:

(A) consists of:

(i) personal assistance services that aid an individual in performing ADLs and instrumental activities of daily living (IADLs) based on the individual's person-centered service plan, including:

(I) non-skilled assistance with the performance of the ADLs and IADLs;

(II) household chores necessary to maintain the home as a clean, sanitary, and safe environment;

(III) escort services, which consist of accompanying and assisting an individual to access services or activities in the community, but do not include transporting an individual; and

(IV) assistance with health-related tasks; and

(ii) habilitation that aids an individual in acquiring, retaining, and improving self-help, socialization, and daily living skills and training the individual on ADLs, IADLs, and health-related tasks, such as:

(I) self-care;

(II) personal hygiene;

(III) household tasks;

(IV) mobility;

(V) money management;

(VI) community integration, including how to get around in the community;

(VII) use of adaptive equipment;

(VIII) personal decision making;

(IX) reduction of challenging behaviors to allow individuals to accomplish ADLs, IADLs, and health-related tasks; and

(X) self-administration of medication; and

(B) does not include transporting the individual, which means driving the individual from one location to another.

(18) CFC support consultation--The term used for support consultation on the IPC of an applicant or individual if the applicant or individual receives only CFC PAS/HAB through the CDS option.

(19) CFC support management--Training regarding how to select, manage, and dismiss an unlicensed service provider of CFC PAS/HAB, as described in the *HCS Handbook.*

(20) Chemical restraint--A medication used to control an individual's behavior or to restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychological condition.

(21) Cognitive rehabilitation therapy--A service that:

(A) assists an individual in learning or relearning cognitive skills that have been lost or altered because of damage to brain cells or brain chemistry in order to enable the individual to compensate for lost cognitive functions; and

(B) includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

(22) Community resource coordination group (CRCG)--A local interagency group composed of public and private agencies that develops service plans for individuals whose needs can be met only through interagency coordination and cooperation. The group's role and responsibilities are described in the Memorandum of Understanding on Coordinated Services to Persons Needing Services from More Than One Agency, which is available on the HHSC website.

(23) Competitive employment--Employment that pays an individual at least minimum wage if the individual is not self-employed.

(24) Consumer directed services option (CDS option)--A service delivery option in which an individual or legally authorized representative employs and retains service providers and directs the delivery of program services.

(25) Contract--A provisional contract or a standard contract.

(26) Controlling person--A person who:

(A) has an ownership interest in a program provider;

(B) is an officer or director of a corporation that is a program provider;

(C) is a partner in a partnership that is a program provider;

(D) is a member or manager in a limited liability company that is a program provider;

(E) is a trustee or trust manager of a trust that is a program provider; or

(F) because of a personal, familial, or other relationship with a program provider, is in a position of actual control or authority with respect to the program provider, regardless of the person's title.

(27) Critical incident--An event listed in the *HCS Provider User Guide* found on the HHSC website.

(28) Critical violation--A violation for which HHSC may assess an administrative penalty before giving a program provider an opportunity to correct the violation. A critical violation:

(A) is an immediate threat;

(B) has resulted in actual harm and is widespread;

(C) has resulted in actual harm and is a pattern; or

(D) has the potential to result in actual harm and is widespread.

(29) DADS--Formerly the Texas Department of Aging and Disability Services. Its functions have been transferred to the Texas Health and Human Services Commission.

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

(31) Emergency--An unexpected situation in which the absence of an immediate response could reasonably be expected to result in risk to the health and safety of an individual or another person.

(32) Emergency Plan--A written plan that describes the actions that will be taken to protect individuals, including evacuation or sheltering-in-place, in the event of an emergency such as a fire or natural disaster.

(33) Emergency situation--An unexpected situation involving an individual's health, safety, or welfare, of which a person of ordinary prudence would determine that the legally authorized representative (LAR) should be informed, such as:

(A) an individual needing emergency medical care;

(B) an individual being removed from his or her residence by law enforcement;

(C) an individual leaving his or her residence without notifying a staff member or service provider and not being located; and

(D) an individual being moved from his or her residence to protect the individual (for example, because of a hurricane, fire, or flood).

(34) Enclosed bed--A protective device that:

(A) is commercially produced;

(B) includes a 360-degree side enclosure, inclusive of a top cover or canopy; and

(C) must be appropriate for the size and weight of the individual.

(35) Exploitation--The illegal or improper act or process of using, or attempting to use, an individual or the resources of an individual for monetary or personal benefit, profit, or gain.

(36) Family-based alternative--A family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(37) Financial management services (FMS)--A service that is provided to an individual participating in the CDS option, as defined in 40 TAC §41.103 (relating to Definitions).

(38) Financial management services agency (FMSA)--An entity that provides financial management services to an individual participating in the CDS option, as defined in 40 TAC §41.103.

(39) Follow-up survey--A review by HHSC of a program provider to determine if the program provider has completed corrective action.

(40) Former military member--A person who served in the United States Army, Navy, Air Force, Marine Corps, Coast Guard, or Space Force:

(A) who declared and maintained Texas as the person's state of legal residence in the manner provided by the applicable military branch while on active duty; and

(B) who was killed in action or died while in service, or whose active duty otherwise ended.

(41) Four-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than four persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service like residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that, if it is the residence of four persons, at least one of those persons receives residential support;

(D) that is not the residence of any persons other than a service provider, the service provider's spouse, or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(E) that is not a dwelling described in §263.101(a)(5) of this title (relating to Eligibility Criteria for HCS Program Services and CFC Services).

(42) General residential operation (GRO)--The term has the meaning set forth in Texas Human Resources Code §42.002.

(43) Good cause--As used in §565.19(10) of this chapter (relating to Community First Choice (CFC) Emergency Response Systems (ERS) Services), a reason outside the control of the CFC ERS provider, as determined by HHSC.

(44) Health-related tasks--Specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health care professionals under state law to be performed by a service provider of CFC PAS/HAB. These include tasks delegated by a registered nurse (RN); health maintenance activities as defined in 22 TAC §225.4 (relating to Definitions), that may not require delegation; and activities assigned to a service provider of CFC PAS/HAB by a licensed physical therapist, occupational therapist, or speech-language pathologist.

(45) Home and Community-based Services Program (HCS Program)--The program operated by HHSC as authorized by CMS in accordance with §1915(c) of the Social Security Act.

(46) HHSC--The Texas Health and Human Services Commission.

(47) Instrumental activities of daily living (IADLs)--Activities related to living independently in the community, including meal planning and preparation; managing finances; shopping for food, clothing, and other essential items; performing essential household chores; communicating by phone or other media; and traveling around and participating in the community.

(48) ICAP--Inventory for Client and Agency Planning.

(49) ICF/IID--Intermediate care facility for individuals with an intellectual disability or related conditions. An ICF/IID is a facility in which the ICF/IID program is:

(A) licensed in accordance with Texas Health and Safety Code Chapter 252; or

(B) certified by HHSC, including a state supported living center.

(50) ICF/IID program--The Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program, which provides Medicaid-funded residential services to individuals with an intellectual disability or related conditions.

(51) Immediate threat--A situation that causes, or is likely to cause, serious injury, harm, impairment to, or the death of an individual.

(52) Implementation plan--A written document developed by the program provider that, for each HCS Program service, except for transportation provided as a supported home living activity, and CFC service, except for CFC support management, on the individual's IPC to be provided by the program provider, includes:

(A) a list of outcomes identified in the person-directed plan (PDP) that will be addressed using HCS Program and CFC services;

(B) specific objectives to address the outcomes required by subparagraph (A) of this paragraph that are:

(i) observable, measurable, and outcome-oriented; and

(ii) derived from assessments of the individual's strengths, personal goals, and needs;

(C) a target date for completion of each objective;

(D) the number of units of HCS Program and CFC services needed to complete each objective;

(E) the frequency and duration of HCS Program and CFC services needed to complete each objective; and

(F) the signature and date of the individual, LAR, and program provider.

(53) Individual--A person enrolled in the HCS Program.

(54) Individual plan of care (IPC)--A written plan that:

(A) states:

(i) the type and amount of each HCS Program service and each CFC service, except for CFC support management, to be provided to the individual during an IPC year;

(ii) the services and supports to be provided to the individual through resources other than HCS Program services or CFC services, including natural supports, medical services, and educational services; and

(iii) if an individual will receive CFC support management; and

(B) is authorized by HHSC.

(55) Initial certification survey--A review by HHSC of a program provider with a provisional contract to determine if the program provider complies with the certification standards.

(56) Initial IPC--The first IPC for an individual developed before the individual's enrollment into the HCS Program.

(57) Intellectual disability--Significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(58) Intellectual Disability/Related Conditions Assessment (ID/RC Assessment)--A form used by HHSC for level of care (LOC) determination and level of need (LON) assignment.

(59) Intermittent survey--A review by HHSC of a program provider, which may originate from a complaint, that is not an initial certification survey, a recertification survey, or a follow-up survey, to determine if the program provider complies with the certification standards.

(60) IPC cost--Estimated annual cost of HCS Program services included on an IPC.

(61) IPC year--A 12-month time period starting on the date an initial or renewal IPC begins. A revised IPC does not change the begin or end date of an IPC year.

(62) Isolated--The scope of a violation that has affected a very limited number of individuals or that has occurred only occasionally.

(63) Legally authorized representative (LAR)--A person authorized by law to act on behalf of a person in a matter described in this subchapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(64) Level of care (LOC)--A determination given to an individual as part of the eligibility determination process based on data submitted on the ID/RC Assessment.

(65) Level of need (LON)--An assignment given by HHSC to an individual upon which reimbursement for host home/companion care, supervised living, residential support, and individualized skills and socialization is based.

(66) Licensed vocational nurse (LVN)--A person licensed to practice vocational nursing in accordance with Texas Occupations Code Chapter 301.

(67) Local intellectual and developmental disability authority (LIDDA)--An entity designated by the HHSC Executive Commissioner, in accordance with Texas Health and Safety Code §533A.035.

(68) Managed care organization--This term has the meaning set forth in Texas Government Code §536.001.

(69) Means of escape--A continuous and unobstructed path of travel from an occupied portion of a building to an outside area.

(70) Mechanical restraint--A mechanical device, material, or equipment used to control an individual's behavior by restricting the ability of the individual to freely move part or all of the individual's body.

(71) Medical Assistance Only Medicaid (MAO Medicaid)--A type of Medicaid for which an applicant or individual qualifies financially for Medicaid assistance but does not receive Supplemental Security Income benefits.

(72) Microboard--A program provider:

(A) that is a non-profit corporation:

(i) that is created and operated by no more than 10 persons, including an individual;

(ii) the purpose of which is to address the needs of the individual and directly manage the provision of HCS Program services or CFC services; and

(iii) in which each person operating the corporation participates in addressing the needs of the individual and directly managing the provision of HCS Program services or CFC services; and

(B) that has a service capacity designated in the HHSC data system of no more than three individuals.

(73) Military family member--A person who is the spouse or child (regardless of age) of:

(A) a military member; or

(B) a former military member.

(74) Military member--A member of the United States military serving in the Army, Navy, Air Force, Marine Corps, Coast Guard, or Space Force on active duty who has declared and maintains Texas as the member's state of legal residence in the manner provided by the applicable military branch.

(75) Natural supports--Unpaid persons, including family members, volunteers, neighbors, and friends, who assist an individual.

(76) Neglect--A negligent act or omission that caused physical or emotional injury or death to an individual or placed an individual at risk of physical or emotional injury or death.

(77) Nursing facility--A facility licensed in accordance with Texas Health and Safety Code Chapter 242.

(78) Pattern--The scope of a violation that is not widespread but represents repeated failures by the program provider to comply with certification standards and the failures:

(A) are found throughout the services provided by the program provider; or

(B) involve or affect the same individuals, service providers, or volunteers.

(79) Permanency planning--A philosophy and planning process that focuses on the outcome of family support for an applicant or individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.

(80) Permanency Planning Review Screen--A screen in the HHSC data system, completed by a LIDDA, that identifies community supports needed to achieve an applicant's or individual's permanency planning outcomes and provides information necessary for approval to provide supervised living or residential support to the applicant or individual.

(81) Person-directed plan (PDP)--A written plan, based on person-directed planning and developed with an applicant or individual in accordance with the HHSC Person-Directed Plan form and discovery tool found on the HHSC website, that describes the supports and services necessary to achieve the desired outcomes identified by the applicant or individual (and LAR on the applicant's or individual's behalf) and ensure the applicant's or individual's health and safety.

(82) Person-directed planning--An ongoing process that empowers the applicant or individual (and the LAR on the applicant's or individual's behalf) to direct the development of a PDP. The process:

(A) identifies supports and services necessary to achieve the applicant's or individual's outcomes;

(B) identifies existing supports, including natural supports and other supports available to the applicant or individual and negotiates needed services system supports;

(C) occurs with the support of a group of people chosen by the applicant or individual (and the LAR on the applicant's or individual's behalf); and

(D) accommodates the applicant's or individual's style of interaction and preferences.

(83) Physical abuse--Any of the following:

(A) an act or failure to act performed knowingly, recklessly, or intentionally, including incitement to act, that caused physical injury or death to an individual or placed an individual at risk of physical injury or death;

(B) an act of inappropriate or excessive force or corporal punishment, regardless of whether the act results in a physical injury to an individual;

(C) the use of a restraint on an individual in a manner that is not in compliance with federal and state laws, rules, and regulations; or

(D) seclusion.

(84) Physical restraint--Any manual method used to control an individual's behavior, except for physical guidance or prompting of brief duration that an individual does not resist, that restricts:

(A) the free movement or normal functioning of all or a part of the individual's body; or

(B) normal access by an individual to a portion of the individual's body.

(85) Plan of correction--A plan documented on the HHSC Plan of Correction form that includes the corrective action that a program provider will take for each violation identified on a final survey report.

(86) Plan of removal--A written plan that describes the action a program provider will take to remove an immediate threat that HHSC identifies.

(87) Post 45-day follow-up survey--A follow-up survey conducted at least 46 calendar days after the exit conference of the survey in which the violation requiring corrective action was identified.

(88) Post-move monitoring visit--A visit conducted by the service coordinator in accordance with the *Intellectual and Developmental Disability Preadmission Screening and Resident Review (IDD-PASRR) Handbook.*

(89) Pre-enrollment minor home modifications--Minor home modifications, as described in the *HCS Program Billing Requirements,* completed before an applicant is discharged from a nursing facility, an ICF/IID, or a GRO and before the effective date of the applicant's enrollment in the HCS Program.

(90) Pre-enrollment minor home modifications assessment--An assessment performed by a licensed professional as required by the *HCS Program Billing Requirements* to determine the need for pre-enrollment minor home modifications.

(91) Pre-move site review--A review conducted by the service coordinator in accordance with HHSC's *IDD-PASRR Handbook.*

(92) Program provider--A "person" as defined in 40 TAC §49.102 (relating to Definitions) that has a contract with HHSC to provide HCS Program services, excluding an FMSA.

(93) Protective Device--An item or device, such as a safety vest, lap belt, bed rail, safety padding, adaptation to furniture, or helmet, used only to protect an individual from injury, or for body positioning of the individual to ensure health and safety, and not used to modify or control behavior. The device or item is considered a protective device only when used in accordance with §565.37 of this chapter (relating to Protective Devices).

(94) Provisional contract--A contract that HHSC enters into with a program provider in accordance with 40 TAC §49.208 (relating to Provisional Contract Application Approval) that has a term of no more than three years, not including any extension agreed to in accordance with §49.208(e).

(95) Public emergency personnel--Personnel of a sheriff's department, police department, emergency medical service, or fire department.

(96) Recertification survey--A review by HHSC of a program provider with a standard contract to determine if the program provider complies with the certification standards and will be certified for a new certification period.

(97) Registered nurse (RN)--A person licensed to practice professional nursing in accordance with Texas Occupations Code Chapter 301.

(98) Related condition--A severe and chronic disability that:

(A) is attributed to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior, similar to that of individuals with an intellectual disability, and requires treatment or services similar to those required for individuals with an intellectual disability;

(B) is manifested before the individual reaches age 22;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in at least three of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

(99) Relative--A person related to another person within the fourth degree of consanguinity or within the second degree of affinity. A more detailed explanation of this term is included in the *HCS Program Billing Requirements.*

(100) Renewal IPC--An IPC developed for an individual in accordance with §263.302(a) of this title (relating to Renewal and Revision of an IPC).

(101) Repeated violation--A violation that is based on the same certification standard and involves the same HCS Program service or CFC service as a previous violation.

(102) Residence--A host home/companion care, three-person, or four-person residence, as defined by the *HCS Program Billing Requirements.*

(103) Residential survey--A review of a residence HHSC to determine if the program provider complies with §565.23 of this chapter (relating to Residential Requirements).

(104) Responder--A person designated to respond to an alarm call activated by an individual.

(105) Restraint--Any of the following:

(A) a physical restraint;

(B) a mechanical restraint; or

(C) a chemical restraint.

(106) Revised IPC--An initial IPC or a renewal IPC that is revised during an IPC year, in accordance with §263.302(b) or (d) of this title, to add a new HCS Program service or CFC service or change the amount of an existing service.

(107) Seclusion--The involuntary placement of an individual in an area from which the individual is prevented from leaving.

(108) Service backup plan--A plan that ensures continuity of critical program services if service delivery is interrupted.

(109) Service coordination--A service as defined in Chapter 331 of this title (relating to LIDDA Service Coordination).

(110) Service coordinator--An employee of a LIDDA who provides service coordination to an individual.

(111) Service planning team--One of the following:

(A) for an applicant or individual other than one described in subparagraphs (B) or (C) of this paragraph, a planning team consisting of:

(i) an applicant, individual, and LAR;

(ii) service coordinator; and

(iii) other persons chosen by the applicant, individual, or LAR, for example, a staff member of the program provider, a family member, a friend, or a teacher;

(B) for an applicant 21 years of age or older who is residing in a nursing facility and enrolling in the HCS Program, a planning team consisting of:

(i) the applicant and LAR;

(ii) a service coordinator;

(iii) a staff member of the program provider;

(iv) providers of specialized services;

(v) a nursing facility staff person who is familiar with the applicant's needs;

(vi) other persons chosen by the applicant or LAR, for example, a family member, friend, or teacher; and

(vii) at the discretion of the LIDDA, and with the approval of the individual or LAR, other persons who are directly involved in the delivery of services to persons with an intellectual or developmental disability; or

(C) for an individual 21 years of age or older who has enrolled in the HCS Program from a nursing facility or has enrolled in the HCS Program as a diversion from admission to a nursing facility, for 365 calendar days after enrollment, a planning team consisting of:

(i) the individual and LAR;

(ii) a service coordinator;

(iii) a staff member of the program provider;

(iv) other persons chosen by the individual or LAR, for example, a family member, a friend, or a teacher; and

(v) with the approval of the individual or LAR, other persons who are directly involved in the delivery of services to persons with an intellectual or developmental disability.

(112) Service provider--A person, who may be a staff member, who directly provides an HCS Program service or CFC service to an individual.

(113) Sexual abuse--Any of the following:

(A) sexual exploitation of an individual;

(B) non-consensual or unwelcomed sexual activity with an individual; or

(C) consensual sexual activity between an individual and a service provider, staff member, volunteer, or controlling person, unless a consensual sexual relationship with an adult individual existed before the service provider, staff member, volunteer, or controlling person became a service provider, staff member, volunteer, or controlling person.

(114) Sexual activity--An activity that is sexual in nature, including kissing, hugging, stroking, or fondling with sexual intent.

(115) Sexual exploitation--A pattern, practice, or scheme of conduct against an individual that can reasonably be construed as being for the purposes of sexual arousal or gratification of any person:

(A) which may include sexual contact; and

(B) does not include obtaining information about an individual's sexual history within standard accepted clinical practice.

(116) Specialized services--The services defined in §303.102 of this title (relating to Definitions).

(117) SSI--Supplemental Security Income.

(118) Staff member--An employee or contractor of an HCS Program provider.

(119) Standard contract--A contract that HHSC enters into with a program provider in accordance with 40 TAC §49.209 (relating to Standard Contract) that has a term of no more than five years, not including any extension agreed to in accordance with 40 TAC §49.209(d).

(120) State Medicaid claims administrator--The entity contracting with the state as the Medicaid claims administrator and fiscal agent.

(121) State supported living center--A state-supported and structured residential facility operated by HHSC to provide to persons with an intellectual disability a variety of services, including medical treatment, specialized therapy, and training in acquiring personal, social, and vocational skills, but does not include a community-based facility owned by HHSC.

(122) Support consultation--A service, as defined in 40 TAC §41.103, that is provided to an individual participating in the CDS option at the request of the individual or LAR.

(123) Survey--An initial certification survey, a recertification survey, a follow-up survey, and an intermittent survey.

(124) System check--A test of the CFC ERS equipment to determine if:

(A) the individual can successfully activate an alarm call; and

(B) the equipment is working properly.

(125) Three-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than three persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service like residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that is not the residence of any person other than a service provider, the service provider's spouse, a person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(D) that is not a dwelling described in §263.101(a)(5) of this title.

(126) Transition plan--As described in §303.102 of this title, a written plan developed by the service planning team for an applicant who is residing in a nursing facility and enrolling in the HCS Program. A transition plan includes essential and nonessential services and supports the applicant needs to transition from a nursing facility to a community setting.

(127) Transition assistance services (TAS)--Services provided to assist an applicant in setting up a household in the community before being discharged from a nursing facility, an ICF/IID, or a GRO and before enrolling in the HCS Program. TAS consists of:

(A) for an applicant whose proposed initial IPC does not include residential support, supervised living, or host home/companion care:

(i) paying security deposits required to lease a home, including an apartment, or to establish utility services for a home;

(ii) purchasing essential furnishings for a home, including a table, a bed, chairs, window blinds, eating utensils, and food preparation items;

(iii) paying for expenses required to move personal items, including furniture and clothing, into a home;

(iv) paying for services to ensure the health and safety of the applicant in a home, including pest eradication, allergen control, or a one-time cleaning before occupancy; and

(v) purchasing essential supplies for a home, including toilet paper, towels, and bed linens; and

(B) for an applicant whose initial proposed IPC includes residential support, supervised living, or host home/companion care:

(i) purchasing bedroom furniture;

(ii) purchasing personal linens for the bedroom and bathroom; and

(iii) paying for allergen control.

(128) Transportation plan--A written plan based on person-directed planning and developed with an applicant or individual using the HHSC Individual Transportation Plan form found on the HHSC website. A transportation plan is used to document how transportation as a supported home living activity will be delivered to support an individual's desired outcomes and purposes for transportation as identified in the PDP.

(129) Vendor hold--A temporary suspension of payments that are due to a program provider under a contract.

(130) Verbal or emotional abuse--Any act or use of verbal or other communication, including gestures:

(A) to:

(i) harass, intimidate, humiliate, or degrade an individual; or

(ii) threaten an individual with physical or emotional harm; and

(B) that:

(i) results in observable distress or harm to the individual; or

(ii) is of such a serious nature that a reasonable person would consider it harmful or a cause of distress.

(131) Violation--A finding by HHSC that a program provider is not or was not in compliance with a certification standard.

(132) Volunteer--A person who works for a program provider without compensation, other than reimbursement for actual expenses.

(133) Widespread--The scope of a violation that:

(A) is pervasive throughout the services provided by the program provider; or

(B) represents a systemic failure by the program provider that affects or has the potential to affect a large portion of, or all, individuals.

(134) Willfully interfering--Acting or not acting to intentionally prevent, interfere with, or impede, or to attempt to intentionally prevent, interfere with, or impede.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 1, 2023.

TRD-202302018
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: June 21, 2023
Proposal publication date: February 17, 2023
For further information, please call: (512) 438-3161

♦ ♦ ♦

SUBCHAPTER C. CERTIFICATION STANDARDS: INDIVIDUAL'S RIGHTS

26 TAC §565.5

STATUTORY AUTHORITY

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

§565.5. Rights of Individuals.

(a) The program provider cannot prohibit:

(1) an individual, or the legally authorized representative (LAR) on behalf of the individual, from exercising the same rights and responsibilities exercised by people without disabilities; and

(2) a LAR or family members from encouraging the individual to exercise the same rights and responsibilities exercised by people without disabilities.

(b) The program provider must develop and implement policies that ensure the individual is informed of his or her rights and can exercise his or her rights without interference, coercion, discrimination, or retaliation from the program provider. This includes the right to:

(1) manage, be trained to manage, or have assistance in managing financial affairs upon documentation of the individual's written request for assistance;

(2) access public accommodations;

(3) be informed of the requirements for participation;

(4) be informed, both orally and in writing, of all the HCS Program and CFC services available and rules pertaining to the individual's enrollment and participation in the program provider's program, including those related to the use of restraint, as well as any changes in these that occur;

(5) be informed of the individual plan of care (IPC), implementation plan, and transportation plan, including any restrictions affecting the individual's rights;

(6) participate in decisions and be informed of the reasons for decisions regarding plans for enrollment, service termination, transfer, relocation, or denial of Home and Community-based Services Program (HCS) Program or Community First Choice (CFC) services;

(7) be informed about the individual's own health, mental condition, and related progress;

(8) be informed of the name and qualifications of any person serving or treating the individual and to choose among various available service providers;

(9) receive visitors without prior notice to the program provider;

(10) have privacy in visitation with family and other visitors;

(11) make and receive telephone calls in private;

(12) send and receive sealed and uncensored mail;

(13) attend or refuse to attend religious activities;

(14) participate in developing a pre-discharge plan that addresses assistance for the individual after he or she leaves the program;

(15) be free from the use of unauthorized restraints;

(16) live in a normative residential living environment;

(17) access free public schooling according to Texas Education Code;

(18) live where the individual is within proximity of and can access treatment and services that are best suited to meet the individual's needs and abilities and enhance that individual's strengths;

(19) have a personalized IPC, implementation plan, and transportation plan based on individualized assessments that meet the individual's needs and abilities and enhance that individual's strengths;

(20) help decide what the implementation plan and transportation plan will be;

(21) be informed as to the progress or lack of progress being made in the execution of the implementation plan and transportation plan;

(22) choose from the same services that are available to all community members, including those without disabilities;

(23) be evaluated as needed, but at least annually, to determine the individual's strengths, needs, preferences, and appropriateness of the implementation plan and transportation plan;

(24) complain at any time to a staff member or service provider;

(25) receive appropriate support and assistance from a staff member or service provider to address concerns if the individual dislikes or disagrees with the services being rendered or thinks that his or her rights are being violated;

(26) live free from abuse, neglect, or exploitation in a healthful and safe environment;

(27) participate in decisions regarding the individual's living environment, including location, furnishings, personal property, other individuals residing in the residence, and moves to other residential locations;

(28) have service providers who are responsive to the individual and, at the same time, are responsible for the overall functioning of the HCS Program;

(29) have active personal assistance in exercising civil and self-advocacy rights attainment by provisions for:

(A) complaints;

(B) voter registration;

(C) citizenship information and education;

(D) advocacy services; and

(E) guardianship;

(30) receive counseling concerning the use of money;

(31) possess and to use money in personal and individualized ways or learn to do so;

(32) access all financial records regarding the individual's funds;

(33) have privacy during treatment and care of personal needs;

(34) have privacy during visits by his or her spouse if living apart;

(35) share a room when both spouses are living in the same residence;

(36) be free from serving as a source of labor when residing with persons other than family members;

(37) communicate, associate, and meet privately with any person of his or her choice, including other individuals, unless this violates the rights of another individual;

(38) participate in social, recreational, and community group activities;

(39) have his or her LAR involved in activities, including:

(A) being informed of all rights and responsibilities when the individual is enrolled in the program provider's program, as well as any changes in rights or responsibilities before they become effective;

(B) participating in the planning for HCS Program and CFC services; and

(C) advocating for all rights of the individual;

(40) be informed of the individual's option to transfer to other program providers as chosen by the individual or LAR as often as desired;

(41) complain to HHSC when the program provider's resolution of a complaint is unsatisfactory to the individual or LAR, and to be informed of the Intellectual and Developmental Disability Ombudsman telephone number to initiate complaints (1-800-252-8154); and

(42) have opportunities for leisure time activities, vacation periods, religious observances, holidays, and days off, consistent with the individual's choice and routines of other members of the community.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 1, 2023.

TRD-202302019
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: June 21, 2023
Proposal publication date: February 17, 2023
For further information, please call: (512) 438-3161

♦ ♦ ♦

SUBCHAPTER D. CERTIFICATION STANDARDS: STAFF MEMBER AND SERVICE PROVIDER REQUIREMENTS

26 TAC §565.7, §565.9

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§565.9. Program Provider Requirements.

(a) The program provider must ensure the continuous availability of trained and qualified service providers to deliver the required services, as determined by the individual's needs and characteristics.

(b) The program provider must:

(1) comply with 40 Texas Administrative Code (TAC) §49.304 (relating to Background Checks);

(2) comply with 40 TAC §49.312 (relating to Personal Attendants), including when the service provider of supported home living or CFC personal assistance services/habilitation (CFC PAS/HAB) is employed by or contracts with a contractor of a program provider;

(3) obtain the criminal history record of the potential staff member or potential contractor from the Texas Department of Public Safety directly or through a private agency before hiring or contracting with the potential staff member;

(4) not employ or contract with a potential staff member, service provider, or volunteer who:

(A) has been convicted of an offense listed, and for the time periods set forth, in Texas Health and Safety Code §250.006;

(B) is a registered sex offender; or

(C) has been convicted of an offense that the program provider determines is a contraindication;

(5) search the following registries before hire or execution of a contract and every 12 months thereafter to determine if a staff member or service provider is eligible for employment:

(A) the Employee Misconduct Registry; and

(B) the Nurse Aide Registry;

(6) search the following registries before hire or execution of a contract and every month thereafter to determine if an employee or contractor is eligible for employment:

(A) the List of Excluded Individuals and Entities maintained by the United States Department of Health and Human Services; and

(B) the List of Excluded Individuals and Entities maintained by the Texas Health and Human Services Commission (HHSC) Office of Inspector General; and

(7) not hire or continue employment for a staff member or service provider who is listed on:

(A) the Employee Misconduct Registry as unemployable;

(B) the Nurse Aide Registry as revoked or suspended;

(C) the List of Excluded Individuals and Entities maintained by the United States Department of Health; or

(D) the List of Excluded Individuals and Entities maintained by Health and Human Services office of Inspector General or by HHSC Office of Inspector General.

(c) The program provider must develop and implement policy and procedures:

(1) that ensure only staff members and service providers with a valid driver's license and insurance transport individuals; and

(2) are revised if a shortcoming is identified.

(d) If the service provider of supported home living or CFC PAS/HAB is employed by or contracts with a contractor of a program provider, the program provider must ensure that the contractor complies with subsection (b)(2) of this section as if the contractor were the program provider.

(e) The program provider must:

(1) employ or contract with a person or entity of the individual's or legally authorized representative's (LAR's) choice to provide a Home and Community-based Services Program or CFC service to the individual if that person or entity:

(A) is qualified to provide the service; and

(B) is willing to contract with or be employed by the program provider to provide the service in accordance with this subchapter; or

(2) have and document good cause not to employ or contract with the person or entity of the individual's or LAR's choice.

(f) If a program provider contracts with a person or entity to provide transition assistance services (TAS), the person or entity must have a contract to provide TAS in accordance with 40 TAC Chapter 49 (relating to Contracting for Community Services).

(g) The program provider must create and implement a policy that prevents:

(1) conflicts of interest between the program provider, a staff member, or a service provider and an individual, such as the acceptance of payment for goods or services (except payment for room and board) from which the program provider, staff member, or service provider could financially benefit;

(2) financial impropriety toward an individual including:

(A) unauthorized disclosure of information related to an individual's finances; and

(B) any purchase of goods that are not requested for the individual, cannot be used by the individual, or are not intended for the individual's use;

(3) abuse, neglect, or exploitation of an individual;

(4) damage to, or prevention of an individual's access to, the individual's possessions; and

(5) threats of the actions described in paragraphs (2) - (4) of this subsection.

(h) A program provider must comply with 42 United States Code §1396a(w), regarding requirements about advance directives.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 1, 2023.

TRD-202302020
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: June 21, 2023
Proposal publication date: February 17, 2023
For further information, please call: (512) 438-3161

♦ ♦ ♦

SUBCHAPTER E. CERTIFICATION STANDARDS: SERVICE DELIVERY

26 TAC §§565.11, 565.13, 565.15, 565.17, 565.19, 565.21

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§565.11. Service Delivery.

(a) The program provider must:

(1) serve an eligible applicant who has selected the program provider unless the program provider's enrollment has reached its service capacity as identified in the Texas Health and Human Services Commission (HHSC) data system;

(2) serve an eligible applicant without regard to age, sex, race, or level of disability;

(3) provide or obtain as needed and without delay all Home and Community-based Services Program (HCS) Program and Community First Choice (CFC) services for an individual;

(4) maintain a system of delivering HCS Program and CFC services that is continuously responsive to changes in the individual's personal goals, condition, abilities, and needs as identified by the service planning team;

(5) ensure that each applicant or individual, or legally authorized representative (LAR), chooses where the individual or applicant will reside from available options consistent with the applicant's or individual's needs;

(6) ensure that an individual's rights as identified in §565.5 of this chapter (relating to Rights of Individuals) are not violated, unless contraindications are documented with justification in a Behavior Support Plan;

(7) notify the service coordinator if a change in an individual's condition necessitates a change in residential, educational, or work settings;

(8) inform appropriate staff members, service providers, and the service coordinator when a circumstance or event occurs in an individual's life or a change to an individual's condition affects the provision of services to the individual;

(9) notify the service coordinator if the program provider has reason to believe that an individual is no longer eligible for HCS Program services or CFC services or an individual or LAR has requested termination of all HCS Program services or all CFC services;

(10) ensure that the individual plan of care (IPC) for each individual:

(A) is renewed or revised in accordance with §263.302 of this title (relating to Renewal and Revision of an IPC); and

(B) is authorized by the Health and Human Services Commission in accordance with §263.303 of this title (relating to HHSC Review of an IPC);

(11) ensure that HCS Program and CFC services identified in the individual's implementation plan and transportation plan are provided in an individualized manner and are based on the results of assessments of the individual's and the family's strengths, the individual's personal goals, the family's goals for the individual, and the individual's needs rather than which services are available;

(12) ensure that each individual's progress or lack of progress toward desired outcomes is documented in observable, measurable, or outcome-oriented terms;

(13) ensure that individuals who perform work for the program provider are paid on the basis of their production or performance and at a wage level commensurate with that paid to persons who are without disabilities and who would otherwise perform that work, and that compensation is based on local, state, and federal regulations, including Department of Labor regulations, as applicable;

(14) ensure that individuals who produce marketable goods and services in habilitation training programs are paid at a wage level commensurate with that paid to persons who are without disabilities and who would otherwise perform that work. Compensation is based on requirements contained in the Fair Labor Standards Act, which include:

(A) accurate recordings of individual production or performance;

(B) valid and current time studies or monitoring as appropriate; and

(C) prevailing wage rates;

(15) ensure that individuals provide no training, supervision, or care to other individuals unless they are qualified and compensated in accordance with local, state, and federal regulations, including Department of Labor regulations;

(16) ensure that adaptive aids are provided in accordance with the individual's person-directed plan (PDP), IPC, implementation plan, and Appendix C of the HCS Program waiver application, approved by the Centers for Medicare and Medicaid Services (CMS) and found on the HHSC website, and include the full range of lifts, mobility aids, control switches/pneumatic switches and devices, environmental control units, medically necessary supplies, and communication aids and repair and maintenance of the aids, as determined by the individual's needs;

(17) ensure the coordination and compatibility of HCS Program and CFC services with non-HCS Program services and non-CFC services together with an individual's service coordinator;

(18) ensure that an individual has a current implementation plan;

(19) ensure professional therapies:

(A) are provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website:

(i) audiology services;

(ii) speech/language pathology services;

(iii) occupational therapy services;

(iv) physical therapy services;

(v) dietary services;

(vi) social work services;

(vii) behavioral support; and

(viii) cognitive rehabilitation therapy; and

(B) if the service planning team determines that an individual may need cognitive rehabilitation therapy, the program provider:

(i) in coordination with the service coordinator, assists the individual in obtaining, in accordance with the Medicaid State Plan, a neurobehavioral or neuropsychological assessment and plan of care from a qualified professional as a non-HCS Program service; and

(ii) use a qualified professional as described in §565.7 of this chapter (relating to Staff Member and Service Provider Requirements) to provide and monitor the provision of cognitive rehabilitation therapy to the individual in accordance with the plan of care described in clause (i) of this subparagraph;

(20) ensure that individualized skills and socialization is provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website;

(21) ensure that dental treatment is provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website including:

(A) emergency dental treatment;

(B) preventive dental treatment;

(C) therapeutic dental treatment; and

(D) orthodontic dental treatment, excluding cosmetic orthodontia;

(22) ensure that minor home modifications are provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website but are limited to the following categories:

(A) purchase and repair of wheelchair ramps;

(B) modifications to bathroom facilities;

(C) modifications to kitchen facilities;

(D) specialized accessibility and safety adaptations or additions; and

(E) repair and maintenance of minor home modifications not covered by a warranty;

(23) ensure that supported home living:

(A) is available only to an individual who is not receiving:

(i) host home/companion care;

(ii) supervised living; or

(ii) residential support; and

(B) is available to an individual who is receiving foster care services from DFPS;

(24) ensure that supported home living is provided in accordance with the individual's PDP, IPC, implementation plan, transportation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assisting with meal planning and preparation;

(C) providing transportation;

(D) securing transportation;

(E) assisting with housekeeping;

(F) assisting with ambulation and mobility;

(G) reinforcing professional therapy activities;

(H) assisting with medications and the performing tasks delegated by a registered nurse (RN);

(I) supervising of individuals' safety and security;

(J) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(K) habilitation, exclusive of individualized skills and socialization;

(25) ensure that HCS host home/companion care is provided:

(A) by a host home/companion care provider who lives in the residence in which no more than three individuals or other persons receiving similar services are living at any one time; and

(B) in a residence in which the program provider does not hold a property interest;

(26) ensure that host home/companion care is provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assisting with meal planning and preparation;

(C) securing and providing transportation;

(D) assisting with housekeeping;

(E) assisting with ambulation and mobility;

(F) reinforcing professional therapy activities;

(G) assisting with medications and the performance of tasks delegated by an RN;

(H) supervising of safety and security;

(I) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(J) habilitation, exclusive of individualized skills and socialization;

(27) ensure that supervised living is provided:

(A) in a four-person residence that is approved in accordance with §565.23(i) of this chapter (relating to Residential Requirements) or a three-person residence;

(B) by a service provider who provides services and supports as needed by the individuals residing in the residence and is present in the residence and able to respond to the needs of the individuals during normal sleeping hours; and

(C) only with approval by the HHSC commissioner or designee for the initial six months and one six-month extension and only with approval by the HHSC Executive Commissioner after such 12-month period, if provided to an individual under 22 years of age;

(28) ensure that supervised living is provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assisting with meal planning and preparation;

(C) securing and providing transportation;

(D) assisting with housekeeping;

(E) assisting with ambulation and mobility;

(F) reinforcing professional therapy activities;

(G) assisting with medications and the performance of tasks delegated by an RN;

(H) supervising of individuals' safety and security;

(I) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(J) habilitation, exclusive of individualized skills and socialization;

(29) ensure that residential support is provided:

(A) in a four-person residence that is approved in accordance with §565.23(i) of this chapter or in a three-person residence;

(B) by a service provider who is present in the residence and awake whenever an individual is present in the residence;

(C) by service providers assigned on a daily shift schedule that includes at least one complete change of service providers each day; and

(D) only with approval by the HHSC commissioner or designee for the initial six months and one six-month extension and only with approval by the HHSC Executive Commissioner after such 12-month period, if provided to an individual under 22 years of age;

(30) ensure that residential support is provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website, and includes the following elements:

(A) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);

(B) assisting with meal planning and preparation;

(C) securing and providing transportation;

(D) assisting with housekeeping;

(E) assisting with ambulation and mobility;

(F) reinforcing professional therapy activities;

(G) assisting with medications and the performance of tasks delegated by an RN;

(H) supervising of individuals' safety and security;

(I) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and

(J) habilitation, exclusive of individualized skills and socialization;

(31) if making a recommendation to the service planning team that the individual receive residential support, document the reasons for the recommendation, which may include:

(A) the individual's medical condition;

(B) a behavior displayed by the individual that poses a danger to the individual or to others; or

(C) the individual's need for assistance with activities of daily living during normal sleeping hours;

(32) ensure that respite is available on a 24-hour increment or any part of that increment to individuals living in their family homes;

(33) ensure that respite is provided in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website; and:

(A) includes:

(i) training in self-help and independent living skills;

(ii) providing room and board when respite is provided in a setting other than the individual's normal residence;

(iii) assisting with:

(I) ongoing provision of needed waiver services; and

(II) securing and providing transportation; and

(B) is only provided:

(i) to individuals who are not receiving residential support, supervised living, or host home/companion care; and

(ii) when the unpaid caregiver is temporarily unavailable to provide supports;

(34) provide respite in the residence of an individual or in other locations, including residences in which host home/companion care, supervised living, or residential support is provided or in a respite facility or camp, that:

(A) meets HCS Program requirements and is an environment that ensures the health and safety of the individual; and

(B) if respite is provided:

(i) in the residence of another individual, the program provider must obtain permission from that individual or LAR and ensure that the respite visit will cause no threat to the health, safety, or welfare of either individual;

(ii) in a respite facility, the program provider must obtain written approval from the local fire authority having jurisdiction stating that the facility and its operation meet the local fire ordinances before initiating services in the facility if more than three individuals receive services in the facility at any one time; or

(iii) in a camp setting, the program provider must ensure the camp is accredited by the American Camp Association;

(iv) in a home and community-based setting, the setting must comply with §263.501(b) of this title (relating to Requirements for Home and Community-Based Settings);

(35) ensure that employment assistance:

(A) is provided to an individual to help the individual locate competitive employment in the community;

(B) consists of a service provider:

(i) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

(ii) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements;

(iii) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;

(iv) transporting an individual to help the individual locate competitive employment in the community; and

(v) participating in service planning team meetings;

(C) is provided in accordance with an individual's PDP, IPC, implementation plan, and with Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website;

(D) is not provided to an individual with the individual present at the same time that respite, supported home living, individualized skills and socialization, supported employment, or CFC personal assistance services/habilitation (CFC PAS/HAB) is provided; and

(E) does not include using Medicaid funds paid by HHSC to the program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(i) paying an employer:

(I) to encourage the employer to hire an individual; or

(II) for supervision, training, support, or adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(ii) paying an individual:

(I) as an incentive to participate in employment assistance activities; or

(II) for expenses associated with the start-up costs or operating expenses of the individual's business;

(36) ensure that supported employment:

(A) is assistance provided to an individual:

(i) who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which persons without disabilities are employed;

(ii) in order for the individual to sustain competitive employment; and

(iii) in accordance with the individual's PDP, IPC, implementation plan, and Appendix C of the HCS Program waiver application approved by CMS and found on the HHSC website;

(B) consists of a service provider:

(i) making employment adaptations, supervising, and providing training related to an individual's assessed needs;

(ii) transporting an individual to support the individual to be self-employed, work from home, or perform in a work setting; and

(iii) participating in service planning team meetings;

(C) is not provided to an individual with the individual present at the same time that respite, supported home living, individualized skills and socialization, employment assistance, or CFC PAS/HAB is provided; and

(D) does not include:

(i) sheltered work or other similar types of vocational services furnished in specialized facilities; or

(ii) using Medicaid funds paid by HHSC to the program provider for incentive payments, subsidies, or unrelated vocational training expenses such as:

(I) paying an employer:

(-a-) to encourage the employer to hire an individual; or

(-b-) to supervise, train, support, or make adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(II) paying an individual:

(-a-) as an incentive to participate in supported employment activities; or

(-b-) for expenses associated with the start-up costs or operating expenses of the individual's business;

(37) ensure that CFC PAS/HAB is provided in accordance with the individual's PDP, IPC, and implementation plan;

(38) ensure that CFC support management is provided to an individual or LAR if:

(A) the individual is receiving CFC PAS/HAB; and

(B) the individual or LAR requests to receive CFC support management;

(39) inform the service coordinator of changes related to an individual's residential setting that do not require a change to the individual's IPC;

(40) maintain current information in the HHSC data system about the individual and the individual's LAR, including:

(A) the individual's full name, address, location code, and phone number; and

(B) the LAR's full name, address, and phone number;

(41) maintain a single record related to HCS Program and CFC services provided to an individual for an IPC year that includes:

(A) the IPC;

(B) the PDP and, if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form;

(C) the implementation plan;

(D) a behavior support plan, if one has been developed;

(E) a transportation plan, if one is required;

(F) documentation that describes the individual's progress or lack of progress on the implementation plan;

(G) documentation that describes any changes to an individual's personal goals, condition, abilities, or needs;

(H) the Intellectual Disability/Related Conditions Assessment (ID/RC Assessment);

(I) documentation supporting the recommended level of need, including the Inventory for Client and Agency Planning booklet, assessments and interventions by qualified professionals, and time sheets of service providers;

(J) results and recommendations from individualized assessments that support the individual's current need for each service included in the IPC;

(K) documentation concerning any use of restraint as described in §565.33(a)(2) and (3) of this chapter (relating to Restraints);

(L) documentation related to the suspension of an individual's HCS Program services or CFC services;

(M) for an individual under 22 years of age, a copy of the permanency plan; and

(N) documentation required by subsection §565.17(a)(2) of this subchapter (relating to Pre-enrollment Minor Home Modification) and subsection §565.21(a)(2) of this subchapter (relating to Transitional Assistance Service (TAS));

(42) upon request by the service coordinator:

(A) permit the service coordinator access to the record that is required by paragraph (41) of this subsection; and

(B) provide the service coordinator a legible copy, including an electronic copy, of a document in the record at no charge to the service coordinator;

(43) provide a copy of the following documents to the service coordinator:

(A) an individual's IPC; and

(B) an individual's ID/RC Assessment;

(44) if a physician delegates a medical act to an unlicensed service provider in accordance with Texas Occupations Code Chapter 157, and the program provider has concerns about the health or safety of the individual in performance of the medical act, communicate the concern to the delegating physician and take additional steps as necessary to ensure the health and safety of the individual;

(45) for an individual receiving host home/companion care, residential support, or supervised living, ensure that the individual or LAR is involved in planning the individual's residential relocation, except in the case of an emergency;

(46) for an HCS Program or CFC service identified on the PDP as critical to meeting the individual's health and safety:

(A) develop a service backup plan that:

(i) contains the name of the critical service;

(ii) specifies the time period in which an interruption to the critical service would result in an adverse effect to the individual's health or safety; and

(iii) in the event of a service interruption resulting in an adverse effect, as described in clause (ii) of this subparagraph, describe the actions the program provider will take to ensure the individual's health and safety;

(B) ensure that:

(i) if the action in the service backup plan required by subparagraph (A) of this paragraph identifies a natural support, that the natural support receives pertinent information about the individual's needs and can protect the individual's health and safety; and

(ii) a person identified in the service backup plan, if paid to provide the service, meets the qualifications described in this subchapter; and

(C) if the service backup plan required by subparagraph (A) of this paragraph is implemented:

(i) discuss the implementation of the service backup plan with the individual and the service providers or natural supports identified in the service backup plan to determine whether the plan was effective;

(ii) document whether the plan was effective; and

(iii) revise the plan if the program provider determines the plan was ineffective;

(47) for an applicant 21 years of age or older who is residing in a nursing facility and enrolling in the HCS Program:

(A) participate as a member of the service planning team, which includes attending service planning team meetings scheduled by the service coordinator;

(B) assist in the implementation of the applicant's transition plan as described in the plan; and

(C) be physically present for the pre-move site review and assist the service coordinator during the review as requested; and

(48) for 365 calendar days after an individual 21 years of age or older has enrolled in the HCS Program from a nursing facility or has enrolled in the HCS Program as a diversion from admission to a nursing facility:

(A) be physically present for each post-move monitoring visit and assist the service coordinator during the visit as requested;

(B) assist in the implementation of the individual's transition plan as described in the plan;

(C) participate as a member of the service planning team, which includes attending service planning team meetings scheduled by the service coordinator; and

(D) within one calendar day after becoming aware of an event or condition that may put the individual at risk of admission or readmission to a nursing facility, notify the service planning team of the event or condition.

(b) A program provider may suspend HCS Program services or CFC services because an individual is temporarily admitted to a setting described in §263.705(a) of this title (relating to Suspension of HCS Program Services and CFC Services).

(1) If a program provider suspends HCS Program services or CFC services, the program provider must:

(A) notify HHSC of the suspension by entering data in the HHSC data system in accordance with HHSC instructions; and

(B) notify the service coordinator of the suspension within one business day after services are suspended.

(2) A program provider may not suspend HCS Program services or CFC services for more than 270 calendar days without approval from HHSC as described in §263.705(h) of this title.

§565.13. Nursing.

(a) A program provider must:

(1) ensure that nursing is provided in accordance with the individual's person-directed plan (PDP); individual plan of care (IPC); implementation plan; Texas Occupations Code Chapter 301 (Nursing Practice Act); 22 Texas Administrative Code (TAC) Chapter 217 (relating to Licensure, Peer Assistance and Practice); 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions); and Appendix C of the HCS Program waiver application approved by the Centers for Medicare and Medicaid Services (CMS) and found on the Texas Health and Human Services Commission (HHSC) website, and consists of performing health care activities and monitoring the individual's health conditions;

(2) this includes:

(A) administering medication;

(B) monitoring the individual's use of medications;

(C) monitoring health risks, data, and information, including ensuring that an unlicensed service provider is performing only those nursing tasks identified from a nursing assessment;

(D) assisting the individual to secure emergency medical services;

(E) making referrals for appropriate medical services;

(F) performing health care procedures ordered or prescribed by a physician or medical practitioner and required by standards of professional practice or law to be performed by a registered nurse (RN) or licensed vocational nurse (LVN);

(G) delegating nursing tasks to an unlicensed service provider and supervising the performance of those tasks in accordance with state law and rules;

(H) teaching an unlicensed service provider about the specific health needs of an individual;

(I) performing an assessment of an individual's health condition;

(J) ensuring a registered nurse (RN):

(i) performs a nursing assessment for each individual:

(I) before an unlicensed service provider performs a nursing task for the individual, unless a physician has delegated the task as a medical act under Texas Occupations Code Chapter 157, as documented by the physician; and

(II) as determined necessary by an RN, including if the individual's health needs change;

(ii) documents information from performance of a nursing assessment;

(iii) if an individual is receiving a service through the consumer directed services (CDS) option, provides a copy of the documentation described in clause (ii) of this subparagraph to the individual's service coordinator;

(iv) develops the nursing service portion of an individual's implementation plan, which includes developing a plan and schedule for monitoring and supervising delegated nursing tasks; and

(v) makes and documents decisions related to the delegation of a nursing task to an unlicensed service provider; and

(K) in accordance with Texas Human Resources Code Chapter 161:

(i) allowing an unlicensed service provider to provide administration of medication to an individual without the delegation or oversight of an RN if:

(I) an RN has performed a nursing assessment and based on the results of the assessment, determined that the individual's health permits the administration of medication by an unlicensed service provider;

(II) the medication is:

(-a-) an oral medication;

(-b-) a topical medication; or

(-c-) a metered dose inhaler;

(III) the medication is administered to the individual for a predictable or stable condition; and

(IV) the unlicensed service provider has been:

(-a-) trained by an RN or a licensed vocational nurse (LVN) under the direction of an RN regarding the proper administration of medication; or

(-b-) determined to be competent by an RN or LVN under the direction of an RN regarding proper administration of medication, including through a demonstration of proper technique by the unlicensed service provider; and

(ii) ensuring that an RN or LVN under the supervision of an RN reviews the administration of medication to an individual by an unlicensed service provider at least annually and after any significant change in the individual's condition.

(b) A program provider may determine that an individual does not require a nursing assessment if:

(1) nursing services are not on the individual's IPC and the program provider has determined that no nursing task will be performed by an unlicensed service provider as documented on HHSC form "Nursing Task Screening Tool"; or

(2) a nursing task will be performed by an unlicensed service provider and a physician has delegated the task as a medical act under Texas Occupations Code Chapter 157, as documented by the physician.

(c) If an individual or LAR refuses a nursing assessment described in subsection (a)(1)(J)(i) of this section, the program provider must not:

(1) provide nursing services to the individual; or

(2) provide host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, individualized skills and socialization, or CFC PAS/HAB to the individual unless:

(A) an unlicensed service provider does not perform nursing tasks in the provision of the service; and

(B) the program provider determines that it can ensure the individual's health, safety, and welfare in the provision of the service.

(d) If an individual or LAR refuses a nursing assessment and the program provider determines that the program provider cannot ensure the individual's health, safety, and welfare in the provision of a service as described in subsection (c) of this section, the program provider must:

(1) immediately notify the individual or LAR and the individual's service coordinator, in writing, of the determination; and

(2) include in the notification required by paragraph (1) of this subsection the reasons for the determination and the services affected by the determination.

(e) If notified by the service coordinator that the individual or LAR refuses the nursing assessment after the discussion with the service coordinator as described in §263.901(e)(22) of this title (relating to LIDDA Requirements for Providing Service Coordination in the HCS Program), the program provider must immediately send the written notification described in subsection (d) of this section to HHSC.

§565.15. Individuals under the Age of 22.

The program provider must:

(1) request from and encourage the parent or legally authorized representative (LAR) of an individual under 22 years of age receiving supervised living or residential support to provide the program provider with the following information:

(A) the parent's or LAR's:

(i) name;

(ii) address;

(iii) telephone number;

(iv) driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(v) place of employment and the employer's address and telephone number;

(B) name, address, and telephone number of a relative of the individual or other person whom the Texas Health and Human Services Commission (HHSC) or the program provider may contact in an emergency situation, a statement indicating the relationship between that person and the individual, and at the parent's or LAR's option:

(i) that person's driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer; and

(C) a signed acknowledgement of responsibility stating that the parent or LAR agrees to:

(i) notify the program provider of any changes to the contact information submitted; and

(ii) make reasonable efforts to participate in the individual's life and in planning activities for the individual;

(2) inform the parent or LAR that if the information described in paragraph (1) of this subsection is not provided or is not accurate and the service coordinator and HHSC are unable to locate the parent or LAR as described in §263.902(e)(33) of this title (relating to Permanency Planning) and §263.903 of this title (relating to Referral from HHSC to DFPS), HHSC refers the case to DFPS;

(3) for an individual under 22 years of age receiving supervised living or residential support:

(A) make reasonable accommodations to promote the participation of the LAR in all planning and decision-making regarding the individual's care, including participating in meetings conducted by the program provider;

(B) take the following actions to assist a local intellectual and developmental disability authority (LIDDA) in conducting permanency planning:

(i) cooperate with the LIDDA responsible for conducting permanency planning by:

(I) allowing access to an individual's records or providing other information in a timely manner, as requested by the local authority or HHSC;

(II) participating in meetings to review the individual's permanency plan; and

(III) identifying, in coordination with the individual's LIDDA, activities, supports, and services that can be provided by the family, LAR, program provider, or the LIDDA to prepare the individual for an alternative living arrangement;

(ii) encourage regular contact between the individual and the LAR and, if desired by the individual and LAR, between the individual and advocates and friends in the community to continue supportive and nurturing relationships;

(iii) keep a copy of the individual's current permanency plan in the individual's record; and

(iv) refrain from providing the LAR with inaccurate or misleading information regarding the risks of moving the individual to another institutional setting or to a community setting;

(C) if an emergency situation occurs, attempt to notify the parent or LAR and service coordinator as soon as the emergency situation allows and request a response from the parent or LAR; and

(D) if the program provider determines it is unable to locate the parent or LAR, notify the service coordinator of such determination.

§565.17. Pre-enrollment Minor Home Modification.

The program provider must provide pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment in accordance with this subsection.

(1) The program provider must:

(A) complete a pre-enrollment minor home modifications assessment in accordance with the *Home and Community-based Services (HCS) Program Billing Requirements;*

(B) provide pre-enrollment minor home modifications to an applicant for whom the program provider receives from the service coordinator a completed Pre-enrollment Minor Home Modifications/Assessments Authorization form authorized by the Texas Health and Human Services Commission (HHSC), as described in §263.104(k)(8)(C) of this title (relating to Process for Enrollment of Applicants);

(C) provide to the applicant the specific pre-enrollment minor home modifications identified on the form;

(D) provide the pre-enrollment minor home modifications for the applicant within the monetary amount identified on the form;

(E) ensure pre-enrollment minor home modifications and pre-enrollment minor home modifications assessments are provided in accordance with Appendix C of the HCS Program waiver application approved by the Centers for Medicare and Medicaid Services (CMS) and found on the HHSC website; and

(F) complete the pre-enrollment minor home modifications at least two days before the date of the applicant's discharge from the nursing facility, intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID), or general residential operation (GRO) unless the delay in completion is beyond the control of the program provider.

(2) If the program provider does not complete pre-enrollment minor home modifications in accordance with paragraph (1) of this subsection, the program provider must:

(A) document:

(i) a description of the pending modifications;

(ii) the reason for the delay;

(iii) the date the program provider anticipates it will complete the pending modifications or specific reasons why the program provider cannot anticipate a completion date; and

(iv) a description of the program provider's ongoing efforts to complete the modifications; and

(B) at least two days before the date of the applicant's discharge from the nursing facility, ICF/IID, or GRO, provide the information described in subparagraph (A) of this paragraph to:

(i) the applicant or legally authorized representative (LAR); and

(ii) the service coordinator.

(3) Within one business day after completion of the pre-enrollment minor home modifications, the program provider must notify the service coordinator and the applicant or LAR that the modifications have been completed.

§565.19. Community First Choice (CFC) Emergency Response Systems (ERS) Services.

CFC ERS must be provided in accordance with this section.

(1) A program provider must ensure that CFC ERS is provided only to an individual who:

(A) is not receiving host home/companion care, supervised living, or residential support;

(B) lives alone, who is alone for significant parts of the day, or has no regular caregiver for extended periods of time; and

(C) would otherwise require extensive routine supervision.

(2) A program provider must ensure that CFC ERS is provided in accordance with the individual's person-directed plan, individual plan of care (IPC), and implementation plan.

(3) A program provider must ensure that CFC ERS equipment is installed within 14 business days after one of the following dates, whichever is later:

(A) the date the Texas Health and Human Services Commission authorizes the proposed IPC that includes CFC ERS; or

(B) the effective date of the individual's IPC as determined by the service planning team.

(4) At the time CFC ERS equipment is installed, a program provider must ensure that:

(A) the equipment is installed in accordance with the manufacturer's installation instructions;

(B) an initial test of the equipment is made;

(C) the equipment has an alternate power source in the event of a power failure;

(D) the individual is trained on the use of the equipment, including:

(i) demonstrating how the equipment works; and

(ii) having the individual activate an alarm call;

(E) an explanation is given to the individual that the individual must:

(i) participate in a system check each month; and

(ii) contact the CFC ERS provider if:

(I) the individual's telephone number or address changes; or

(II) one or more of the individual's responders change; and

(F) the individual is informed that a responder, in response to an alarm call, may forcibly enter the individual's home if necessary.

(5) A program provider must ensure that the date and time of the CFC ERS equipment installation and compliance with the requirements in paragraphs (3) and (4) of this section are documented in the individual's record.

(6) A program provider must ensure that, on or before the date CFC ERS equipment is installed:

(A) an attempt is made to obtain from an individual, the names and telephone numbers of at least two responders, such as a relative or neighbor;

(B) public emergency personnel:

(i) are designated as a second responder if the individual provides the name of only one responder; or

(ii) are designated as the sole responder if the individual does not provide the names of any responders; and

(C) the name and telephone number of each responder is documented in the individual's record.

(7) At least once during each calendar month a program provider must ensure that a system check is conducted on a date and time agreed to by the individual.

(8) A program provider must ensure that the date, time, and result of the system check is documented in the individual's record.

(9) If, because of the system check:

(A) the equipment is working properly but the individual is unable to successfully activate an alarm call, the program provider must ensure that a request is made of the service coordinator to hold a service planning team meeting to determine if CFC ERS meets the individual's needs; or

(B) the equipment is not working properly, the program provider must ensure that, within three calendar days of the system check, the equipment is repaired or replaced.

(10) If a system check is not conducted in accordance with paragraph (7) of this section, the program provider must ensure that:

(A) the failure to comply is because of good cause; and

(B) the good cause is documented in the individual's record.

(11) A program provider must ensure that an alarm call is responded to 24 hours a day, seven days a week.

(12) A program provider must ensure that, if an alarm call is made, the CFC ERS provider:

(A) within 60 seconds of the alarm call, attempts to contact the individual to determine if an emergency exists;

(B) immediately contacts a responder after attempting to contact the individual, if:

(i) the CFC ERS provider confirms there is an emergency; or

(ii) the CFC ERS provider is unable to communicate with the individual; and

(C) documents in the individual's record when the information becomes available:

(i) the name of the individual;

(ii) the date and time of the alarm call, recorded in hours, minutes, and seconds;

(iii) the response time, recorded in seconds;

(iv) the time the individual was called in response to the alarm call, recorded in hours, minutes, and seconds;

(v) the name of the contacted responder, if applicable;

(vi) a brief description of the reason for the alarm call; and

(vii) if the reason for the alarm call is an emergency, a statement of how the emergency was resolved.

(13) If an alarm call results in a responder being dispatched to the individual's home for an emergency, the program provider must ensure that:

(A) the service coordinator receives written notice of the alarm call within one business day after the alarm call;

(B) if the CFC ERS provider is a contracted provider, the program provider receives written notice from the contracted provider within one business day after the alarm call; and

(C) the written notices required by subparagraphs (A) and (B) of this paragraph are maintained in the individual's record.

(14) A program provider must ensure that, if an equipment failure occurs, other than during a system check required by paragraph (7) of this section:

(A) the individual is informed of the equipment failure; and

(B) the equipment is replaced within one business day after the failure becomes known by the CFC ERS provider.

(15) If an individual is not informed of the equipment failure and the equipment is not replaced in compliance with paragraph (14) of this section, the program provider must ensure that:

(A) the failure to comply is because of good cause; and

(B) as soon as possible, the individual is informed of the equipment failure and the equipment is replaced.

(16) A program provider must ensure that, if the CFC ERS equipment registers five or more "low battery" signals in a 72-hour period:

(A) a visit to an individual's home is made to conduct a system check within five business days after the low battery signals occur; and

(B) if the battery is defective, the battery is replaced during the visit.

(17) A program provider must ensure that, if a system check or battery replacement is not made in accordance with paragraph (16) of this section:

(A) the failure to comply is because of good cause; and

(B) as soon as possible, the program provide makes a system check or battery replacement.

(18) A program provider must document in an individual's record:

(A) the date the equipment failure or low battery signal became known by the CFC ERS provider;

(B) the equipment or subscriber number;

(C) a description of the problem;

(D) the date the equipment or battery was repaired or replaced; and

(E) the good cause for failure to comply as described in paragraphs (15)(A) and (17)(A) of this section.

§565.21. Transitional Assistance Service (TAS).

The program provider must provide TAS in accordance with this section.

(1) The program provider must:

(A) provide TAS to an applicant for whom the program provider receives from the service coordinator a completed Form 8604, *Transition Assistance Services (TAS) Assessment and Authorization* authorized by HHSC, as described in §263.104(k)(6)(C) of this title (relating to Process for Enrollment of Applicants);

(B) purchase TAS for the applicant within the monetary amount identified on the form;

(C) deliver to the applicant the specific TAS identified on the form;

(D) ensure TAS is provided in accordance with the individual's person-directed plan and Appendix C of the HCS Program waiver application approved by the Centers for Medicare and Medicaid and found on the HHSC website; and

(E) complete the delivery of TAS at least two days before the date of the applicant's discharge from the nursing facility, ICF/IID, or GRO unless the delay in completion is beyond the control of the program provider.

(2) If the program provider does not deliver TAS in accordance with paragraph (1) of this section, the program provider must:

(A) document the following:

(i) a description of the pending TAS;

(ii) the reason for the delay;

(iii) the date the program provider anticipates it will deliver the pending TAS or specific reasons why the program provider cannot anticipate a delivery date; and

(iv) a description of the program provider's ongoing efforts to deliver the TAS; and

(B) at least two days before the date of the applicant's discharge from the nursing facility, ICF/IID, or GRO, provide the information described in subparagraph (A) of this paragraph to:

(i) the applicant or LAR; and

(ii) the service coordinator.

(3) Within one business day after the TAS has been delivered, the program provider must notify the service coordinator and the applicant or LAR that the TAS has been delivered.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 1, 2023.

TRD-202302021
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: June 21, 2023
Proposal publication date: February 17, 2023
For further information, please call: (512) 438-3161

♦ ♦ ♦

SUBCHAPTER F. CERTIFICATION STANDARDS: QUALITY ASSURANCE

26 TAC §§565.23, 565.25, 565.27, 565.29, 565.31, 565.33, 565.35, 565.37, 565.39

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§565.23. Residential Requirements.

(a) This applies to all three-person and four-person residences and host home/companion care settings, unless otherwise specified.

(b) A program provider must ensure that:

(1) the residence, neighborhood, and community meet the needs of the individual and provide an environment that ensures the health, safety, and welfare of the individual;

(2) the home is modified to meet the specific adaptive needs of the individual;

(3) adaptive equipment is functional for the individual or, if the equipment is not functional, the provider has documented:

(A) the broken equipment;

(B) the order date of new or replacement equipment;

(C) the date of the new or replacement equipment installment; and

(D) alternative strategies used during the interim;

(4) mattresses are off the floor and a mattress cover is utilized unless contraindicated and documented by the service planning team;

(5) home furnishings are safe and fit for use;

(6) the home is clean and sanitary;

(7) the home is free of infestations including bugs, rodents, and other pests;

(8) the walls, ceilings, floors, and windows are in good condition and not hazardous to the individual;

(9) the bathrooms are functional and safe to use;

(10) there is hot water available at sinks and in bathing facilities;

(11) the temperature of the hot water at sinks and bathing facilities does not exceed 120 degrees Fahrenheit unless the program provider, in accordance with subsection (c) of this section, conducts a competency-based skills assessment showing that all individuals in the residence can independently regulate the temperature of the hot water from the sinks and bathing facilities;

(12) the major home appliances are in working order, including kitchen appliances and heating and cooling systems;

(13) the individual's bedroom door has a lock that:

(A) is operable by the individual;

(B) only the individual, a roommate of the individual if applicable, and staff designated by the program provider have keys to the individual's bedroom door; and

(C) is not purchased and installed at the individual's or LAR's expense;

(14) the individual does not require a lock if:

(A) the individual lives in a host home/companion care setting and the service provider is the LAR; or

(B) there is a documented modification in the individual's person-directed plan;

(15) household cleaners and chemicals are stored securely;

(16) perishable foods are refrigerated or stored safely;

(17) animals and pets are kept free of disease and vaccinated as required by Texas Health and Safety Code, Chapter 826; and

(18) the interior and exterior of the home:

(A) is free of accumulation of waste and trash;

(B) is accessible and free of hazards to an individual; and

(C) does not compromise the health or safety of an individual.

(c) If the program provider conducts the competency-based skills assessment described in subsection (b)(11) of this section:

(1) the assessment must:

(A) be conducted by a staff member who is not a service provider of residential support, supervised living, or host home/companion care who works or lives in the residence;

(B) be conducted for each individual;

(C) evaluate the individual's cognitive and physical ability to independently mix or regulate the hot water temperature without assistance or guidance from each sink and bathing facility in the residence; and

(D) be based on a face-to-face demonstration by the individual; and

(2) the program provider must:

(A) complete the assessment at least annually;

(B) document the results of the assessment; and

(C) keep a copy of the results in the residence.

(d) The program provider must ensure that each residence has:

(1) exterior doors that are unobstructed and accessible to all individuals living in the residence;

(2) two means of escape from the residence;

(3) two means of escape from an individual's bedroom, unless the program provider has a fire sprinkler system that is checked and maintained according to Texas Insurance Code, Chapter 6003, at which point there can be one means of escape from an individual's bedroom;

(4) working smoke alarms in each bedroom and immediately outside the bedrooms; and

(5) fire extinguishers that are:

(A) accessible and unobstructed to the service provider;

(B) on each level of the home;

(C) serviced or replaced after each use; and

(D) if unused, serviced according to the manufacturer's instructions, or as required by the state or local fire marshal.

(e) The program provider, as it relates to fire drills, must:

(1) conduct at each residence at least:

(A) one fire drill every 90 days;

(B) four fire drills every 365 days; and

(C) two of the fire drills listed in subparagraph (B) of this paragraph must be conducted during sleeping hours;

(2) ensure that each staff member participates in a fire drill within 90 days of hire and at least annually thereafter;

(3) ensure that the staff member can explain the emergency plans for the residence;

(4) provide training for a staff member who does not follow the emergency plan during the fire drill; and

(5) revise the emergency plan to ensure the individual can exit the residence safely if the individual is unable to exit the home according to the emergency plan.

(f) The program provider, as it relates to emergency plans, must:

(1) ensure that a staff member reviews the emergency plans for each individual at a residence before providing services;

(2) instruct staff members on where to locate the emergency plans at the residence; and

(3) maintain documentation related to emergency preparedness accessible to staff members at the residence, including:

(A) emergency plans that address:

(i) the relevant emergencies given the geographic location;

(ii) the needs of the individuals living in the residence; and

(iii) fire drill responses; and

(B) emergency numbers publicly posted in an area of the residence that is easily accessible to staff members.

(g) A program provider must implement and maintain personnel practices that safeguard individuals against infectious and communicable diseases, which includes:

(1) using standard precautions in the care of all individuals, including hand hygiene and maintaining a sanitary environment to avoid sources and transmission of infections;

(2) creating written policies for the prevention and control of communicable diseases among employees and individuals, including the appropriate use of transmission-based precautions and protective measures the program provider must take if an employee contracts a communicable disease; and

(3) revising a policy or practice if a shortcoming is identified.

(h) A program provider must implement and maintain medication administration and storage practices that safeguard an individual's medication, which includes:

(1) creating written policies for preventing unauthorized access to medications;

(2) using a procedure that ensures safe medication administration to the individual;

(3) ensuring staff are trained and knowledgeable about the individuals' medications;

(4) ensuring staff who are administering medications have been trained and delegated by a registered nurse (RN);

(5) maintaining accurate, current, and accessible documentation of medication administration; and

(6) revising a policy or practice if a shortcoming is identified.

(i) A program provider must comply with the requirements in this subsection regarding a four-person residence.

(1) Before providing residential support in a four-person residence, the program provider must:

(A) obtain an inspection by the local fire marshal, or the Texas State Fire Marshal's office in locations where there is no local fire marshal, and correct any items cited by the local fire marshal or Texas State Fire Marshal's Office to the satisfaction of those authorities; and

(B) obtain Texas Health and Human Services Commission (HHSC)approval of the residence in accordance with §565.43 of this chapter(relating to HHSC Approval of Four Person Residences).

(2) HHSC inspects for certification, as described in paragraph(1)(A) of this subsection, only if the program provider submits to the HHSC Architectural Unit:

(A) one of the following:

(i) if the four-person residence is located in a jurisdiction with a local fire safety authority:

(I) a completed HHSC Form 5606, *Life Safety Code Certification,* available on the HHSC website, documenting that the local fire safety authority having jurisdiction refused to inspect for certification using the code (i.e., the Life Safety Code or International Fire Code) for that jurisdiction; and

(II) written documentation from the Texas State Fire Marshal's Office that it refused to inspect for certification using the Life Safety Code; or

(ii) if the four-person residence is located in a jurisdiction without a local fire safety authority, written documentation from the Texas State Fire Marshal's Office that it refused to inspect for certification using the Life Safety Code; and

(B) a completed HHSC Form 5604, *HCS Program Provider Request for Life Safety Inspection,* available on the HHSC website.

(3) The program provider must:

(A) obtain the certification required by this subsection annually; and

(B) ensure that a four-person residence:

(i) contains a copy of the most recent inspection of the residence by the local fire safety authority, Texas State Fire Marshal's Office, or HHSC; and

(ii) is in continuous compliance with all applicable local building codes and ordinances and state and federal laws, rules, and regulations.

§565.25. Programmatic Requirements.

(a) Before providing services to an individual in a residence in which supervised living or residential support is provided, and annually thereafter, the program provider must:

(1) conduct an on-site inspection to ensure that, based on the individual's needs, the environment is safe, accessible and suited for the individual's abilities, and complies with applicable federal, state, and local regulations for the community in which the individual lives;

(2) complete any action identified in the on-site inspection for a residence in which supervised living or residential support will be provided:

(A) before an individual moves in; or

(B) within 30 days if an individual is already in the residence; and

(C) document justification for any actions that cannot be completed before the individual moving in or within 30 days with a plan for completion.

(b) Before providing services to an individual in a residence in which host home/companion care is provided and quarterly thereafter, the program provider must:

(1) conduct an on-site inspection to ensure that, based on the individual's needs, the environment is safe, accessible, and suited for the individual's abilities and needs, and complies with applicable federal, state, and local regulations for the community in which the individual lives; and

(2) require proof of completion of any action identified in the on-site inspection for a residence in which host home/companion care will be provided to ensure that the residence meets the needs of the individual:

(A) before an individual moves in; or

(B) within 30 days if an individual is already in the residence; and

(C) document justification for any actions that cannot be completed before the individual moving in or within 30 days and include a plan for completion.

(c) The program provider must establish an ongoing consumer/advocate advisory committee composed of individuals, legally authorized representatives (LARs), community representatives, and family members that meets at least quarterly. The committee:

(1) at least annually, reviews the information provided to the committee by the program provider in accordance with subsection(l)(6) of this section; and

(2) based on the information reviewed, makes recommendations to the program provider for improvements to the processes and operations of the program provider.

(d) The program provider must make available all records, reports, and other information related to the delivery of HCS Program and CFC services as requested by the Texas Health and Human Services Commission (HHSC), other authorized agencies, or the Centers for Medicare and Medicaid and deliver such items, as requested, to a specified location or delivered electronically if available.

(e) The program provider must establish a procedure to assess at least annually the satisfaction of all individuals and LARs in the program provider's services and act within 60 days regarding any areas of dissatisfaction.

(f) The program provider must comply with 40 Texas Administrative Code (TAC) §49.309 (relating to Complaint Process).

(g) In all respite facilities and all residences in which a service provider of residential assistance or the program provider hold a property interest, the program provider must post in a conspicuous location:

(1) the name, address, and telephone number of the program provider;

(2) the effective date of the contract; and

(3) the name of the legal entity named on the contract.

(h) A program provider must report the death of an individual:

(1) to HHSC and the local intellectual and developmental disability authority by the end of the next business day after the program provider becomes aware of the death; and

(2) if the program provider reasonably believes that the LAR does not know of the individual's death, to the LAR as soon as possible, but not later than 24 hours after the program provider becomes aware of the death.

(i) A program provider must not retaliate against:

(1) a staff member, service provider, individual, or other person who files a complaint, presents a grievance, or otherwise provides good faith information relating to the possible abuse, neglect, or exploitation of an individual, including:

(A) use of seclusion; and

(B) use of a restraint not in compliance with federal and state laws, rules, and regulations; and

(2) an individual because a person on behalf of the individual files a complaint, presents a grievance, or otherwise provides good faith information relating to the possible abuse, neglect, or exploitation of an individual, including:

(A) use of seclusion; and

(B) use of a restraint not in compliance with federal and state laws, rules, and regulations.

(j) A program provider must enter critical incident data in the HHSC data system no later than the last calendar day of the month that follows the month being reported in accordance with HHSC guidance found on the HHSC website.

(k) A program provider must ensure that:

(1) the name and phone number of an alternate to the Chief Executive Officer (CEO) of the program provider is entered in the HHSC data system; and

(2) the alternate to the CEO:

(A) performs the duties of the CEO during the CEO's absence; and

(B) acts as the contact person in an HHSC investigation if the CEO is named as an alleged perpetrator of abuse, neglect, or exploitation of an individual, and complies with§565.31(d) - (f) of this subchapter (relating to Requirements Related to the Abuse, Neglect, and Exploitation).

(l) At least annually, the program provider must:

(1) evaluate information about the satisfaction of individuals and LARs with the program provider's services and identify program process improvements to increase the satisfaction;

(2) review complaints, as described in 40 TAC §49.309, and identify program process improvements to reduce the need for filing complaints;

(3) review all final investigative reports from HHSC and, based on the review, identify program process improvements that help prevent the occurrence of abuse, neglect, and exploitation and improve the delivery of services;

(4) review the reasons for terminating HCS Program or CFC services and identify any related need for program process improvements;

(5) evaluate critical incident data described in subsection (j) of this section, compare the program provider's use of restraint to aggregate data provided by HHSC on the HHSC website, and identify program process improvements that help prevent the reoccurrence of restraints and improve service delivery;

(6) provide all information the program provider reviewed, evaluated, and created as described in paragraphs (1) - (5) of this subsection to the consumer/advocate advisory committee required by subsection (c) of this section;

(7) implement any program process improvements identified by the program provider in accordance with this subsection; and

(8) review recommendations made by the consumer/advocate advisory committee as described in subsection (c)(2) of this section and implement the recommendations approved by the program provider.

(m) The program provider must ensure that all personal information concerning an individual is kept confidential, such as lists of names, addresses, and records obtained by the program provider, and that the use or disclosure of such information and records is limited to purposes directly connected with the administration of the program provider's HCS Program or provision of CFC services and is otherwise neither directly nor indirectly used or disclosed unless the consent of the individual to whom the information applies or the individual's LAR is obtained beforehand.

(n) The program provider must include the individual or LAR in planning the individual's residential relocation, except in cases of emergency.

§565.27. Finances and Rent.

(a) The program provider must comply with this subsection regarding charges against an individual's personal funds.

(1) The program provider must, in accordance with this paragraph, collect a monthly amount for room from an individual who lives in a three-person or four-person residence. The cost for room must consist only of:

(A) an amount equal to:

(i) rent of a comparable dwelling in the same geographical area that is unfurnished; or

(ii) the program provider's ownership expenses, limited to the interest portion of a mortgage payment, depreciation expense, property taxes, neighborhood association fees, and property insurance; and

(B) the cost of:

(i) shared appliances, electronics, and housewares;

(ii) shared furniture;

(iii) monitoring for a security system;

(iv) monitoring for a fire alarm system;

(v) property maintenance, including personnel costs, supplies, lawn maintenance, pest control services, carpet cleaning, septic tank services, and painting;

(vi) utilities, limited to electricity, gas, water, garbage collection, and a landline telephone; and

(vii) shared television and Internet service used by the individuals who live in the residence.

(2) Except as provided in subparagraphs (B) and (C) of this paragraph, a program provider must collect a monthly amount for board from an individual who lives in a three-person or four-person residence.

(A) The cost for board must consist only of the cost of food, including food purchased for an individual to consume while away from the residence as a replacement for food and snacks normally prepared in the residence, and of supplies used for cooking and serving, such as utensils and paper products.

(B) A program provider is not required to collect a monthly amount for board from an individual if collecting such an amount may make the individual ineligible for the Supplemental Nutrition Assistance Program operated by the Texas health and Human Services Commission(HHSC).

(C) A program provider must not collect a monthly amount for board from an individual if the individual chooses to purchase the individual's own food, as documented in the individual's implementation plan.

(3) To determine the maximum room and board charge for each individual, a program provider must:

(A) develop a process or formula that divides the rent equitably and considers:

(i) the number of residents receiving HCS Program services or similar services that the residence has been developed to support plus the number of service providers and other persons who live in the residence; and

(ii) the features or space to which an individual has exclusive or shared access, unless the additional space is requested and needed for accessibility purposes;

(B) divide the board cost described in paragraph (2) of this subsection by the number of persons consuming the food; and

(C) add the amounts calculated in accordance with subparagraphs (A)and (B) of this paragraph.

(4) A program provider must not increase the charge for room and board because a resident moves from the residence.

(5) A program provider:

(A) must not charge an individual a room and board amount that exceeds an amount determined in accordance with paragraphs (1) - (3)of this subsection; and

(B) must maintain documentation demonstrating that the room and board charge was determined in accordance with paragraphs (1) - (3)of this subsection.

(6) Before an individual or legally authorized representative (LAR)selects a residence, the program provider must ensure the individual or LAR has a written residential agreement with:

(A) the program provider if the individual lives in a three-person residence or four-person residence; or

(B) the service provider of host home/companion care if the individual does not own the residence or lease the residence from another person.

(7) Except as provided in paragraph (8) of this subsection, a program provider may not charge or collect payment from any person for room and board provided to an individual receiving host home/companion care.

(8) If a program provider makes a payment to an individual's host home/companion care provider while waiting for the individual's federal or state benefits to be approved, the program provider may seek reimbursement from the individual for such payments.

(9) For a program provider who manages personal funds of an individual who receives host home/companion care, the program provider:

(A) must pay the agreed upon amount for the host home/companion care services;

(B) must pay the host home/companion care provider directly from the individual's account;

(C) may pay a room and board charge for the individual that is less than the host home/companion care provider's cost of room and board, as determined using the calculations described in paragraphs (1) and(2) of this subsection, for a three-person or four-person residence, divided by the number of persons living in the host home/companion care provider's home; and

(D) must not pay a host home/companion care provider a room and board charge that exceeds the host home/companion care provider's cost of room and board, as determined using the calculations described in paragraphs (1) and (2) of this subsection for a three-person or four-person residence, divided by the number of persons living in the host home/companion care provider's home.

(10) For an item or service other than room and board, the program provider must apply a consistent method in assessing a charge against the individual's personal funds that ensures that the charge for the item or service is reasonable and comparable to the cost of a similar item or service generally available in the community.

(b) The program provider must inform the individual and LAR orally or in writing of any charges assessed by the program provider against the individual's personal funds, the purpose of those charges, and effects of the charges in relation to the individual's financial status.

(c) The program provider must ensure that the individual or LAR has agreed in writing to all charges assessed by the program provider against the individual's personal funds before the charges are assessed.

(d) The program provider must not assess charges against the individual's personal funds for costs for items or services reimbursed through the HCS Program or through CFC.

(e) At the written request of an individual or LAR, the program provider must manage the individual's personal funds entrusted to the program provider, without charge to the individual or LAR in accordance with this subsection.

(1) The program provider must not commingle the individual's personal funds with the program provider's funds.

(2) The program provider must maintain a separate, detailed record of:

(A) all deposits into the individual's account; and

(B) all expenditures from the individual's account.

(3) If an expenditure is for the individual to use as personal spending money, the program provider must have a process to show the individual acknowledged receiving the funds.

(4) The program provider may accrue an expense for necessary items and services for which the individual's personal funds are not available for payment, such as room and board, medical and dental services, legal fees or fines, and essential clothing.

(5) If an expense is accrued as described in paragraph (4) of this subsection, the program provider must enter a written payment plan with the individual or LAR for reimbursement of the funds.

§565.31. Requirements Related to Abuse, Neglect, and Exploitation.

(a) A program provider must:

(1) ensure that an individual and legally authorized representative(LAR), at the time the individual begins receiving a Home and Community-based Services (HCS) Program or Community First Choice(CFC) service and at least annually thereafter, are:

(A) informed of how to report allegations of abuse, neglect, or exploitation to:

(i) the Texas Department of Family and Protective Services (DFPS)and given the toll-free telephone number, 1-800-647-7418, in writing; and

(ii) HHSC Complaint and Incident Intake (CII) by calling the toll-free telephone number, 1-800-458-9858; and

(B) educated about protecting the individual from abuse, neglect, and exploitation;

(2) ensure that each staff member, service provider, and volunteer are:

(A) trained and knowledgeable of:

(i) acts that constitute abuse, neglect, and exploitation;

(ii) signs and symptoms of abuse, neglect, and exploitation; and

(iii) methods to prevent abuse, neglect, and exploitation;

(B) instructed to report to DFPS immediately, but not later than one hour after having knowledge or suspicion, that an individual has been or is being abused, neglected, or exploited, by:

(i) calling the DFPS Abuse Hotline toll-free telephone number, 1-800-647-7418; or

(ii) using the DFPS Abuse Hotline website; and

(C) given the instructions described in subparagraph (B) of this paragraph in writing;

(3) ensure that each staff member, service provider, and volunteer sign an acknowledgement that they understand all individuals must live free of abuse, neglect, and exploitation; and

(4) conduct the activities described in paragraph (2) and (3) of this subsection before a staff member, service provider, or volunteer assumes job duties and at least annually thereafter.

(b) Except as provided by §559.241(a) of this title (relating to Reporting Abuse, Neglect, Exploitation, or Incidents to HHSC), if a program provider, staff member, service provider, volunteer, or controlling person knows or suspects an individual is being or has been abused, neglected, or exploited, the program provider must report or ensure that the person with knowledge or suspicion reports the allegation of abuse, neglect, or exploitation to DFPS immediately, but not later than one hour after having knowledge or suspicion, by:

(1) calling the DFPS Abuse Hotline toll-free telephone number, 1-800-647-7418; or

(2) using the DFPS Abuse Hotline website.

(c) If a report required by subsection (b) of this section alleges abuse, neglect, or exploitation by a person who is not a service provider, staff member, volunteer, or controlling person, a program provider must:

(1) assess the individual and allegation and as necessary:

(A) obtain appropriate medical or psychological services for the individual; and

(B) assist in obtaining ongoing medical or psychological services for the individual;

(2) discuss with the individual or LAR safety measures, including alternative residential settings or individualized skills and socialization providers that may help ensure the individual's safety;

(3) when taking the actions described in paragraphs (1) and (2) of this subsection, avoid compromising the investigation or further traumatizing the individual; and

(4) preserve and protect evidence related to the allegation.

(d) If a report required by subsection (b) of this section alleges abuse, neglect, or exploitation by a service provider, staff member, volunteer, or controlling person; or if a program provider is notified by HHSC of an allegation of abuse, neglect, or exploitation by a service provider, staff member, volunteer, or controlling person, the program provider must:

(1) assess the individual and allegation as necessary:

(A) obtain appropriate medical or psychological services for the individual; and

(B) assist in obtaining ongoing medical or psychological services for the individual;

(2) take actions to secure the safety of the individual, including if necessary, ensuring that the alleged perpetrator does not have contact with the individual or any other individual until HHSC completes the investigation;

(3) when taking the actions described in paragraphs (1) and (2) of this subsection, avoid compromising the investigation or further traumatizing the individual;

(4) preserve and protect evidence related to the allegation; and

(5) notify, as soon as possible, but no later than 24 hours after the program provider reports or is notified of the allegation, the individual, the LAR, and the service coordinator of:

(A) the allegation report; and

(B) the actions the program provider has taken or will take based on the allegation, the condition of the individual, and the nature and severity of any harm to the individual, including the actions required by paragraph (2) of this subsection.

(e) During an HHSC investigation of an alleged perpetrator who is a service provider, staff member, volunteer, or controlling person, a program provider must:

(1) cooperate with the investigation as requested by HHSC, including providing documentation and participating in an interview;

(2) provide HHSC access to:

(A) sites owned, operated, or controlled by the program provider;

(B) individuals, service providers, staff members, volunteers, and controlling persons; and

(C) evidence pertinent to the investigation of the allegation; and

(3) ensure that staff members, service providers, volunteers, and controlling persons comply with paragraphs (1) and (2) of this subsection.

(f) After a program provider receives a final investigative report from HHSC for an investigation described in subsection (e) of this section, the program provider must:

(1) if the allegation of abuse, neglect, or exploitation is confirmed by HHSC:

(A) review the report, including any concerns and recommendations by HHSC; and

(B) take action within the program provider's authority to prevent the reoccurrence of abuse, neglect or exploitation, including disciplinary action against the service provider, staff member, or volunteer confirmed to have committed abuse, neglect, or exploitation;

(2) if the allegation of abuse, neglect, or exploitation is unconfirmed, inconclusive, or unfounded:

(A) review the report, including any concerns and recommendations by HHSC; and

(B) take appropriate action within the program provider's authority, to ensure the individual's safety, as necessary;

(3) immediately, but not later than five calendar days after the date the program provider receives the HHSC final investigative report:

(A) notify the individual, the LAR, and the service coordinator of:

(i) the investigation finding; and

(ii) the action taken by the program provider in response to the HHSC investigation as required by paragraphs (1) and (2) of this subsection; and

(B) notify the individual or LAR of:

(i) the process to appeal the investigation finding as described in Chapter 711, Subchapter J of this title (relating to Appealing the Investigation Finding); and

(ii) the process for requesting a copy of the investigative report from the program provider;

(4) within 14 calendar days after the date the program provider receives the final investigative report, complete and send to HHSC the Form 8494, *Notification Regarding an Investigation of Abuse, Neglect or Exploitation,* located on the HHSC website; and

(5) upon request of the individual or LAR, provide to the individual or LAR a copy of the HHSC final investigative report after removing any information that would reveal the identity of the reporter or of any individual who is not the alleged victim.

(g) The program provider must ensure the coordination of services with the licensed individualized skills and socialization provider, including information regarding abuse, neglect, and exploitation.

§565.35. Enclosed Beds.

(a) The program provider may allow the use of an enclosed bed in a residence if the enclosed bed is purchased, obtained, and complies with the requirements in subsection (c) of this section prior to June 19, 2023.

(b) An enclosed bed is prohibited in a residence if it is purchased or obtained on or after June 19, 2023, even if it complies with subsection (c) of this section.

(c) If the program provider allows the use of an enclosed bed in a residence, the program provider must:

(1) visually inspect the enclosed bed to ensure it meets the criteria of an enclosed bed as defined in §565.3 of this chapter(related to Definitions);

(2) ensure that a physician, occupational therapist, or physical therapist:

(A) conducts an annual assessment to determine:

(i) if the individual has a medical need for the enclosed bed;

(ii) the circumstances under which the enclosed bed may be used;

(iii) that less restrictive methods would be ineffective in protecting the individual and the reasons for that determination;

(iv) how to use the enclosed bed and any contraindications specific to the individual;

(v) how and when to document the use of the enclosed bed; and

(vi) how to monitor the use of the enclosed bed to ensure it is being used in accordance with the assessment; and

(B) follows up after any significant change to determine if the individual still has a medical need for the enclosed bed;

(3) obtain and retain the following documentation:

(A) a letter of medical necessity from the prescribing physician or professional therapist; and

(B) a receipt from a durable medical equipment company for the enclosed bed;

(4) develop and implement policies and procedures that require:

(A) routine checks of the enclosure bed to ensure it is in good repair and safe for the individual;

(B) a documented quarterly review by a registered nurse (RN) or professional therapist to ensure the enclosed bed is still safe and necessary given the individual's current needs and other less restrictive options available; and

(C) an order for the enclosed bed updated annually, or sooner if the RN has determined there is a significant change to the individual's condition.

(d) To prevent misuse or overuse of the enclosed bed, the program provider must:

(1) develop and implement a usage plan that details when the enclosed bed will be used that is consistent with the assessment and order;

(2) require any staff member who provides services to an individual with an enclosed bed to read and document understanding of the usage plan before providing services; and

(3) make the usage plan readily available to staff members providing services.

(e) All enclosed beds are prohibited after June 19, 2028.

§565.37. Protective Devices.

(a) Except as provided in §565.35 of this subchapter (relating to Enclosed Beds), if a protective device is used, the program provider must ensure that it is used in accordance with this section.

(b) A program provider must not use a protective device:

(1) to modify or control an individual's behavior;

(2) for disciplinary purposes;

(3) for staff convenience; or

(4) as a substitute for an effective, less restrictive method.

(c) If a need for a protective device is identified, the program provider must ensure that a physician, occupational therapist, physical therapist, or registered nurse (RN):

(1) conducts an initial assessment to determine:

(A) if the individual has a medical need for a protective device;

(B) that less restrictive methods would be ineffective in protecting the individual, and the reasons for that determination;

(C) the type of protective device to be used, which must be the least restrictive protective device that will protect the individual;

(D) the circumstances under which the protective device may be used;

(E) how to use the protective device and any contraindications specific to the individual;

(F) how and when to document the use of the protective device; and

(G) how to monitor the use of the protective device to ensure it is being used in accordance with the assessment; and

(2) then annually and after any significant change to determine:

(A) if the individual has a medical need for a protective device;

(B) that less restrictive methods would be ineffective in protecting the individual, and the reasons for that determination; and

(C) the type of protective device to be used, which must be the least restrictive protective device that will protect the individual.

(d) Before a program provider uses a protective device, the program provider must:

(1) obtain and retain in the individual's record:

(A) an order for the use of the protective device identified in the initial assessment;

(B) complete initial and subsequent assessments from subsection (c)of this section; and

(C) consent of the individual or legally authorized representative(LAR) to use the protective device;

(2) provide oral and written notification to the individual or LAR of the right at any time to withdraw consent for the use of the protective device; and

(3) develop a policy and procedure to ensure that each service provider who will use the protective device has been trained in the proper use of the protective device, in accordance with the initial assessment.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 1, 2023.

TRD-202302022
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: June 21, 2023
Proposal publication date: February 17, 2023
For further information, please call: (512) 438-3161

SUBCHAPTER G. HHSC ACTIONS

26 TAC §§565.41, 565.43, 565.47, 565.49

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

§565.49. Program Provider Compliance and Corrective Action.

(a) If the Texas Health and Human Services Commission (HHSC) determines from a survey that a program provider complies with the certification standards, HHSC:

(1) sends the program provider a final survey report stating that the program provider complies with the certification standards;

(2) does not require any action by the program provider; and

(3) if the survey is an initial or a recertification survey, certifies the program provider as described in §565.41(f) of this subchapter (relating to HHSC Surveys of a Program Provider).

(b) If HHSC determines from a survey that a program provider is not in compliance with a certification standard and the violation is an immediate threat, HHSC notifies the program provider of the determination. The program provider must immediately provide HHSC with a plan of removal.

(c) In a plan of removal provided in accordance with subsection (b) of this section, a program provider must specify the time by which the program provider will remove the immediate threat. HHSC approves or disapproves the plan of removal and monitors to ensure the immediate threat is removed.

(d) If a program provider that is required to provide a plan of removal does not provide a plan of removal, HHSC does not approve the program provider's plan of removal, or the program provider does not implement the plan of removal approved by HHSC, HHSC:

(1) denies or terminates certification of the program provider; and

(2) coordinates with the local intellectual and developmental disability authorities (LIDDAs) the immediate provision of alternative services for the individuals.

(e) If HHSC determines from a survey that a program provider is not in compliance with a certification standard, HHSC sends to the program provider, within 10 business days after the date of the exit conference:

(1) a final survey report with a list of violations;

(2) a letter notifying the program provider that the program provider may request an informal dispute resolution to dispute a violation in the final survey report; and

(3) if HHSC imposes an administrative penalty in accordance with §565.45 of this subchapter (relating to Administrative Penalties), a written notice of the administrative penalty as described in 40 TAC §49.535(b) (relating to Administrative Penalties in the HCS and TxHmL Programs).

(f) If HHSC determines from an initial certification survey, recertification survey, or intermittent survey that a program provider is not in compliance with a certification standard, the program provider must submit to HHSC, within 14 calendar days after the date the program provider receives the final survey report, a plan of correction for each violation identified by HHSC in the final survey report. The program provider must submit a plan of correction in accordance with this subsection even if the program provider disagrees with the violation or requests an informal dispute resolution.

(g) In a plan of correction submitted in accordance with subsection (f) of this section, a program provider must specify a date by which the program provider will complete corrective action for each violation and such date must:

(1) for a critical violation, be no later than 30 calendar days after the date of the survey exit conference; and

(2) for a violation that is not a critical violation, be no later than 45 calendar days after the date of the survey exit conference.

(h) After HHSC receives the plan of correction required by subsection (f) of this section, HHSC notifies the program provider whether the plan is approved or not approved.

(i) If HHSC does not approve a plan of correction required by subsection (f) of this section, the program provider must submit a revised plan of correction within five business days after the date of HHSC's notice that the plan of correction was not approved. After HHSC receives the revised plan of correction, HHSC notifies the program provider whether the revised plan is approved or not approved.

(j) If the program provider does not submit a plan of correction required by subsection (f) of this section or a revised plan of correction required by subsection (i) of this section, or if HHSC notifies the program provider that a revised plan of correction is not approved, HHSC:

(1) imposes a vendor hold against the program provider until HHSC approves a plan of correction submitted by the program provider; or

(2) denies or terminates certification of the program provider.

(k) If HHSC approves a plan of correction, HHSC takes the following actions to determine if a program provider has completed its corrective action:

(1) requests that the program provider submit evidence of correction to HHSC; and

(2) conducts:

(A) for a critical violation, a follow-up survey after the date specified in the plan of correction for correcting the violation but within 45 calendar days after the survey exit conference, unless HHSC conducts an earlier follow-up survey as described in subsection (l) of this section; or

(B) for a violation that is not critical, a post 45-day follow-up survey, unless HHSC conducts an earlier follow-up survey as described in subsection (l) of this section.

(l) At the request of a program provider, HHSC may conduct a follow-up survey earlier than the timeframes described in subsection (k)(2) of this section.

(1) If HHSC determines from the earlier follow-up survey that corrective action has been completed and the program provider has not yet submitted a plan of correction to HHSC in accordance with subsection (f) of this section, the program provider must include the corrective action taken on the plan of correction that is submitted.

(2) If HHSC determines from the earlier follow-up survey that corrective action has not been completed for a violation that is not critical, HHSC conducts the post 45-day follow-up survey.

(m) If HHSC determines from a follow-up survey described in subsections (k)(2)(A) or (l) of this section that the program provider has completed corrective action for a critical violation, the administrative penalty stops accruing on the date corrective action was completed, as determined by HHSC. HHSC sends the program provider a written notice as described in 40 TAC §49.535(c).

(n) If HHSC determines from a follow-up survey described in subsections (k)(2)(A) or (l) of this section that the program provider has not completed the corrective action for a critical violation, HHSC:

(1) continues the administrative penalty and conducts another follow-up survey to determine if the program provider completed the corrective action;

(2) imposes a vendor hold against the program provider; or

(3) denies or terminates certification of the program provider.

(o) HHSC takes the actions described in this subsection regarding a follow-up survey described in subsection (n)(1) of this section.

(1) If HHSC determines from the survey that the program provider has completed the corrective action, the administrative penalty stops accruing on the date corrective action was completed, as determined by HHSC. HHSC sends the program provider a written notice as described in 40 TAC §49.535(c).

(2) If HHSC determines from the survey that the program provider has not completed the corrective action, the administrative penalty stops accruing and HHSC:

(A) imposes a vendor hold against the program provider; or

(B) denies or terminates certification of the program provider.

(p) If HHSC determines from a post 45-day follow-up survey or an earlier survey described in subsection (l) of this section that a program provider has completed corrective action for a violation that is not critical, HHSC does not impose an administrative penalty for the non-critical violation.

(q) If HHSC determines from a post 45-day follow-up survey that a program provider has not completed corrective action for a violation that is not critical, HHSC:

(1) imposes an administrative penalty for the non-critical violation in accordance with §565.45 of this subchapter;

(2) notifies the program provider of the administrative penalty, as described in 40 TAC §49.535(b); and

(3) conducts a survey:

(A) at least 31 calendar days after the date of the post 45-day exit conference of the follow-up survey; or

(B) earlier than 31 calendar days after the date of the exit conference of the post 45-day follow-up survey if the program provider has submitted evidence of corrective action to HHSC during the 30-day period.

(r) HHSC takes the actions described in this subsection regarding a survey described in subsection (q)(3) of this section.

(1) If HHSC determines from the survey that the program provider has completed corrective action, the administrative penalty stops accruing on the date corrective action was completed, as determined by HHSC. HHSC sends the program provider a written notice as described in 40 TAC §49.535(c).

(2) If HHSC determines from the survey that the program provider has not completed the corrective action, the administrative penalty stops accruing and HHSC:

(A) imposes a vendor hold against the program provider; or

(B) denies or terminates certification of the program provider.

(s) If HHSC determines that a program provider committed any of the actions described in §565.45(a)(2) of this subchapter, HHSC takes one of the following actions:

(1) imposes an administrative penalty against the program provider as described in §565.45 of this subchapter;

(2) imposes a vendor hold against the program provider; or

(3) denies or terminates certification of the program provider.

(t) If HHSC imposes a vendor hold in accordance with this section:

(1) for a program provider with a provisional contract, HHSC initiates termination of the program provider's contract in accordance with 40 TAC §49.534 (relating to Termination of Contract by HHSC); or

(2) for a program provider with a standard contract, HHSC conducts a survey at least 31 calendar days after the effective date of the vendor hold to determine if the program provider completed the corrective action required to release the vendor hold and:

(A) if the program provider completed the corrective action, HHSC releases the vendor hold; or

(B) if the program provider has not completed the corrective action, HHSC denies or terminates certification.

(u) If HHSC determines that a program provider is out of compliance with §565.9(b)(2) of this chapter (relating to Program Provider Requirements), corrective action required by HHSC may include the program provider paying or ensuring payment to a service provider of supported home living or CFC PAS/HAB who was not paid the wages required by §565.9(b)(2) of this chapter, the difference between the amount required and the amount paid to the service provider.

(v) HHSC does not cite a program provider for violation of a certification standard based solely on the action or inaction of a person who is not a service provider or a staff member. HHSC may cite a program provider for violation of a certification standard based on the program provider's response to the action or inaction of such a person.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 1, 2023.

TRD-202302023
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: June 21, 2023
Proposal publication date: February 17, 2023
For further information, please call: (512) 438-3161

CHAPTER 748. MINIMUM STANDARDS FOR GENERAL RESIDENTIAL OPERATIONS

The Texas Health and Human Services Commission (HHSC) adopts amendments to §748.105, concerning What are the requirements for my personnel policies and procedures, §748.363, concerning What information must the personnel record of an employee include, and §748.505, concerning What minimum qualifications must all employees meet; and new §748.751, con-

cerning What are the requirements for obtaining and verifying an applicant's employment history, and §748.753, concerning What are the requirements for completing an applicant's reference checks, in Texas Administrative Code, Title 26, Chapter 748, Minimum Standards for General Residential Operations.

New §748.751 and §748.753 are adopted with changes to the proposed text as published in the March 17, 2023, issue of the *Texas Register* (48 TexReg 1531). These rules will be republished.

Amended §§748.105, 748.363, and 748.505 are adopted without changes to the proposed text as published in the March 17, 2023, issue of the *Texas Register* (48 TexReg 1531). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The amended and new sections are necessary to support the June 9, 2022, court filing regarding the June 6, 2022, status hearing in the MD v. Abbott litigation. The filing, signed by the court, refers to an agreement by HHSC to initiate rulemaking to require operations to contact all an applicant's job references prior to commencement of employment. In addition to this court filing, CCR has determined that the rules will improve the safety of children in care in general residential operations by requiring a more thorough vetting of prospective employees.

Accordingly, HHSC Child Care Regulation (CCR) is adopting new and amended rules to establish (1) employment history verification standards that require a General Residential Operation (GRO) to obtain and verify the most recent five years of an applicant's employment history; and (2) applicant reference check requirements that require a GRO to complete reference checks for each applicant by obtaining at least two references and contacting each of those references as part of an operation's pre-employment screening process.

COMMENTS

The 31-day comment period ended April 17, 2023. During this period, HHSC received 22 comments regarding the rules from the Texas Alliance of Child and Family Services (TACFS). HHSC also received one additional comment from Amarillo Children's Home, a GRO that is a member of TACFS and provided input into TACFS' comments, stating their support for TACFS' comments. A summary of the comments relating to the rules and HHSC's responses follows.

Comment: Regarding §748.363, one commenter recommended that HHSC ensure there is only one citable subsection for each requirement related to employment verification and employee reference checks. The commenter also recommended that documentation requirements be weighted medium-low or lower.

Response: HHSC agrees that only one subsection for each requirement should be citable but declines to revise the rule because the comment is not related to the rule content or language. With respect to the comment, CCR will not assign a weight to this rule because CCR will cite the specific rules referenced in this rule in the event CCR determines an operation violated these requirements.

Comment: Regarding §748.505(b)(5) and the rules in general, one commenter recommended HHSC clearly communicate that citations should not be "stacked" so that CCR staff do not cite an operation for this rule while also citing identical, referenced requirements in §748.751, What are the requirements for obtaining and verifying an applicant's employment history, or §748.753, What are the requirements for completing an applicant's reference checks.

Response: HHSC agrees that training CCR staff on regulatory expectations is important but declines to revise the rules, as this issue relates to training and not rule content or language. Accordingly, CCR will continue its current practice of including this message in the training CCR provides to staff on an ongoing basis and when new rules are adopted. In the event an operation disagrees with a citation or wishes to contest a citation as evidence of "stacking," the operation retains the right to request an administrative review, as outlined in Texas Administrative Code, Title 26, Chapter 745, Licensing, Subchapter M, Administrative Reviews and Due Process Hearings.

Comment: Regarding §§748.505(b)(5), 748.751, and 748.753, one commenter recommended each rule be amended to remove the requirement that all applicants clear a pre-employment screening that includes employment history verification and applicant reference checks. The commenter stated that the requirements should be applicable only to employees who are counted in ratio or have unsupervised contact with children.

Response: HHSC disagrees with the comment and declines to revise the rules. Employees may pose a risk to children in care even if they do not provide care directly to children or have unsupervised access to children in care. Therefore, any employee in an operation that serves children, whether in a direct care role or an ancillary role, should be thoroughly vetted to ensure the safety of children.

Comment: Regarding §748.751, one commenter requested HHSC maintain the technical assistance (TA) information included in the informal proposal that specified that organizations may use existing forms and applications to meet and document the requirements in the new rules.

Response: HHSC agrees with the comment and intends to publish the TA as indicated by the commenter in the TA box that follows the rule in the minimum standards courtesy publication.

Comment: Regarding §748.751, one commenter recommended HHSC include an optional employment history verification form that meets the documentation requirements outlined in the rule.

Response: HHSC agrees with the comment and will publish a TA document that contains the employment verification requirements for use as an optional reference for operations. The document will be maintained in CCR's TA library.

Comment: Regarding §748.751, one commenter recommended HHSC explicitly clarify that the rule applies to paid employees in accordance with the other definitions in Chapter 748 and does not apply to interns or volunteers.

Response: HHSC disagrees with the comment and declines to revise the rule. The rule contains language that clarifies it applies only to applicants under consideration for employment. Moreover, Chapter 748 includes a definition for employee that specifies that an employee is a person an operation employs full-time or part-time to work for wages, salary, or other compensation.

Comment: Regarding §748.751(a)(1), one commenter recommended HHSC explicitly clarify in rule that an applicant must provide five years of employment history only when an applicant has five years of employment history.

Response: HHSC agrees with the comment and updated the rule to address situations when a person has not continuously

been employed for the last five years or has never been employed.

Comment: Regarding §748.751 and §748.753, one commenter recommended HHSC clarify that an applicant who is a survivor of commercial exploitation is not required to include employment history or list employment references from their recovery or trauma history that would violate the survivor's privacy and recovery. The commenter recommended that HHSC include suggestions for other reference options in such situations.

Response: HHSC agrees that maintaining the safety of survivors of commercial exploitation is important but declines to revise the rule because an operation may request a variance to the rules in such circumstances. HHSC added language to this effect in the TA box that follows the rule in the minimum standards courtesy publication.

Comment: Regarding §748.751(c) and §748.753(e), one commenter issued a statement of support regarding the applicability of the rules to applicants on or after August 9, 2023.

Response: HHSC appreciates support of the rules.

Comment: Regarding §748.753, one commenter recommended that the language for when an employer is unable to obtain information from a reference should mirror that for §748.751(b)(2).

Response: HHSC agrees with the comment and updated the rule to address situations when the reference is permanently unreachable.

Comment: Regarding §748.753, one commenter recommended HHSC clarify that a professional reference may be the same as someone who provides information regarding an applicant's employment history.

Response: HHSC agrees with the comment but declines to revise the rule. HHSC does not believe this recommendation warrants a rule change because the rules do not prohibit the person verifying employment from providing a reference. However, to help ensure consistent interpretation of the rules, HHSC added this clarification to the TA box that follows the rule in the minimum standards courtesy publication.

Comment: Regarding the rules in general, one commenter issued a statement of support for changes that HHSC made from the informal draft rules to the proposed rules. In particular, the commenter recognized the following changes: moving away from asking references to opine on an applicant's mental and emotional fitness; being less prescriptive in the number and manner of attempts a prospective employer must make to contact a former employer or reference; and moving away from requiring contact to every employer in preceding five years and focusing on the recent (but still significant) history.

Response: HHSC appreciates support of the rules.

Comment: Regarding the rules in general, one commenter stated the proposal will layer on administrative and compliance burdens and impede provider capacity to serve children in need without a commensurate improvement to safety, as employers are almost universally disinclined to provide the type of meaningful reference information the rule presumes that operations can obtain. The commenter stated that the rules will cause delays in hiring staff and make it even more challenging to find qualified employees.

Response: HHSC disagrees with the comment and declines to revise the rules. The rules are necessary to support the June 9, 2022, court filing regarding the June 6, 2022, status hearing in the MD v. Abbott litigation. The filing, signed by the court, refers to an agreement by HHSC to initiate rulemaking to require operations to contact all an applicant's job references prior to commencement of employment. In addition to this court filing, CCR has determined that the rules will improve the safety of children in care in general residential operations by requiring a more thorough vetting of prospective employees.

Comment: Regarding the rules in general, one commenter stated that it would have been far more impactful for HHSC to have offered meaningful technical assistance (rather than mandatory and prescriptive rules) around risk mitigation through the hiring and interview process, and ways to support new employees to minimize risk.

Response: HHSC disagrees with the comment and declines to revise the rules. The rules are necessary to support the June 9, 2022, court filing regarding the June 6, 2022, status hearing in the MD v. Abbott litigation. The filing, signed by the court, refers to an agreement by HHSC to initiate rulemaking to require operations to contact all an applicant's job references prior to commencement of employment. In addition to this court filing, CCR has determined that the rules will improve the safety of children in care in general residential operations by requiring a more thorough vetting of prospective employees. HHSC also believes that the rules and CCR's provision of meaningful technical assistance will further reduce risk to children in care.

Comment: Regarding the rules in general, one commenter recommended HHSC implement the proposed employment history verification and reference check requirements for CCR staff.

Response: HHSC disagrees with the comment. HHSC has polices that require all CCR employees to undergo both background checks and reference checks prior to employment.

Comment: Regarding the rules in general, one commenter stated that employers would need additional staff resources to meet pre-employment screening requirements, without additional funding to conduct the required activities, maintain documentation, implement quality assurance practices to assure that the activities and documentation are occurring, and for increasingly many of them, pay a third-party to carry out these functions because the administrative lift cannot be borne in-house without detriment to current programming. The commenter also asserted that regardless of whether a provider handles the activities themselves or somehow comes up with resources to pay a third-party, they will periodically be required to pay private services such as The Work Number to conduct employment verification.

Response: HHSC disagrees with the comment and declines to revise the rules. The rules are necessary to support the June 9, 2022, court filing regarding the June 6, 2022, status hearing in the MD v. Abbott litigation. The filing, signed by the court, refers to an agreement by HHSC to initiate rulemaking to require operations to contact all an applicant's job references prior to commencement of employment. In addition to this court filing, CCR has determined that the rules will improve the safety of children in care in general residential operations by requiring a more thorough vetting of prospective employees. HHSC noted that some operations may incur increased costs to implement the pre-employment screening requirements and some may not. HHSC is unable to determine the extent of the impact to individual operations due to the variability in existing screening processes across GROs.

Comment: Regarding the rules in general, one commenter recommended HHSC withdraw the proposal and allow for continued discretion in hiring by private sector employees who are already regulated.

Response: HHSC disagrees with the comment and declines to withdraw the proposal. The rules are necessary to support the June 9, 2022, court filing regarding the June 6, 2022, status hearing in the MD v. Abbott litigation. The filing, signed by the court, refers to an agreement by HHSC to initiate rulemaking to require operations to contact all an applicant's job references prior to commencement of employment. In addition to this court filing, CCR has determined that the rules will improve the safety of children in care in general residential operations by requiring a more thorough vetting of prospective employees.

SUBCHAPTER C. ORGANIZATION AND ADMINISTRATION

DIVISION 1. REQUIRED PLANS AND POLICIES, INCLUDING DURING THE APPLICATION PROCESS

26 TAC §748.105

STATUTORY AUTHORITY

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2023.

TRD-202302042
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: August 9, 2023
Proposal publication date: March 17, 2023
For further information, please call: (512) 438-3269

♦ ♦ ♦

SUBCHAPTER D. REPORTS AND RECORD KEEPING

DIVISION 3. PERSONNEL RECORDS

26 TAC §748.363

STATUTORY AUTHORITY

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2023.

TRD-202302044
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: August 9, 2023
Proposal publication date: March 17, 2023
For further information, please call: (512) 438-3269

♦ ♦ ♦

SUBCHAPTER E. PERSONNEL

DIVISION 1. GENERAL REQUIREMENTS

26 TAC §748.505

STATUTORY AUTHORITY

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2023.

TRD-202302043
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: August 9, 2023
Proposal publication date: March 17, 2023
For further information, please call: (512) 438-3269

♦ ♦ ♦

DIVISION 8. PRE-EMPLOYMENT SCREENING

26 TAC §748.751, §748.753

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Government Code §531.02011, which transferred the regulatory functions of the Texas Department of Family and Protective Services to HHSC. In addition, Texas Human Resources Code

§42.042(a) requires HHSC to adopt rules to carry out the requirements of Chapter 42 of the Texas Human Resources Code.

§748.751. What are the requirements for obtaining and verifying an applicant's employment history?

(a) Before hiring an applicant for a position, you must:

(1) Obtain in writing the applicant's employment history for the last five years, which may include:

(A) Any history for an applicant who has not continuously been employed during the last five years; or

(B) A statement that the applicant has no employment history during the last five years; and

(2) When the applicant's employment history indicates the applicant has been employed within the last five years, verify whether the applicant was employed as described in the applicant's employment history by contacting:

(A) Each employer included in the five-year employment history; or

(B) The applicant's three most recent employers, at a minimum, if the five-year employment history includes more than three employers; and

(b) If you hire the applicant, you must maintain documentation of the following in the applicant's personnel file:

(1) The applicant's employment history required by subsection (a)(1) of this section; and

(2) If the applicant has been employed in the last five years, the results of any contact with an applicant's previous employers related to employment verification. If you are unable to contact an employer or obtain the information described in subsection (a)(2) of this section from an employer:

(A) Any refusal by the employer to provide the information; or

(B) Your diligent efforts to contact the employer, which must include more than one attempt to contact an employer who is not permanently unreachable. If the employer is permanently unreachable, your documentation must include the reason why you made that determination. Examples of an employer being unreachable include:

(i) The employer is out of business and there is no alternative contact information to obtain information from the employer; or

(ii) The employer is deceased.

(c) This rule applies only to applicants who seek employment with your operation on or after August 9, 2023.

§748.753. What are the requirements for completing an applicant's reference checks?

(a) Before hiring an applicant for a position, you must complete the applicant's reference checks by:

(1) Obtaining from the applicant the name and contact information of at least two individuals unrelated to the applicant who can serve as references by answering questions related to the applicant's suitability to work with or around children; and

(2) Contacting each of the two required references to verify that the applicant is suitable to work with or around children. You may contact the reference through an interview or in writing.

(b) For an applicant who is currently or was previously employed in a position responsible for providing care or services to children within the past five years, at least one of the reference checks required in subsection (a) of this section must be a current or prior employer who has supervised or is otherwise familiar with the history and performance of the applicant in that capacity.

(c) For any reference check you are unsuccessful in completing as required by subsection (a) or (b) of this section, you must document:

(1) Any refusal by the reference to provide the information; or

(2) Your diligent efforts to contact the reference, which must include more than one attempt to contact a reference who is not permanently unreachable. If the reference is permanently unreachable, your documentation must include the reason why you made that determination. Examples of a reference being unreachable include:

(A) The reference is out of business and there is no alternative contact information to obtain information from the employer; or

(B) The reference is deceased; and

(3) Your assessment of the applicant's suitability to work with or around children.

(d) For each person you hire, you must maintain in the employee's personnel file:

(1) Documentation of each reference check that includes:

(A) The reference's name;

(B) The relation of the reference to the applicant;

(C) The reference's contact information;

(D) The date you completed the check;

(E) Information you obtained from the check, documented as:

(i) A summary of the interview; or

(ii) A copy of the written information provided by the reference; and

(F) If you conducted the check through an interview, the name of the person who interviewed the reference; and

(2) If you were unsuccessful in completing a reference check, documentation required by subsection (c) of this section.

(e) This rule applies only to applicants who seek employment with your operation on or after August 9, 2023.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2023.

TRD-202302045
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: August 9, 2023
Proposal publication date: March 17, 2023
For further information, please call: (512) 438-3269

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 19. LICENSING AND REGULATION OF INSURANCE PROFESSIONALS

The commissioner of insurance adopts the repeal of 28 TAC §§19.703, 19.1019, 19.1303, 19.1320, 19.1905, 19.3001 - 19.3005, and 19.4001 - 19.4017.

The commissioner also adopts amendments to 28 TAC §§19.103, 19.602, 19.702, 19.704 - 19.706, 19.708, 19.709, 19.712, 19.801, 19.802, 19.805, 19.902, 19.906, 19.1002, 19.1003, 19.1012, 19.1304, 19.1308, 19.1403, 19.1407, 19.1604, 19.1605, 19.1704, 19.1810, 19.1820, 19.1902, 19.1908, and 19.2004.

The repeal of 28 TAC §§19.703, 19.1019, 19.1303, 19.1320, 19.1905, 19.3001 - 19.3005, and 19.4001 - 19.4017 and §§19.103, 19.602, 19.702, 19.705, 19.706, 19.708, 19.709, 19.801, 19.802, 19.805, 19.902, 19.906, 19.1012, 19.1304, 19.1308, 19.1604, 19.1605, 19.1902, and 19.1908 are adopted without changes to the proposed text published in the January 13, 2023, issue of the *Texas Register* (48 TexReg 111) and will not be republished. Sections 19.704, 19.712, 19.1002, 19.1003, 19.1403, 19.1407, 19.1704, 19.1810, 19.1820, and 19.2004 are adopted with nonsubstantive changes to the proposed text to reflect TDI style preferences and proper punctuation and will be republished.

REASONED JUSTIFICATION. The repeal of §19.703 implements Senate Bill 1060, 84th Legislature, 2015. The repeals of §§19.1019, 19.1905, and 19.3001 - 19.3005 implement House Bill 4030, 87th Legislature, 2021. The repeal of §19.1303 eliminates the forms adopted by reference in that section that are now obsolete. The repeal of §19.1320 reflects that copies of the Texas Insurance Code and Texas Administrative Code are readily available online through the Secretary of State website. The repeals of §§19.4001 - 19.4017 remove Subchapter W, which implemented former Chapter 4154 of the Insurance Code. That chapter expired on September 1, 2017, rendering Subchapter W obsolete.

The amended sections implement HB 4030 as well as Senate Bills 1060 and 876, both of the 84th Legislature, 2015. HB 4030 removed the subagent designation, references to life and health insurance counselor and insurance service representative licenses, the affidavit requirement for nonresident public insurance adjusters, and the requirement to report and register each branch location; discontinued the registration for home office salaried employees; and increased ethics continuing education requirements. SB 1060 eliminated the trainee designation, and SB 876 changed the expiration date for a license issued to an individual.

In addition to amendments to implement the referenced legislation, the amendments also include nonsubstantive changes to conform to plain language standards and current department language preferences and drafting practices. The amendments also update citations to statutes and rules by inserting their titles, and update or eliminate obsolete email and mailing addresses.

The amended sections are described in the following paragraphs, organized by subchapter.

Subchapter B. Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, and Medicare Part D Plans.

Section 19.103. Reporting Requirement. Amendments to §19.103 replace a mailing address with a reference to contact information on TDI's website and replace "subchapter" with "title."

Subchapter G. Licensing of Insurance Adjusters.

Section 19.602. Types of Adjuster's Licenses. Amendments to §19.602 update a code reference and insert the title of a cited provision; remove subsection (c), which addresses an expiration date for adjusters' licenses, to conform with Insurance Code §4003.001; redesignate the subsections that follow subsection (c) as appropriate to reflect removal of the subsection; replaces the words "pursuant to" with "under" and the word "shall" with "must"; and correct the title of §19.801.

Subchapter H. Licensing of Public Insurance Adjusters.

Section 19.702. Types of Public Insurance Adjuster Licenses. Amendments to §19.702 update a code reference and insert the title of the provision cited, and they replace "shall" with "will" and "pursuant to" with "under."

Section 19.704. Public Insurance Adjuster Licensing. Amendments to §19.704 update code references; insert the titles of the provisions cited; remove paragraph (5) of subsection (c), which addresses a branch office registration requirement; and renumber the paragraphs that follow paragraph (5) as appropriate to reflect its removal. The amendments also replace "10 percent" with "10%." The amendments replace "shall" with more appropriate words under the context of the provision. The amendments to §19.704(l) add a comma between "Disciplinary Action" and "or Insurance Code §4102.201."

Proposed amendments to capitalize the word "commissioner" throughout the section are not adopted, based on a change to TDI's rule drafting preferences.

Section 19.705. Financial Responsibility Requirement. Amendments to §19.705 remove subsection (b) and all references to "trainee,"; update a code reference; and insert the title of a cited provision.

Section 19.706. Demonstrating Financial Responsibility. Amendments to §19.706 remove a reference to "trainee" and replace "shall" with "must."

Section 19.708. Public Insurance Adjuster Contracts. Amendments to 19.708 update the mailing address in subsection (b)(10) with the current mailing address, replace "10 percent" with "10%," replace "prior to" with "before," and replace "in determining" with "to determine." Amendments also remove a reference to a former Insurance Code provision, insert the title of another Insurance Code provision, and revise notice language to remove the use of all capital letters, to improve readability.

Section 19.709. Nonresident Applicants and License Holders. Amendments to §19.709 remove subsection (b), which addresses a nonresident affidavit requirement in order to implement HB 4030 and replaces the word "shall" with "will."

Section 19.712. Advertisement. Amendments to §19.712 update a code reference, insert the title of the provision cited, replace the phrase "internet web sites" with "websites" and replace the words "audio visual" with "audiovisual."

The text of §19.712(a) as proposed has been changed to delete an unnecessary comma.

Subchapter I. General Provisions Regarding Fees, Applications, and Renewals.

Section 19.801. General Provisions. Amendments to §19.801 remove portions of the section concerning subagents and redesignates subsections as appropriate for consistency with the proposed removal of text. The amendments replace a reference to "Texas.gov" with a reference to the department's website. The amendments also add the titles of Administrative Code and Insurance Code provisions cited in the section.

Section 19.802. Amount of Fees. Amendments to §19.802 remove portions of text concerning insurance service representatives, full-time home office salaried employee registration, and life and health insurance counselors. The amendments also remove language concerning subagent appointment fees. In addition, amendments renumber paragraphs as appropriate to reflect the removal of text, and they add the titles of cited Insurance Code provisions.

Section 19.805. Application for a New Individual License. Amendments to §19.805 insert the titles of Insurance Code and Administrative Code provisions cited in the section, remove a paragraph concerning home office salaried employees, and renumber a paragraph as appropriate to reflect this change. The amendments also replace "12 month" with "12-month," "preceding" with "before," "being" with "is," and "at the time of submitting to TDI" with "with." The amendments delete subsection (d), as that subsection is now outdated and anyone required to provide the information listed in it would have done so by now. Finally, the amendments replace a reference to §§19.1901 - 19.1910 with a reference to the subchapter where those sections are located.

Subchapter J. Standards of Conduct for Licensed Agents.

Section 19.902. One Agent, One License. Amendments to §19.902 update references to the State Board of Insurance, and they remove the branch office registration requirement. The amendments remove a reference to a form that no longer exists and instead reference instructions for registration of an agent's assumed name on TDI's website. The amendments also replace the words "shall" with "must," "utilized" with "used," "thereunder" with "under it," "which" with "that," update a code reference, and insert the titles of a Business and Commerce Code provision and an Insurance Code provision cited in the section.

Section 19.906. Last Known Address. Amendments to §19.906 update references to the State Board of Insurance, clarify that an agent's address is presumed to be the most recent address on file with the department, and replace a mailing address with a reference to filing instructions on TDI's website. The amendments also replace "shall" with "must" or "will," as appropriate.

Subchapter K. Continuing Education, Adjuster Prelicensing Education Programs, and Certification Courses.

Section 19.1002. Definitions. Amendments to §19.1002 remove references to life and health insurance counselors and insurance service representatives. The amendments correct improper citations to §19.1009(c) and §19.1009(d) by instead citing to §19.1009(g) and §19.1009(h), respectively. The amendments also remove nine uses of the word "the" and two unnecessary uses of a comma in statutory citations, remove an instance of the word "shall," replace "shall be" with "is," replace the word "subchapter" with "title," replace "as set forth in" with "under," move the word "only" to a more grammatically appropriate place, replace the word "which" with "that," update code references, and insert titles of Insurance Code provisions and other code provisions cited in the section. For clarification the amendments replace "and" with "or" in §19.1002(b)(17)(A) and newly numbered §19.1002(b)(17)(C) and insert the word "or" between newly numbered §19.1002(b)(17)(D) and (E). The text of §19.1002(b)(5) as proposed has been changed to remove a comma between "Insurance Code" and "§101.051." The text of §19.1002(b)(17)(A) as proposed has been changed to add a comma between "Subchapter I" and "concerning."

Section 19.1003. Licensee Hour and Completion Requirements. Amendments to §19.1003 change the ethics requirement specified in the section from two hours to three hours, as mandated by HB 4030. The amendments also replace the terms "prior to" with "before," "10 hour" and "24 hour" with "10-hour" and "24-hour," and "50 percent" with "50%." Finally, the amendments insert titles for Insurance Code and Administrative Code provisions cited within this section and cite subchapters in lieu of specific sections in §19.1003(a).

The text of §19.1003(a) as proposed has been changed to correct an incorrect reference to "Limited Life, Life, Accent and Health License," and change it to "Limited Life, Accident, and Health License."

Section 19.1012. Forms and Fees. Amendments to §19.1012 amend the section to generally refer interested persons to TDI's website for information on provider registration and courses. The amendments also remove an outdated mailing address and email address, and they replace "shall" with "will" where appropriate.

Subchapter N. Licensing and Regulation of Risk Managers.

Section 19.1304. Last Known Address. Amendments to §19.1304 update reference to the State Board of Insurance, clarify that a risk manager's address is presumed to be the most recent address on file with the department, and remove a mailing address, adding a reference to filing instructions on TDI's website in its place. The amendments also replace "shall" with "must" or "will," as appropriate.

Section 19.1308. Application for License. Amendments to §19.1308 update references to the State Board of Insurance and remove a mailing address, adding a reference to filing instructions on TDI's website in its place. The amendments also replace "shall" with "must."

Subchapter O. Procedures and Requirements for Reinsurance Intermediaries (Brokers and Managers).

Section 19.1403. Requirements for Bond or Errors and Omissions Policy. Amendments to §19.403 update the mailing address and recipient, and they replace "shall" with "must" or "will," as appropriate.

A proposed amendment to capitalize the word "commissioner" is not adopted, based on a change to TDI's rule drafting preferences.

Section 19.1407. Approval of Reinsurance Intermediary Manager's Contracts. Amendments to §19.1407 remove a mailing address, adding a reference to filing instructions on TDI's website in its place. The amendments also update outdated code references, insert titles of Insurance Code provisions referenced in the section, replace "shall" with "must" or "will," as appropriate, replace "which" with "that," and replace "occur in the provisions set forth in" with "are made to."

A proposed amendment to capitalize the word "commissioner" is not adopted, based on a change to TDI's rule drafting preferences.

Subchapter Q. Discount Health Care Program Registration and Renewal Requirements.

Section 19.1604. Renewal. Amendments to §19.1604 amend the section to provide that TDI will send renewal notices by email rather than mail. The amendments clarify that a discount health care program operator's current address is presumed to be the address on file with TDI. The amendments also clarify the renewal submission requirements by using plain language and replacing an address with references to TDI's website. The amendments replace "shall" with "will" and "subchapter" and "chapter" with "title," update the title of an Occupations Code section, and delete five unnecessary uses of the word "the." Finally, the amendments insert titles of Insurance Code provisions referenced in the section.

Section 19.1605. Requirements Related to Discount Health Care Program Information. Amendments to §19.1605 clarify filing requirements by removing a mailing address, email address, phone number, and fax number and instead reference TDI's website. The amendments also replace "shall" with "must," "subchapter" with "title," and delete four unnecessary uses of the word "the." Finally, the amendments insert the title of an Insurance Code provision referenced in the section.

Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy.

Section 19.1704. Certification or Registration of URAs. Amendments to §19.1704 update a mailing address with a current mailing address. The amendments also insert titles of Insurance Code provisions referenced in the section.

Proposed amendments to capitalize the word "commissioner" are not adopted, based on a change to TDI's rule drafting preferences.

Subchapter S. Forms to Request Prior Authorization.

Section 19.1810. Prior Authorization Request Form for Health Care Services, Required Acceptance, and Use. Amendments to §19.1810 replace an outdated or old mailing address with a current mailing address and insert the title of an Administrative Code section cited within the section.

Proposed amendments to capitalize the word "commissioner" are not adopted, based on a change to TDI's rule drafting preferences.

Section 19.1820. Prior Authorization Request Form for Prescription Drug Benefits, Required Acceptance, and Use. Amendments to §19.1820 replace an outdated or old mailing address with a current mailing address. The amendments also replace "facsimile (fax)" with "fax."

Proposed amendments to capitalize the word "commissioner" are not adopted, based on a change to TDI's rule drafting preferences.

Subchapter T. Specialty Insurance License.

Section 19.1902. Definitions. Amendments to §19.1902 remove the defined term "registered location" and renumber the following paragraph as appropriate. The amendments also update Insurance Code citations, replace "10 percent" with "10%," and remove "shall" as appropriate. Finally, the amendments insert titles of Insurance Code provisions referenced in the section.

Section 19.1908. Notice to Department. Amendments to §19.1908 remove a paragraph addressing locations from which insurance sales are conducted under a specialty license and renumbers the following paragraphs as appropriate. The amendments also replace "shall" with "must" and insert "or" where appropriate.

Subchapter U. Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage.

Section 19.2004. Certificate or Registration of URAs. Amendments to §19.2004 insert the word "and" and they replace an old or out of date mailing address with a current mailing address. The amendments also insert titles of Insurance Code and Administrative Code provisions referenced in the section.

Proposed amendments to capitalize the word "commissioner" are not adopted, based on a change to TDI's rule drafting preferences.

SUMMARY OF COMMENTS. The department did not receive any comments on the proposed amendments and repeals.

SUBCHAPTER B. MEDICARE ADVANTAGE PLANS, MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS, AND MEDICARE PART D PLANS

28 TAC §19.103

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.103 under Insurance Code §36.001.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301966
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER G. LICENSING OF INSURANCE ADJUSTERS

28 TAC §19.602

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.602 under Insurance Code §4101.005 and §36.001.

Insurance Code §4101.005 provides that the commissioner may adopt rules necessary to implement Insurance Code Chapter 4101 and meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301967
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER H. LICENSING OF PUBLIC INSURANCE ADJUSTERS

28 TAC §§19.702, 19.704 - 19.706, 19.708, 19.709, 19.712

STATUTORY AUTHORITY. The commissioner adopts amendments to §§19.702, 19.704 - 19.706, 19.708, 19.709, and 19.712 under Insurance Code §§4001.005, 4102.004, and 36.001.

Insurance Code §4001.005 provides that the commissioner may adopt any rules necessary to implement Title 13 of the Insurance Code and to meet the minimum requirements of federal law, including regulations.

Insurance Code §4102.004 provides that the commissioner may adopt reasonable and necessary rules to implement Insurance Code Chapter 4102.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§19.704. Public Insurance Adjuster Licensing.

(a) Any individual that desires a public adjuster license must file with the department a fully completed license application, on a form as required by the commissioner, and otherwise meet the licensing qualification requirements of Insurance Code Chapter 4102, Subchapter B, concerning License Requirements, and this subchapter.

(b) Any corporation or partnership that desires a public insurance adjuster license must file with the department a fully completed license application on a form as required by the commissioner.

(c) The department will issue a license to a resident or nonresident corporation or partnership if the department finds that:

(1) the corporation or partnership is:

(A) organized under the laws of this state or any other state or territory of the United States;

(B) admitted to conduct business in this state by the secretary of state, if required; and

(C) authorized by its articles of incorporation or its partnership agreement to act as a public insurance adjuster;

(2) the corporation or partnership meets the definition of that entity adopted under Insurance Code §4001.003, concerning Definitions;

(3) at least one officer of the corporation or one active partner of the partnership and all other persons performing any acts of a public insurance adjuster on behalf of the corporation or partnership in this state are individually licensed by the department separately from the corporation or partnership;

(4) the corporation or partnership intends to be actively engaged in the business of public insurance adjusting;

(5) the corporation or partnership has submitted the application, appropriate fees, proof of financial responsibility, and any other information required by the department; and

(6) no officer, director, member, manager, partner, or any other person who has the right or ability to control the license holder has:

(A) had a license suspended or revoked or been the subject of any other disciplinary action by a financial or insurance regulator of this state, another state, or the United States; or

(B) committed an act for which a license may be denied under Insurance Code §4005.101, concerning Grounds for License Denial or Disciplinary Action, or §4102.201, concerning Denial, Suspension, or Revocation of License.

(d) Nothing contained in this section may be construed to permit any unlicensed employee or representative of any corporation or partnership to perform any act of a public insurance adjuster without obtaining a public insurance adjuster license.

(e) Each corporation or partnership applying for a public insurance adjuster license must file, under oath, on a form developed by the department, biographical information for each of its executive officers and directors or unlicensed partners who administer the entity's operations in this state, and shareholders who are in control of the corporation, or any other partners who have the right or ability to control the partnership. If any corporation or partnership is owned, in whole or in part, by another entity, a biographical form is required for each individual who is in control of the parent entity.

(f) Each corporation or partnership must notify the department not later than the 30th day after the date of:

(1) a felony conviction of a licensed public insurance adjuster of the entity or any individual associated with the corporation or partnership who is required to file biographical information with the department;

(2) an event that would require notification under Insurance Code §81.003, concerning Notification of Certain Disciplinary Actions Occurring in Other States; Civil Penalty; and

(3) the addition or removal of an officer, director, partner, member, or manager.

(g) A person may not acquire in any manner any ownership interest in an entity licensed as a public insurance adjuster under this subchapter if the person is, or after the acquisition would be directly or indirectly in control of the license holder, or otherwise acquire control of or exercise any control over the license holder, unless the person has filed the following information with the department under oath:

(1) a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected;

(2) a statement certifying that no person who is acquiring an ownership interest in or control of the license holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United States;

(3) a statement certifying that, immediately on the change of control, the license holder will be able to satisfy the requirements for the issuance of the public insurance adjuster license; and

(4) any additional information that the commissioner may prescribe as necessary or appropriate to the protection of the insurance consumers of this state or as in the public interest.

(h) If a person required to file a statement under subsection (g) of this section is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information required by paragraphs (1) - (4) of that subsection for an individual be provided regarding each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If the partner, member, or person is a corporation or the person required to file the statement under subsection (g) of this section is a corporation, the commissioner may require that the information required by paragraphs (1) - (4) of that subsection be provided regarding:

(1) the corporation;

(2) each individual who is an executive officer or director of the corporation; and

(3) each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

(i) The department may disapprove an acquisition of control if, after notice and opportunity for hearing, the commissioner determines that:

(1) immediately on the change of control the license holder would not be able to satisfy the requirements for the public insurance adjuster license;

(2) the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the license holder are such that it would not be in the interest of the insurance consumers of this state to permit the acquisition of control; or

(3) the acquisition of control would violate the Insurance Code or another law of this state, another state, or the United States.

(j) Notwithstanding subsection (h) of this section, a change in control is considered approved if the department has not proposed to deny the requested change before the 61st day after the date the department receives all information required by this section.

(k) The commissioner is the corporation's or partnership's agent for service of process in the manner provided by Insurance Code Chapter 804, concerning Service of Process, in a legal proceeding against the corporation or partnership if:

(1) the corporation or partnership licensed to transact business in this state fails to appoint or maintain an agent for service in this state;

(2) an agent for service cannot with reasonable diligence be found; or

(3) the license of a corporation or partnership is revoked.

(l) If a license holder does not maintain the qualifications necessary to obtain the license, the department will revoke or suspend the license or deny the renewal of the license under Insurance Code §4005.101, concerning Grounds for License Denial or Disciplinary Action, or Insurance Code §4102.201, concerning Denial, Suspension, or Revocation of License.

(m) Each public insurance adjuster must maintain all insurance records, including all records relating to customer complaints received from customers and the department, separate from the records of any other business in which the person may be engaged and in the manner specified in Insurance Code Chapter 4102, concerning Public Insurance Adjusters.

(n) The department may license a depository institution or entity chartered by the federal Farm Credit Administration under the farm credit system established under 12 U.S.C. Section 2001 et seq., as amended, to act as a public insurance adjuster in the manner provided for the licensing of a corporation under this section.

§19.712. Advertisement.

(a) As used in Insurance Code Chapter 4102, concerning Public Insurance Adjusters, "advertisement" includes:

(1) printed and published material, audiovisual material and descriptive literature of a public insurance adjuster used in direct mail, newspapers, magazines, radio, telephone and television scripts, websites, billboards, and similar displays;

(2) descriptive literature and promotional aids of all kinds issued by a public insurance adjuster for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters;

(3) prepared promotional talks, presentations and materials for use by a public insurance adjuster, and those representations made on a recurring basis by a public insurance adjuster to members of the public;

(4) material used to:

(A) solicit contracts from insureds; or

(B) modify existing contracts;

(5) material included with a contract when the contract is delivered and materials used in the solicitation of contract renewals, extensions or reinstatements, except those extensions or reinstatements provided for in the contract;

(6) lead card solicitations, defined as communications distributed to the public which, regardless of form, content, or stated purpose, are intended to result in the compilation or qualification of a list containing names or other personal information regarding insureds who have expressed a specific interest in obtaining assistance with having their claims settled, and which are intended to be used to solicit residents of this state for the execution of a contract for a public insurance adjuster's services; and

(7) any other communication directly or indirectly related to a public insurance adjuster contract, and intended to result in the eventual execution of such a contract.

(b) "Advertisement" does not include:

(1) communications or materials used within a public insurance adjuster's own organization, not used as promotional aids and not disseminated to the public;

(2) communications with insureds other than materials soliciting insureds to enter, renew, extend or reinstate a contract for a public insurance adjuster's services; and

(3) material used solely for the recruitment, training, and education of a public insurance adjuster's personnel and subcontractors, provided it is not also used to induce the public to enter, renew, extend or reinstate a contract for a public insurance adjuster's services.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301968
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

28 TAC §19.703

STATUTORY AUTHORITY. The commissioner adopts the repeal of §19.703 under Insurance Code §4102.004 and §36.001.

Insurance Code §4102.004 provides that the commissioner may adopt reasonable and necessary rules to implement Insurance Code Chapter 4102.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202302028
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER I. GENERAL PROVISIONS REGARDING FEES, APPLICATIONS, AND RENEWALS

28 TAC §§19.801, 19.802, 19.805

STATUTORY AUTHORITY. The commissioner adopts amendments to §§19.801, 19.802, and 19.805 under Insurance Code §4001.005 and §36.001.

Insurance Code §4001.005 provides that the commissioner may adopt any rules necessary to implement Title 13 of the Insurance Code and to meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301970
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER J. STANDARDS OF CONDUCT FOR LICENSED AGENTS

28 TAC §19.902, §19.906

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.902 and §19.906 under Insurance Code §4001.005 and §36.001.

Insurance Code §4001.005 provides that the commissioner may adopt any rules necessary to implement Title 13 of the Insurance Code and to meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301971
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER K. CONTINUING EDUCATION, ADJUSTER PRELICENSING EDUCATION PROGRAMS, AND CERTIFICATION COURSES

28 TAC §§19.1002, 19.1003, 19.1012

STATUTORY AUTHORITY. The commissioner adopts amendments to §§19.1002, 19.1003, and 19.1012 under Insurance Code §4001.005 and §36.001.

Insurance Code §4001.005 provides that the commissioner may adopt any rules necessary to implement Title 13 of the Texas Insurance Code and to meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§19.1002. Definitions.

(a) Words and terms defined in Insurance Code §4001.003, concerning Definitions; §4004.151, concerning Agent Education Programs; or §4004.201, concerning Definition have the same meaning when used in this subchapter.

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

(1) Adjuster--An individual licensed under Insurance Code Chapter 4101, concerning Insurance Adjusters.

(2) Application level--Demonstration of the ability to use learned materials in a new situation, usually involving the application of rules, policies, methods, computations, laws, theories, or any other relevant and available information.

(3) Assignee--Any provider that is authorized under §19.1008(f) of this title (relating to Certified Course Advertising, Modification, and Assignment).

(4) Authorized provider representative--The individual a provider designates as the contact individual responsible for all of the provider's communications and filings with the department.

(5) Business of insurance--Has the same meaning as set forth in Insurance Code §101.051, concerning Conduct that Constitutes the Business of Insurance.

(6) Classroom course--A course complying with §19.1009(g) of this title (relating to Types of Courses).

(7) Classroom equivalent course--A course complying with §19.1009(h) of this title.

(8) Certificate of completion--A document complying with §19.1007(a)(7) of this title (relating to Course Certification Submission Applications, Course Expirations, and Resubmissions).

(9) Certification course--A course designed to enhance the student's knowledge, understanding, and professional competence regarding specified subjects for an insurance product. The term includes courses that satisfy the requirements for the Long-Term Care Certification required by Insurance Code Chapter 1651, Subchapter C, concerning Partnership for Long-Term Care Program and Human Resources Code Chapter 32, Subchapter F, concerning Partnership for Long-Term Care Program; the Medicare-Related Product Certification required by Insurance Code Chapter 4004, Subchapter D, concerning Agent Education Programs; the Small Employer Health Benefit Plan Specialty Certification required by Insurance Code Chapter 4054, Subchapter H, concerning Specialty Certification for Agents Serving Certain Employer Groups; and the Annuity Certification required by Insurance Code §1115.056, concerning Agent Training Requirements.

(10) Certified course--A classroom, classroom equivalent, or self-study course offered by a registered provider that the department or its designee has determined meets the requirements of this subchapter.

(11) Department--Texas Department of Insurance.

(12) Disinterested third party--An individual who is:

(A) not related to a student by blood, adoption, or marriage as a parent, child, grandparent, sibling, niece, nephew, aunt, uncle, or first cousin; or

(B) not an employee or subordinate of the student.

(13) Ethics course--A course that deals with usage and customs among members of the insurance profession, involving their moral and professional duties toward one another, toward clients, toward insureds, and toward insurers.

(14) Insurance course--A course primarily focused on teaching subjects related to the business of insurance.

(15) Interactive inquiries--An interactive electronic component that complies with §19.1009(g)(2) of this title.

(16) Knowledge level--Recall of specific facts, patterns, methods, rules, dates, or other information that must be committed to memory.

(17) Licensee--An individual licensed under one or more of the following Insurance Code provisions:

(A) Chapter 4051, Subchapter B, concerning General Property and Casualty License; Subchapter C, concerning Limited Property and Casualty License; Subchapter E, concerning County Mutual Agent License; or Subchapter I, concerning Personal Lines Property and Casualty Agent;

(B) Chapter 4053, concerning Managing General Agents;

(C) Chapter 4054, Subchapter B, concerning General Life, Accident, and Health License; Subchapter C, concerning Limited Life, Accident, and Health License; Subchapter E, concerning Life Insurance Not Exceeding $25,000; or Subchapter G, concerning Life Agent;

(D) Chapter 4101, concerning Insurance Adjusters; or

(E) Chapter 4102, concerning Public Insurance Adjusters.

(18) Long-term care partnership insurance policy--For purposes of §19.1022 of this title (relating to Long-Term Care Partnership Certification Course) and §19.1023 of this title (relating to Long-Term Care Partnership Continuing Education) only, a policy established under Human Resources Code Chapter 32, Subchapter F, and Insurance Code Chapter 1651, Subchapter C.

(19) National designation certification--A professional designation that is:

(A) nationally recognized in the insurance industry; and

(B) issued by an entity that maintains a not-for-profit status and has been in existence for at least five years.

(20) One-time-event--A type of classroom course complying with §19.1009(j) of this title.

(21) Provider--An individual or organization including a corporation, partnership, depository institution, insurance company, or entity chartered by the Farm Credit Administration as defined in Insurance Code §4001.108, concerning Issuance of License to Entity Chartered by Federal Farm Credit Administration, registered with the department to offer continuing education courses for licensees, prelicensing instruction for adjusters, or long-term care partnership certification courses for licensees.

(22) Provider registration--The process of a provider seeking permission to offer continuing education courses for licensees, prelicensing education for adjusters, or long-term care partnership certification courses for licensees.

(23) Qualifying course--Insurance courses for which a licensee may receive continuing education credit and are:

(A) offered for credit by accredited colleges, universities, or law schools;

(B) part of a national designation certification program;

(C) approved for classroom, classroom equivalent, or participatory credit by the continuing education approval authority of a state bar association or state board of public accountancy; or

(D) certified or approved for continuing education credit under the guidelines of the Federal Crop Insurance Corporation.

(24) Reporting period--The period from the issue date or last renewal date of the license to the expiration date of the license, generally a two-year period.

(25) Self-study--A course complying with §19.1009(i) of this title.

(26) Speaker--An individual who is speaking from special knowledge regarding the business of insurance obtained through experience and position in professional or social organizations, industry, or government.

(27) Student--A licensee or adjuster applicant enrolled in and attending a certified course for credit.

(28) TDI license number--An identification number the department assigns to the licensee and found on the license certificate.

(29) Visually monitored environment--An environment permitting visual identification of students and visual confirmation of attendance, including observation by camera.

§19.1003. Licensee Hour and Completion Requirements.

(a) Continuing education hour requirement. Except as provided in subsections (c) - (e) of this section, for each license and reporting period that the individual is licensed, each licensee must complete 24 hours of continuing education, except that licensees holding only a license issued under Insurance Code Chapter 4051, Subchapter C, concerning Limited Property and Casualty License; Chapter 4051, Subchapter E, concerning County Mutual Agent License; Chapter 4054, Subchapter C, concerning Limited Life, Accident, and Health License; or Chapter 4054, Subchapter E, concerning Life Insurance not Exceeding $25,000 must complete 10 hours of continuing education. The following requirements apply:

(1) licensees must:

(A) complete all required continuing education hours during the reporting period to avoid fines and be eligible to renew the license. A licensee who obtains a new license during the reporting period for an existing license held by the licensee may count all prior continuing education credits earned in the reporting period for the active license towards the new license if the licenses have the same expiration date;

(B) complete at least two hours of the licensee's continuing education requirement in certified ethics or consumer protection courses;

(C) complete at least 50% of the licensee's required continuing education hours in certified classroom or classroom equivalent courses; and

(D) complete the remainder of the continuing education requirement by completing certified courses applicable to any license type.

(2) Continuing education credit will not be granted for:

(A) any continuing education course credit received before the date the license is issued by TDI, including course credit earned while acting under a temporary license or a provisional permit, towards complying with the licensee's applicable continuing education requirement, except as provided in §19.1021 of this title (relating to Flood Insurance Education Course) and subsection (e) of this section;

(B) carry forward excess hours completed in one reporting period to a subsequent reporting period; or

(C) the current reporting period for any credit hours completed under Insurance Code §4004.055, concerning Consequences of Failure to Complete Continuing Education Requirement, to correct a shortage of hours in a previous reporting period.

(b) Maximum hour requirement. Licensees holding more than one license issued under the Insurance Code are not required to complete more than the number of continuing education hours required under their greatest single license requirement for a license held by the licensee during the reporting period, three hours of which must be in certified ethics or consumer protection courses, within each reporting period. This requirement applies even if the licensee chooses to cancel or nonrenew the license with the requirement. If the licensee is required to complete certain continuing education courses or course hours to maintain a voluntary certification, including certifications under §19.1022 of this title (relating to Long-Term Care Partnership Certification Course), §19.1023 of this title (relating to Long-Term Care Partnership Continuing Education), §19.1024 of this title (relating to Medicare-Related Product Certification Course), §19.1025 of this title (relating to Medicare-Related Product Continuing Education), §19.1026 of this title (relating to Small Employer Health Benefit Plan Specialty Certification Course), §19.1027 of this title (relating to Small Employer Health Benefit Plan Specialty Continuing Education), §19.1028 of this title (relating to Annuity Certification Course), and §19.1029 of this title (relating to Annuity Continuing Education), the licensee must complete the requirement to maintain the certification even if the total number of hours would exceed the limit specified in this subsection.

(c) Adjuster prelicensing education. Adjuster applicants seeking an examination exemption under Insurance Code §4101.056(a)(4), concerning Exemption from Examination Requirement, must complete both a certified adjuster prelicensing education course of not less than 40 hours, and pass the course examination testing the applicant's knowledge and qualifications set forth in this subchapter. Adjuster applicants must complete at least 30 hours of the course requirement through classroom or classroom equivalent course work.

(d) Prorated requirement. Licensees holding a license that was issued with a term of less than two years and those licensees who convert from nonresident to resident licenses during a reporting period, excluding adjusters with a license under which Texas is the designated home state, must complete continuing education hours based on a prorated schedule, as follows:

(1) for license types with a 24-hour requirement, one hour for each whole month between the issue or last renewal date of the license, or the date of Texas residency, to the end of the license period up to the maximum number of hours required for the license type during the reporting period; and

(2) for license types with a 10-hour requirement, the number of hours required in Figure: 28 TAC §19.1003(d)(2) for the license period between the issue date or last renewal date of the license, or the date of Texas residency, to the end of the license period up to the maximum number of hours required for the license type during the reporting period.

Figure: 28 TAC §19.1003(d)(2)

(3) Notwithstanding paragraphs (1) and (2) of this subsection, a licensee is not required to complete continuing education for the reporting period if the prorated reporting period is less than six months; and

(4) a licensee may not apply hours completed before becoming a Texas resident licensee towards compliance with the continuing education requirement.

(e) Texas designated home state adjuster requirement. A designated home state adjuster licensee under which Texas is the designated home state must complete continuing educations under the same requirements as a Texas resident adjuster. A licensee that converts from the Texas designated home state adjuster license to a Texas resident adjuster license during the reporting period:

(1) must complete continuing education in the same manner as a Texas resident adjuster for the combined period the individual held the Texas designated home state adjuster license and the Texas resident adjuster license; and

(2) does not qualify for completing continuing education on a prorated basis if the licensee becomes a Texas resident between renewals of the Texas designated home state adjuster license.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301972
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

28 TAC §19.1019

STATUTORY AUTHORITY. The commissioner adopts the repeal of §19.1019 under Insurance Code §4001.005 and §36.001.

Insurance Code §4001.005 provides that the commissioner may adopt any rules necessary to implement Title 13 of the Insurance Code and to meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202302030
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER N. LICENSING AND REGULATION OF RISK MANAGERS

28 TAC §19.1303, §19.1320

STATUTORY AUTHORITY. The commissioner adopts the repeal of §19.1303 and §19.1320 under Insurance Code under Insurance Code §4153.003 and §36.001.

Insurance Code §4153.003 provides that the commissioner may adopt rules necessary to carry out Chapter 4153 and to regulate risk managers.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202302031
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

28 TAC §19.1304, §19.1308

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.1304 and §19.1308 under Insurance Code §4153.003 and §36.001.

Insurance Code §4153.003 provides that the commissioner may adopt rules necessary to carry out Chapter 4153 and to regulate risk managers.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301974
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER O. PROCEDURES AND REQUIREMENTS FOR REINSURANCE INTERMEDIARIES (BROKERS AND MANAGERS)

28 TAC §19.1403, §19.1407

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.1403 and §19.1407 under Insurance Code §4152.004 and §36.001.

Insurance Code §4152.004 provides that the commissioner may adopt reasonable rules as necessary to implement Chapter 4152.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§19.1403. Requirements for Bond or Errors and Omissions Policy.

Any reinsurance intermediary must file and maintain a bond with the commissioner for the protection of all insurers represented or file and maintain an errors and omissions policy, meeting the following criteria.

(1) The bond must be executed by the reinsurance intermediary as principal and by a surety company authorized to do business in this state, as surety, or surplus lines insurer eligible in this state, in the principal sum of $100,000 for a broker and in the principal sum of $250,000 for a manager, payable to the Texas Department of Insurance for the use and benefit of all insurers represented. The bond must provide that a copy of any cancellation or nonrenewal notice must be mailed to Agent and Adjuster Licensing Office, Texas Department of Insurance, MC: CO-AAL, P.O. Box 12030, Austin, Texas 78711-2030. The executed bond must be furnished to the Texas Department of Insurance.

(2) The errors and omissions policy must be in a form acceptable to the Texas Department of Insurance, and must be filed with Agent and Adjuster Licensing Office at the address listed in paragraph (1) of this section. The policy must provide that the Texas Department of Insurance will be a certificate holder and will receive a copy of any cancellation or nonrenewal notice, which must be mailed to the deputy commissioner for licensing at the address listed in paragraph (1) of this section. The errors and omissions policy must cover all negligent acts or omissions of the reinsurance intermediary and any person acting on its behalf and must provide coverage of at least $100,000 for each occurrence for brokers and must provide coverage of at least $250,000 for each occurrence for managers.

(3) The commissioner may determine that special circumstances require an additional amount of coverage for the bond or policy.

§19.1407. Approval of Reinsurance Intermediary Manager's Contracts.

(a) A written contract, which specifies the responsibilities of each party, must be approved by the insurer's board of directors or attorney in fact and executed by a responsible officer of an insurer and a manager prior to entering into any transaction between the manager and the insurer.

(b) A copy of the executed contract and the approval of the insurer's board of directors or attorney in fact must be filed by the manager with the commissioner for approval at least 30 days before the insurer assumes or cedes any business through the manager.

(c) The contract must include the minimum requirements specified in Insurance Code §4152.201, concerning Contract Between Manager and Insurer. A contract that does not comply with the minimum requirements of the Insurance Code or this section will not be considered to have been filed with the commissioner for approval. The contract will be approved or disapproved within 30 days of its filing.

(d) A failure to file complete and accurate information in all material respects is grounds for disapproval of the contract by the commissioner under Insurance Code §4152.201.

(e) Any disapproval by the commissioner of any contract filed under this section will set forth the specific reasons for such disapproval.

(f) If any material changes are made to the contract filed with the commissioner, an amended contract setting forth such changes must be filed with the commissioner for approval as if it were a new contract.

(g) Contracts subject to this section and Insurance Code §4152.201, must be filed using the method described on the department's website for the purpose of determining compliance with this section. Telephonic or fax transmissions will not constitute proper filing under this section.

(h) This section will be cumulative of and in addition to the requirements of Insurance Code Chapter 4053, concerning Managing General Agents; Chapter 4152, concerning Reinsurance Intermediaries; and Chapter 823, concerning Insurance Holding Company Systems, and related regulations. Nothing contained in this section is intended to exempt an insurer or its reinsurance intermediary manager from other provisions of the Insurance Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301975
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER Q. DISCOUNT HEALTH CARE PROGRAM REGISTRATION AND RENEWAL REQUIREMENTS

28 TAC §19.1604, §19.1605

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.1604 and §19.1605 under Insurance Code §7001.003 and §36.001.

Insurance Code §7001.003 provides that the commissioner will adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement Chapter 7001.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301976

Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY
DIVISION 1. UTILIZATION REVIEWS

28 TAC §19.1704

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.1704 under Insurance Code §4201.003(a) and §36.001.

Insurance Code §4201.003(a) provides that the commissioner may adopt rules to implement Chapter 4201.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§19.1704. Certification or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code §4201.057, concerning Health Maintenance Organizations; Insurance Code §4201.058, concerning Insurers; or Insurance Code §4201.101, concerning Certificate of Registration Required, and this subchapter.

(1) If an insurance carrier or HMO performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier or HMO must be certified.

(2) If an insurance carrier or HMO performs utilization review only for coverage for which it is the payor, the insurance carrier or HMO must be registered.

(b) Application form. The commissioner adopts by reference the:

(1) URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Biographical affidavit, to be used as an attachment to the URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send the URA application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, MC: LH-MCQA, P.O. Box 12030, Austin, Texas 78711-2030.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application or request additional time in writing within 15 working days of the date of TDI's latest notice of the omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting the URA application form to TDI. The URA must also submit a renewal fee in the amount specified by §19.802(b)(19) of this title for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less, a URA may renew the certification or registration by sending a completed renewal application and fee, as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to comply with this subchapter within 90 calendar days after the effective date of this rule. However, the submission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301977

Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER S. FORMS TO REQUEST PRIOR AUTHORIZATION
DIVISION 2. TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

28 TAC §19.1810

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.1810 under Insurance Code §1217.004(a)(1) and §36.001.

Insurance Code §1217.004(a)(1) provides that the commissioner by rule prescribe a single, standard form for requesting prior authorization of health care services.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§19.1810. Prior Authorization Request Form for Health Care Services, Required Acceptance, and Use.

(a) Form requirements. The commissioner adopts by reference the Prior Authorization Request Form for Health Care Services, to be accepted and used by an issuer in compliance with subsection (b) of this section. The form and its instruction sheet are posted on the TDI website at www.tdi.texas.gov/forms/form10.html; or the form and its instruction sheet can be requested by mail from the Texas Department of Insurance, Rate and Form Review Office, MC: LH-MCQA, P.O. Box 12030, Austin, Texas 78711-2030. The form must be reproduced without changes. The form provides space for the following information:

(1) the plan issuer's name, telephone number, and facsimile (fax) number;

(2) the date the request is submitted;

(3) the type of review, whether:

(A) nonurgent; or

(B) urgent. An urgent review should only be requested for a patient with a life-threatening condition or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. A provider or facility may also request an urgent review to authorize treatment of an acute injury or illness if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health;

(4) the type of request (whether an initial request or an extension, renewal, or amendment of a previous authorization);

(5) the patient's name, date of birth, sex, contact telephone number, and identifying insurance information;

(6) the requesting provider's or facility's name, NPI number, specialty, telephone and fax numbers, contact person's name and telephone number, and the requesting provider's signature and date, if required (if a signature is required, a signature stamp may not be used);

(7) the service provider's or facility's name, NPI number, specialty, and telephone and fax numbers;

(8) the primary care provider's name and telephone and fax numbers, if the patient's plan requires the patient to have a primary care provider and that provider is not the requesting provider;

(9) the planned services or procedures and the associated CPT, CDT, or HCPCS codes, and the planned start and end dates of the services or procedures;

(10) the diagnosis description, ICD version number (if more than one version is allowed by the U.S. Department of Health and Human Services), and ICD code;

(11) identification of the treatment location (inpatient, outpatient, provider office, observation, home, day surgery, or other specified location);

(12) information about the duration and frequency of treatment sessions for physical, occupational, or speech therapy, cardiac rehabilitation, mental health, or substance abuse;

(13) if requesting prior authorization for home health care, information about the requested number of home health visits and their duration and frequency, and an indication whether a physician's signed order or a nursing assessment is attached;

(14) if requesting prior authorization for durable medical equipment, an indication whether a physician's signed order is attached, a description of requested equipment or supplies with associated HCPCS codes, duration, and, if the patient is a Medicaid beneficiary, an indication whether a Title 19 Certification is attached;

(15) a place for the requester to include a brief narrative of medical necessity or other clinical documentation. A requesting provider or facility may also attach a narrative of medical necessity and supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.); and

(16) if a requesting provider wants to be called directly about missing information, a place to list a direct telephone number for the requesting provider or facility the issuer can call to ask for additional or missing information if needed to process the request. The phone call can only be considered a peer-to-peer discussion required by §19.1710 of this title (relating to Requirements Prior to Issuing an Adverse Determination) if it is a discussion between peers that includes, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(b) Acceptance and use of the form.

(1) If a provider or facility submits the form to request prior authorization of a health care service for which the issuer's plan requires prior authorization, the issuer must accept and use the form for that purpose. An issuer may also have on its website another electronic process a provider or facility may use to request prior authorization of a health care service.

(2) This form may not be used by a provider or facility:

(A) to request an appeal;

(B) to confirm eligibility;

(C) to verify coverage;

(D) to ask whether a service requires prior authorization;

(E) to request prior authorization of a prescription drug; or

(F) to request a referral to an out of network physician facility or other health care provider.

(c) Effective date. An issuer must accept a request for prior authorization of health care services made by a provider or facility using the form on or after September 1, 2015.

(d) Availability of the form.

(1) A health benefit plan issuer must make the form available on paper and electronically on its website.

(2) A health benefit plan issuer's agent that manages or administers health care services benefits must make the form available on paper and electronically on its website.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301978
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

DIVISION 3. TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

28 TAC §19.1820

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.1820 under Insurance Code §1369.304(a)(1) and §36.001.

Insurance Code §1369.304(a)(1) provides that the commissioner by rule prescribe a single, standard form for requesting prior authorization of prescription drug benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§19.1820. Prior Authorization Request Form for Prescription Drug Benefits, Required Acceptance, and Use.

(a) Form requirements. The commissioner adopts by reference the Prior Authorization Request Form for Prescription Drug Benefits form, to be accepted and used by an issuer in compliance with subsection (b) of this section. The form and its instruction sheet are on TDI's website at www.tdi.texas.gov/forms/form10.html; or the form and its instruction sheet can be requested by mail from the Texas Department of Insurance, Rate and Form Review Office, MC: LH-MCQA, PO Box 12030, Austin, Texas 78711-2030. The form must be reproduced without changes. The form provides space for the following information:

(1) the name of the issuer or the issuer's agent that manages prescription drug benefits, telephone number, and fax number;

(2) the date the request is submitted;

(3) a place to request an expedited or urgent review if the prescribing provider or the prescribing provider's designee certifies that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function;

(4) the patient's name, contact telephone number, date of birth, sex, address, and identifying insurance information;

(5) the prescribing provider's name, NPI number, specialty, telephone and fax numbers, address, and contact person's name and telephone number;

(6) for a prescription drug:

(A) drug name;

(B) strength;

(C) route of administration;

(D) quantity;

(E) number of days' supply;

(F) expected therapy duration; and

(G) to the best of the prescribing provider's knowledge, whether the medication is:

(i) a new therapy; or

(ii) continuation of therapy, and if so, to the best of the prescribing provider's knowledge:

(I) the approximate date therapy was initiated;

(II) whether the patient is adhering to the drug therapy regimen; and

(III) whether the drug therapy regimen is effective;

(7) for a provider administered drug, the HCPCS code, NDC number, and dose per administration;

(8) for a prescription compound drug, its name, ingredients, and each ingredient's NDC number and quantity;

(9) for a prescription device, its name, expected duration of use, and, if applicable, its HCPCS code;

(10) the patient's clinical information, including:

(A) diagnosis, ICD version number (if more than one version is allowed by the U.S. Department of Health and Human Services), and ICD code;

(B) to the best of the prescribing provider's knowledge, the drugs the patient has taken for this diagnosis, including:

(i) drug name, strength, and frequency;

(ii) the approximate dates or duration the drugs were taken; and

(iii) patient's response, reason for failure, or allergic reaction;

(C) the patient's drug allergies, if any; and

(D) the patient's height and weight, if relevant;

(11) a list of relevant lab tests, and their dates and values;

(12) a place for the prescribing provider to:

(A) include pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency;

(B) explain any comorbid conditions and contraindications for formulary drugs; or

(C) provide details regarding titration regimen or oncology staging, if applicable; and

(13) a directive to the prescribing provider stating that:

(A) for a request for prior authorization of continuation of therapy (other than a request for a step-therapy exception as provided in subparagraph (B) of this paragraph), it is not necessary to complete the sections of the form regarding patient clinical information and justification for the therapy unless there has been a material change in the information previously provided; and

(B) for a request for a step-therapy exception, the section of the form regarding justification for the step-therapy exception must be completed.

(b) Acceptance and use of the form.

(1) If a prescribing provider submits the form to request prior authorization of a prescription drug benefit for which the issuer's plan requires prior authorization, the issuer must accept and use the form for that purpose. An issuer may also have on its website another electronic process a prescribing provider may use to request prior authorization of a prescription drug benefit.

(2) This form may be used by a prescribing provider to request prior authorization of:

(A) a prescription drug;

(B) a prescription device;

(C) formulary exceptions;

(D) quantity limit overrides; and

(E) step-therapy requirement exceptions.

(3) This form may not be used by a prescribing provider to:

(A) request an appeal;

(B) confirm eligibility;

(C) verify coverage;

(D) ask whether a prescription drug or device requires prior authorization; or

(E) request prior authorization of a health care service.

(c) Effective date. An issuer must accept a request for prior authorization of prescription drug benefits made by a prescribing provider using the form on or after the effective date of this section. An issuer must accept a request using the form that was in place prior to the effective date of this section for 90 days after the effective date.

(d) Availability of the form.

(1) A health benefit plan issuer must make the form available electronically on its website.

(2) A health benefit plan issuer's agent that manages or administers prescription drug benefits must make the form available electronically on its website.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301979
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

SUBCHAPTER T. SPECIALTY INSURANCE LICENSE

28 TAC §19.1902, §19.1908

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.1902 and §19.1908 under Insurance Code §§4055.003, 4102.004, and 36.001.

Insurance Code §4055.003 provides that the commissioner may adopt rules necessary to implement Insurance Code Chapter 4055 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §4102.004 provides that the commissioner may adopt reasonable and necessary rules to implement Insurance Code Chapter 4102.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301980
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

28 TAC §19.1905

STATUTORY AUTHORITY. The commissioner adopts the repeal of §19.1905 under Insurance Code §§4055.003, 4102.004, and 36.001.

Insurance Code §4055.003 provides that the commissioner may adopt rules necessary to implement Insurance Code Chapter 4055 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §4102.004 provides that the commissioner may adopt reasonable and necessary rules to implement Insurance Code Chapter 4102.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202302032
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE

28 TAC §19.2004

STATUTORY AUTHORITY. The commissioner adopts amendments to §19.2004 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§19.2004. Certificate or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code §4201.057, concerning Health Maintenance Organizations; Insurance Code §4201.058, concerning Insurers; or Insurance Code §4201.101, concerning Certificate of Registration Required, and this subchapter.

(1) If an insurance carrier performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier must be certified.

(2) If an insurance carrier performs utilization review only for coverage for which it is the payor, the insurance carrier must be registered.

(b) Application form. The commissioner adopts by reference the:

(1) URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Biographical affidavit, to be used as an attachment to the URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send the URA application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, MC: LH-MCQA, P.O. Box 12030, Austin, Texas 78711-2030.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application, or request additional time in writing, within 15 working days of the date of TDI's latest notice of omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting the URA application to TDI. A URA must also submit a renewal fee in the amount specified by §19.802 of this title (relating to Amount of Fees) for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less, the URA may renew the certification or registration by sending a completed renewal application and fee as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to comply with this subchapter within 90 calendar days after the effective date of this rule. However, the sub-

mission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301982
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER V. REGISTRATION OF FULL TIME HOME OFFICE SALARIED EMPLOYEES

28 TAC §§19.3001 - 19.3005

STATUTORY AUTHORITY. The commissioner adopts the repeal of Subchapter V of Chapter 19, consisting of §§19.3001 - 19.3005, under Insurance Code §§4001.005 and §36.001.

Insurance Code §4001.005 provides that the Commissioner may adopt any rules necessary to implement Title 13 of the Insurance Code and to meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301964
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

SUBCHAPTER W. REGULATION OF NAVIGATORS FOR HEALTH BENEFIT EXCHANGES

28 TAC §§19.4001 - 19.4017

STATUTORY AUTHORITY. The commissioner adopts the repeal of Subchapter W, consisting of §§19.4001 - 19.4017, under Insurance Code §36.001.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

TRD-202301965
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: June 19, 2023
Proposal publication date: January 13, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦

TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 7. PREPAID HIGHER EDUCATION TUITION PROGRAM

SUBCHAPTER N. TEXAS ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) PROGRAM

34 TAC §§7.181, 7.182, 7.187

The Comptroller of Public Accounts adopts amendments to §7.181, concerning definitions, §7.182, concerning tax exempt status requirements and §7.187, concerning contributions, without changes to the proposed text as published in the February 10, 2023, issue of the *Texas Register* (48 TexReg 641). The rules will not be republished.

The amendments to §7.181 revise the definition of excess contribution in subsection (a)(13) to define it as any contribution that would cause the aggregate balance of an ABLE account to exceed the limit set by the board under Section 529(b)(6) of the Internal Revenue Code, or the aggregate contributions from all contributors in a taxable year to exceed the annual contribution limit set by the Internal Revenue Code.

The amendments to §7.182 clarify in paragraphs (3) and (4) that the board will monitor contributions during each taxable year to the ABLE account and the aggregate balance of an ABLE account to ensure that no excess contribution is made to an ABLE account.

The amendment to §7.187 provides in subsection (b)(3) that an excess contribution will not be accepted for an ABLE account.

The comptroller did not receive any comments regarding adoption of the amendments.

These amendments are adopted under Education Code, §54.904(a), which authorizes the Prepaid Higher Education Tuition Board in the Comptroller of Public Accounts to adopt rules to implement Education Code, Chapter 54, Subchapter J (Texas Achieving a Better Life Experience (ABLE) Program).

These amendments implement Education Code, Chapter 54, Subchapter J.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2023.

TRD-202302048
Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
Effective date: June 22, 2023
Proposal publication date: February 10, 2023
For further information, please call: (512) 475-2220

♦ ♦ ♦

TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 9. INTELLECTUAL DISABILITY SERVICES--MEDICAID STATE OPERATING AGENCY RESPONSIBILITIES

SUBCHAPTER D. HOME AND COMMUNITY-BASED SERVICES (HCS) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)

40 TAC §§9.153, 9.171 - 9.175, 9.177 - 9.180, 9.182, 9.183, 9.187, 9.188

As required by Texas Government Code §531.0202(b), the Department of Aging and Disability Services (DADS) was abolished effective September 1, 2017, after all its functions were transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code §531.0201 and §531.02011. Rules of the former DADS are codified in Title 40, Part 1, and will be repealed or administratively transferred to Title 26, Health and Human Services, as appropriate. Until such action is taken, the rules in Texas Administrative Code (TAC) Title 40, Part 1 govern functions previously performed by DADS that have transferred to HHSC. Texas Government Code §531.0055, requires the Executive Commissioner of HHSC to adopt rules for the operation and provision of services by the health and human services system, including rules in 40 TAC Part 1. Therefore, the Executive Commissioner of HHSC repeals in 40 TAC Part 1, Chapter 9, Subchapter D, Home and Community-based Services (HCS) Program and Community First Choice (CFC) §§9.153, 9.171 - 9.175, 9.177 - 9.180, 9.182, 9.183, 9.187, and 9.188.

The repeal of §§9.153, 9.171 - 9.175, 9.177 - 9.180, 9.182, 9.183, 9.187, and 9.188 is adopted without changes as published in the February 17, 2023, issue of the *Texas Register* (48 TexReg 835). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The repeals are necessary to remove the rules in 40 TAC Part 1, Chapter 9, Subchapter D, and adopt new rules in 26 TAC Part 1, Chapter 565, Home and Community-based Services (HCS) Program Certification Standards.

COMMENTS

The 31-day comment period ended March 20, 2023. During this period, HHSC did not receive any comments regarding the repealed rules.

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 1, 2023.

TRD-202302017
Karen Ray
Chief Counsel
Department of Aging and Disability Services
Effective date: June 21, 2023
Proposal publication date: February 17, 2023
For further information, please call: (512) 438-3161

♦ ♦ ♦