

PROPOSED RULES

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

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

TITLE 1. ADMINISTRATION

PART 8. TEXAS JUDICIAL COUNCIL

CHAPTER 175. COLLECTION IMPROVEMENT PROGRAM

SUBCHAPTER A. GENERAL COLLECTION IMPROVEMENT PROGRAM PROVISIONS

1 TAC §§175.1 - 175.3

The Texas Judicial Council (Council) proposes to amend 1 TAC §§175.1 - 175.3, concerning the Collection Improvement Program (Program). The proposed amendments provide local collections programs greater flexibility in establishing payment plans and codifies the Program's policy that the Program's components do not apply to defendants who have been determined to be indigent.

Glenna Bowman, chief financial officer of the Office of Court Administration (OCA), has determined that for the first five-year period the amendments are in effect there will be no significant fiscal implications for state government.

Scott Griffith, director of research and court services of OCA, has determined that for each year of the first five years the amendments are in effect, the public benefit anticipated as a result of the amendments to these rules will be clarification of the intent and meaning of the Program's rules and greater flexibility for local programs to establish payment plans that defendants can successfully pay.

There will be no cost to small business or individuals as a result of the amendments.

Comments on the proposed amendments may be submitted in writing to Scott Griffith by e-mail at scott.griffith@txcourts.gov, by postal mail at P.O. Box 12066, Austin, Texas 78711-2066, or by fax transmission at (512) 463-1648.

The amendments are proposed under §71.019 of the Texas Government Code, which authorizes the Council to adopt rules expedient for the administration of its functions.

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

§175.1. *Source, Purpose and Scope.*

(a) The source is Article 103.0033 of the Code of Criminal Procedure.

(b) The purpose is to provide notice to counties and municipalities of the scope and components of the Collection Improvement Program and of the audit standards that will be used by the Office of Court Administration to determine program implementation.

(c) The Collection Improvement Program applies to criminal cases in which the defendant agrees to or is required to pay court costs, fees, and fines under a payment plan or extension rather than on the assessment date. The program does not apply to cases in which the defendant has been determined to be indigent. Although the program can be utilized by a judge in virtually every criminal case to effectuate the judge's financial orders, it is not designed to influence the judicial determination of whether to order payment of costs, fees and fines, or otherwise to affect the sentencing or other disposition decision that is within the judge's discretion. The program is simply designed to improve the collection of court costs, fees and fines that have been imposed, while helping defendants who have the ability to pay satisfy their obligations. The program is not intended to conflict with or undermine the provision to defendants of full procedural and substantive rights under the constitution and laws of this state and of the United States.

(d) Although the program focuses on collection of court costs, fees and fines, it should be implemented in the context of local, state and national efforts to develop and apply systemic policy to the competing financial obligations of people in the criminal justice system.

§175.2. *Definitions.*

(a) "Assessment date" is the date on which a defendant becomes obligated to pay court costs, fees and fines. When a defendant remits partial payment of a citation without appearing in person, the assessment date is the date the partial payment was received.

(b) "Contact" means a documented attempt to reach a defendant.

(c) "Contact information" means the defendant's home address and home or primary contact telephone number; the defendant's employer's or source of support's name, address and telephone number; at least two personal references; and the date the information is obtained.

(d) "Designated counties" are those with a population of 50,000 or greater.

(e) "Designated municipalities" are those with a population of 100,000 or greater.

(f) "Eligible case" means a criminal case in which a judgment has been entered by a trial court. The term does not include a criminal case in which a defendant has been determined to be indigent; has been placed on deferred disposition; has elected to take a driving safety course; or is incarcerated, unless the defendant is released and payment is requested.

(g) "Jurisdiction" means a designated county or designated municipality that is subject to this chapter.

(h) "OCA" means the Office of Court Administration of the Texas Judicial System.

(i) "Collection Improvement Program" or "CIP" means the program described in this subchapter.

(j) "Payment ability information" means the defendant's account balances in financial institutions, debt balances and payment amounts, and stated income.

(k) "Payment Plan" or "Extension" means a schedule of payment(s) to be made by a defendant who does not pay all court costs, fees and fines at the time they are assessed and payment is requested. A judge's order that payment is due at a future date constitutes a payment plan or extension.

(l) "Program" or "Local Program" means the collection program implemented by a jurisdiction.

§175.3. Collection Improvement Program Components.

(a) Summary of CIP Components. The CIP has eleven components. Four components relate to the way a local program must be implemented, staffed, and operated. The other seven components relate to the way program staff communicates with defendants and documents those communications. In accordance with Article 103.0033(j), OCA will periodically audit counties and municipalities to confirm implementation of the components of the CIP; the audit standards are more fully described in §175.5. In computing any period of time under these rules, when the last day of the period falls on a Saturday, Sunday, legal holiday, or other day on which the office is not open for business, then the period runs until the end of the next day on which the office is open for business. The CIP components do not apply to defendants who have been determined to be indigent.

(b) Components for Local Program Operations.

(1) Dedicated Program Staff. Each local program must designate at least one employee whose job description contains an essential job function of collection activities. The collection job function may be concentrated in one individual employee or distributed among two or more employees. The collection function need not require 40 hours per week of an employee's time, but must be a priority.

(2) Payment Plan or Extension Compliance Monitoring. Program staff must monitor defendants' compliance with the terms of their payment plans or extensions and document the ongoing monitoring by either an updated payment due list or a manual or electronic tickler system.

(3) Delinquent Cases. Each local program must have a component designed to improve collection of balances more than 60 days past due.

(4) Proper Reporting. The program must report its collection activity data to OCA at least annually in a format approved by OCA, as described in §175.4.

(c) Components for Defendant Communications.

(1) Application or Contact Information. For payment plans or extensions set by a judge, the defendant must provide or acknowledge contact information and program staff must document it. In other cases, the defendant must provide a signed or acknowledged application for extended payment that includes both contact information and payment ability information. Programs may use a single form for both contact information and payment ability information, and the required information must be obtained within one month of the assessment date.

(2) Verification of Contact Information. Within five days of receiving the data, program staff must verify both the home or contact telephone number and the employer or source of support, if applicable. Verification may be conducted by reviewing written proof of the contact information, by telephoning the contacts, or by using a verification service. Verification must be documented by identifying the person conducting it and the date.

(3) Defendant Interviews. Within 14 days of receiving an application or a judge-imposed payment plan or extension, program or court staff must conduct an in-person or telephone interview with the defendant either to review the application and determine an appropriate payment plan or extension, or to review the terms of the judge-imposed payment plan or extension. Interviews must be documented by indicating the name of the interviewer and date of the interview.

(4) Specified Payment Terms.

(A) Documentation. Payment plans or extensions must be documented by notation in the judgment or court order, on a docket sheet, by written or electronic record, or by other means enabling later review.

(B) Payment Guidelines. Payment plans or extensions should require the highest payment amounts, and should require payment in full in the shortest period of time that the defendant can successfully make, considering the amount owed, the defendant's ability to pay, and the defendant's obligations to pay other court-mandated amounts, including child support, victim restitution, and fees for drug testing, rehabilitation programs, or community supervision.

(C) Time Requirements. Time requirements for payment plans or extensions set by a judge are within judicial discretion. ~~[Payment plans or extensions set by program staff must meet the following time requirements:]~~

~~[(i) In municipal and justice court cases, full payment within four months of the assessment date.]~~

~~[(ii) In county and district court cases involving community supervision, full payment at least two months before expiration of the term of community supervision.]~~

~~[(iii) In county and district court cases not involving community supervision and not involving incarceration, full payment within six months of the assessment date.]~~

~~[(iv) Extension of the time requirements for payment in full may be allowed if a defendant has multiple cases.]~~

(5) Telephone Contact for Past-Due Payments. Within one month of a missed payment, a telephone call must be made to a defendant who has not contacted the program staff. Telephone calls may be made by an automated system, but an electronic report or manual documentation of the telephone contact must be available on request.

(6) Mail Contact for Past-Due Payments. Within one month of a missed payment, a written delinquency notice must be sent to a defendant who has not contacted the program. Written notice may be sent by an automated system, but an electronic report or manual documentation of the mail contact must be available on request.

(7) Contact if Capias Pro Fine Sought. If a capias pro fine will be sought, the program must make another telephone call or send another written notice to the defendant within one month of the telephone call described in paragraph (5) of this subsection or the written delinquency notice described in paragraph (6) of this subsection, whichever is later. An electronic report or manual documentation of the contact must be available on request.

(d) Exceptions to Defendant Communications Rules. Exceptions to the defendant communications rules described in subsection (c) of this section are limited to those cases in which timely access to the defendant in order to obtain the required application or contact information is not possible, and efforts to obtain an application or contact information are documented, as provided in paragraphs (1) and (2) of this subsection.

(1) Attempt to Obtain Application or Contact Information. An attempt to obtain an application or contact information described in subsection (c)(1) of this section is made, either by mailing an application or contact information form or by obtaining the information via the telephone before a plea is made by the defendant or within 7 days of the court's acceptance of a plea. An electronic report or manual documentation of the attempt must be available on request. Should a completed application or contact information form not be returned by the defendant and the post office has not returned the application or contact information form as undeliverable, the program must make a second attempt to contact the defendant with any existing available information within one month of the first attempt. An electronic report or manual documentation of the second attempt must be made available on request.

(2) Application or Contact Information Is Obtained. Should a completed application or contact information form be returned to the program by a defendant as the result of an attempt described in paragraph (1) of this subsection, it will be considered timely and all other timing requirements for defendant communications described in subsection (c)(2) and (3) of this section are based on the later of the assessment date or the date the program receives the application or contact information form.

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

Filed with the Office of the Secretary of State on March 10, 2016.

TRD-201601202

Mena Ramon

General Counsel

Texas Judicial Council

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 463-1682



PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 351. COORDINATED PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES

1 TAC §351.701

The Texas Health and Human Services Commission (HHSC) proposes amendments to §351.701, concerning Unrelated Donor Umbilical Cord Blood Bank Program.

BACKGROUND AND JUSTIFICATION

In 2001, the Texas Legislature required the Health and Human Services Commission (HHSC) to establish a grant program for the establishment of an umbilical cord blood bank and authorized HHSC to adopt rules as necessary to implement the umbilical cord blood bank program. See Act of May 27, 2001, 77th Leg., R.S., ch. 1198, 2001 Tex. Gen. Laws 2719, 2719-20 (H.B. 3572). The Texas Legislature has, since that time, appropriated funds to HHSC for the purpose awarding "a grant of start-up money to establish an umbilical cord blood bank for recipients of blood and blood components who are unrelated to the blood donors."

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 59) appropriates \$1,000,000 in General Revenue Funds in fiscal year 2016 and \$1,000,000 in General Revenue Funds in fiscal year 2017 for this purpose. Rider 59 further requires HHSC to enter into a contract with a public cord blood bank in Texas for gathering umbilical cord blood from live births and retaining the blood at an unrelated donor cord blood bank for the primary purpose of making umbilical cord blood available for transplantation purpose. The contracting blood bank must be accredited by the American Association of Blood Banks and the International Organization for Standardization.

The proposed rule amendments are part of the implementation of Rider 59.

The current rule, §351.701, expired by its terms on August 31, 2004, but was never repealed. HHSC is amending the rule to ensure that it clearly applies to the program.

SECTION-BY-SECTION SUMMARY

Proposed §351.701 implements the legislative directive to establish, by contract with a qualified entity, an unrelated donor umbilical cord blood bank for the primary purpose of making cord blood available for transplantation purposes. As amended, the section defines terms; sets conditions for the funding; sets eligibility criteria for potential contractors; and establishes standards for the contract between HHSC and the contractor.

FISCAL NOTE

Ms. Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that during the first five years the proposal is in effect there are no anticipated implications to costs or revenues of state or local governments.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

HHSC has determined that there will be no effect on small businesses or micro businesses to comply with the amended rule. The one contractor currently meeting the criteria to participate in the program does not meet the requirements to be classified as a small business or micro-business.

PUBLIC BENEFIT AND COSTS

Ms. Patricia Vojack, Deputy Executive Commissioner for Health Policy and Clinical Services, has determined that for each year of the first five years the rule is in effect, the public will benefit from the adoption of the rule. The anticipated public benefit will be continued funding for an unrelated donor umbilical cord blood bank in Texas.

Ms. Rymal has also determined there is no cost to persons required to comply with the amendment as proposed. There is no anticipated effect on any local economy or on local employment.

REGULATORY ANALYSIS

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

proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Amy L. Williams, Institutional Outreach Liaison, Brown Heatly Building, 4900 N. Lamar Boulevard, Austin, Texas 78751; by fax to (512) 424-6974; or by e-mail to Amy.Williams2@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

STATUTORY AUTHORITY

The amendments are proposed under the uncodified Act of May 27, 2001, 77th Leg., R.S., ch. 1198, 2001 Tex. Gen. Laws 2719, 2719-20, which requires HHSC to establish a grant program for the establishment of an umbilical cord blood bank; requires the Executive Commissioner to establish eligibility criteria by rule; and provides generally for the adoption of rules necessary to implement the act.

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

§351.701. *Unrelated Donor Umbilical Cord Blood Bank [Grant] Program.*

(a) Purpose. This section establishes ~~implements and is adopted in accordance with the requirements of House Bill 3572 enacted by the 77th Texas Legislature (Acts 2001, 77th Leg., R.S., ch. 1198, at 2574), which authorizes the Health and Human Services Commission to implement~~ a program to award funding for ~~[a grant for the establishment of]~~ an unrelated donor umbilical cord blood bank in Texas.

(b) Funding ~~[Grant]~~ objectives. The funding ~~[grant]~~ awarded pursuant to this section is intended to improve public health in Texas through obtaining efficiently delivered services for gathering and retaining unrelated umbilical cord blood from live births for the primary purpose of making the cord blood available for transplantation purposes.~~;~~

~~[(1) the establishment of an umbilical cord blood bank to serve unrelated donors and recipients;]~~

~~[(2) operation of such services for a minimum period of eight years from the date of the grant award; and]~~

~~[(3) the support and promotion of medical and scientific research opportunities resulting from the operation of an unrelated donor umbilical cord blood bank.]~~

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

(1) Blood bank--A facility that:

(A) obtains a human umbilical cord blood donation from an unrelated donor; ~~[and is either]~~

(B) is licensed, certified, or accredited as a blood bank, blood and tissue center, laboratory, or other health care facility and [that] is authorized by: [state and/or federal law, rule or regulation to collect, process, and preserve human umbilical cord blood donations; or]

~~(i) state and/or federal law, rule, or regulation;~~

~~(ii) the American Association of Blood Banks; and~~

~~(iii) International Organization of Standardization to collect, process, and preserve human umbilical cord blood donations; and~~

~~(C) is operated in compliance with professionally recognized standards regarding [the] quality and safety of collection of human umbilical cord blood donations, including the American Association of Blood Banks and International Organization of Standardization.[, but not limited to:]~~

~~[(i) the American Association of Blood Banks or the American Association of Tissue Banks;]~~

~~[(ii) the American Society of Blood and Marrow Transplanters;]~~

~~[(iii) the Center for Biologies Evaluation and Research of the United States Food and Drug Administration;]~~

~~[(iv) the Foundation for Accreditation of Hematopoietic Cell Therapy;]~~

~~[(v) the International Society for Cellular Therapy;]~~

~~[(vi) the Joint Commission for Accreditation of Health Organizations; or]~~

~~[(vii) the Cord Blood Transplantation Study sponsored by the National, Heart, Blood, and Lung Institute of the National Institutes of Health.]~~

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

(3) Contractor--The recipient of the funding awarded under this section.

(4) ~~[(3)]~~ Donation--Human umbilical cord blood obtained from an unrelated donor and resulting from a live birth.

~~[(4) Grant--The funding assistance authorized by House Bill 3572 enacted by the 77th Texas Legislature (Acts 2001, 77th Leg., R.S., ch. 1198, at 2574) and awarded pursuant to this section for the sole purpose of establishing an unrelated donor umbilical cord blood bank program in Texas.]~~

~~[(5) Grantee--The recipient of the grant awarded under this section.]~~

(5) ~~[(6)]~~ Services--Umbilical cord blood collection, storage, preservation, and/or processing services provided by a blood bank.

(6) ~~[(7)]~~ Unrelated donor--A person who:

(A) is legally authorized or competent;

(B) voluntarily provides a donation; and

(C) is not related by affinity or consanguinity (as determined under Chapter 573, Texas Government Code) to the recipient of the donation.

(7) Unrelated Donor Umbilical Cord Blood Bank Program or Program--The Contractor-operated public blood bank program that provides for gathering and retaining umbilical cord blood for transplantation to recipients who are unrelated to the blood donors.

(d) General conditions of the funding [grant]. The funding [grant] awarded pursuant to this section, and any extension, continuation, or addition to such funding, is [grant, are] subject to:

(1) the availability of appropriated state funds;

(2) an [a competitive] award process as established by the commission;

(3) the requirements of Chapter 531, Texas Government Code, and any administrative rules adopted thereunder, including Chapter 391 of this title (relating to Purchase of Goods and Services by the Texas Health and Human Services Commission); [the Uniform Grant and Contract Management Standards Act, Chapter 783, Government Code and the rules and standards adopted by the Office of the Governor in accordance with Chapter 783, Government Code, and codified at Title 1, Texas Administrative Code. Sections 5.141, et seq.];

(4) the requirements of the contract executed by the commission with the Contractor [grantee] as required under subsection (f) of this section; and

(5) an audit by the commission, the State Auditor's Office, or an entity approved by the commission of the Contractor's [grantee's] performance of the services or compliance with applicable auditing standards and State and federal law. [the rules and standards adopted by the Office of the Governor in accordance with Chapter 783, Government Code, and codified at Title 1, Texas Administrative Code. Sections 5.141, et seq.]

(e) Applicant eligibility criteria. To be eligible [A blood bank may apply] for the funding [grant] awarded under this section, a blood bank [and] must, at a minimum, demonstrate:

(1) the ability to establish, operate, and maintain an unrelated donor umbilical cord blood bank in Texas and to provide related services, including[; but not limited to:]

[(A)] experience operating similar facilities in this state.[;]

[(B)] affiliation or agreements with research institutions or other similar blood banks and facilities to conduct related research or improve the accessibility of umbilical cord blood services in Texas[;]

(2) possession of an appropriate, current license, certification, or certificate of good standing to operate as a blood bank from the American Association of Blood Banks and International Organization of Standardization;

(3) a plan to continue the operation of the unrelated donor umbilical cord blood bank beyond the term of the contract required by subsection (f) of this section, including an appropriate financial plan;

(4) the financial stability and resources sufficient to ensure the achievement of the funding [grant] objectives and operation of the unrelated donor umbilical cord blood bank;

(5) appropriate skills, qualifications, financial resources, and experience necessary to perform the services and provide the deliverables (both of which are specified in the contract entered under subsection (f) of this section) in an efficient and cost-effective manner, with the highest degree of quality and responsiveness within the context of the requirements of the contract; and [donor and recipient management plans, protocols, including long-term management plans where clinically appropriate];

(6) policies relating to non-discrimination regarding the selection and treatment of donors and recipients of donations on the basis of race, sex, national origin, or ability to pay.[;]

[(7)] a quality improvement process or mechanism to[;]

[(A)] identify problems relating to the delivery of the services[;]

[(B)] measure and document improvement in the delivery of the services; and]

[(C)] provide appropriate monitoring of patient outcomes, to the degree permitted under state and federal law and the informed consent of donors and recipients of donations.[;]

(f) Contract. The Contractor [grantee] must enter into a contract with the commission that requires, among other things, [that] the Contractor to [grantee]:

(1) operate and maintain an unrelated donor umbilical cord blood bank in this state in accordance with standards described in subsection (c)(1)[(C)] of this section;

[(2)] operate the blood bank at least until the eighth anniversary of the effective date of the contract[;]

(2) [(3)] gather, collect, and preserve umbilical cord blood [only] from live births only;

(3) [(4)] comply with any financial or reporting requirements imposed on the Contractor [grantee] specified in the contract; and

(4) [(5)] comply with all applicable federal and state laws[; as amended,] and their implementing regulations.

[(g)] Expiration. This section expires August 31, 2004.[;]

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

Filed with the Office of the Secretary of State on March 14, 2016.

TRD-201601213

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 424-6900



CHAPTER 354. MEDICAID HEALTH SERVICES

SUBCHAPTER A. PURCHASED HEALTH SERVICES

DIVISION 27. COMMUNITY FIRST CHOICE

1 TAC §§354.1361, 354.1363 - 354.1368

The Texas Health and Human Services Commission (HHSC) proposes amendments to §354.1361, concerning Definitions; §354.1363, concerning Assessment; §354.1364, concerning Services and Limitations; §354.1365, concerning Provider Qualifications; and §354.1366, concerning Consumer Directed Services and Service Responsibility Option. HHSC proposes new §354.1367, concerning Person-Centered Service Plan; and §354.1368, concerning Fair Hearing.

BACKGROUND AND JUSTIFICATION

Community First Choice (CFC) is a state plan option to provide certain home and community based services and supports to qualified individuals. The CFC option was implemented in Texas in June 2015.

The new rules and proposed rule amendments add information about person-centered service planning and fair hearing rights related to CFC; make a change related to Senate Bill 202, 84th Legislature, Regular Session, 2015, regarding emergency response services; and clarify various aspects of the CFC option. HHSC operates CFC in compliance with a state plan amendment and a 1915(b)(4) waiver agreed upon with the Centers for Medicare & Medicaid Services.

SECTION-BY-SECTION SUMMARY

Proposed amendments to §354.1361 add definitions for "CLASS," "DBMD," "DSHS," "ICF-IID," "MAO," "Service Planning Team," "STAR Health," "STAR+PLUS," "STAR+PLUS home and community-based services (HCBS)," and "SSI." Multiple other definitions are amended for clarity.

Proposed amendments to §354.1363 revise language to be consistent with revisions to the definitions in §354.1361 and make other small revisions for clarity.

Proposed amendments to §354.1364 add minor clarifications and remove one component of CFC habilitation to match the approved state plan amendment. New subsection (d) clarifies that CFC services are limited by functional need as determined by the assessment, and new subsection (e) clarifies that managed care organizations (MCOs) are required to offer all CFC services to those MCO members who are eligible and need the services.

Proposed amendment to §354.1365 removes "licensed" from personal emergency response services agency, pursuant to Senate Bill 202, 84th Legislature, Regular Session, 2015. These agencies no longer need state licensure. A capitalization error is also corrected.

Proposed amendment to §354.1366 clarifies that a provider agency is an available alternative to the consumer-directed services option or service-responsibility option.

Proposed new §354.1367 sets forth requirements related to the person-centered service planning process, person-centered service plan facilitators, and the contents of the person-centered service plan.

Proposed new §354.1368 clarifies that an individual may request a fair hearing for eligibility denial; lack of prompt eligibility determination; or termination, suspension, denial, or reduction of CFC services.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that during the first five-year period the amendments and new rules are in effect, there will be no impact to costs and revenues of state and local governments. The impact to local intellectual and developmental disability authorities was included in Texas Department of Aging and Disability Services fiscal impact statements accompanying amendments to Title 40, Part 1, Chapter 2 (Local Authority Responsibilities), §2.560 (Staff Person Training).

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

HHSC has determined that there will be no adverse impact on small businesses or micro-businesses for adoption of the proposed rules. No Texas Medicaid MCO qualifies as a small business or micro-business. Impact to entities such as providers was included in Texas Department of Aging and Disability Services fiscal impact statements accompanying amendments to Title 40, Part 1, Chapter 42 (Deaf Blind With Multiple Disabilities (DBMD)

Program and Community First Choice), §42.403 (Training), and Title 40, Part 1, Chapter 45 (Community Living Assistance and Support Services and Community First Choice), §45.804 (Training of DSA Staff Persons).

PUBLIC BENEFIT

Gary Jessee, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be more consistent and appropriate delivery of CFC services to individuals who qualify for these services.

Ms. Rymal has also determined that there are probable anticipated economic costs to persons who are required to comply with the amendments and new rules. The total maximum annual cost statewide to all MCOs is anticipated to be \$222,000 for both SFY 2016 and SFY 2017. This proposal merely reflects in rule changes already made to the standard MCO contract for person-centered planning. Therefore, business-process changes for this proposal are already included in the capitation rates for MCOs.

Ms. Rymal has also determined the proposed rules have no anticipated negative impact on local employment.

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Jennie Costilow, Senior Policy Advisor, 4900 North Lamar Boulevard, MC-H310, Austin, Texas 78751; by fax to (512) 730-7477; or by e-mail to jennie.costilow@hhsc.state.tx.us, within 30 days of publication of this proposal in the *Texas Register*.

STATUTORY AUTHORITY

The amendments and new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority, and 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.

The proposed amendments and new rules implement Texas Human Resources Code, Chapter 32; Texas Government Code, Chapter 531; and §32.074(a), Texas Human Resources Code. No other statutes, articles, or codes are affected by this proposal.

§354.1361. Definitions.

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

(1) Activities of daily living (ADLs)--Basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(2) CFC emergency response services--Back-up systems and supports including electronic devices to ensure continuity of services and supports.

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

(4) CFC personal assistance services--Services provided to assist an individual in performing ADLs, IADLs, and health-related tasks based on the individual's person-centered service plan.

(5) CFC support management--Voluntary training on how to select, manage, and dismiss attendants.

(6) CFR--Code of Federal Regulations.

(7) CLASS--The Community Living Assistance and Support Services Program operated by DADS as authorized by the Centers for Medicare & Medicaid Services in accordance with §1915(c) of the Social Security Act.

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

(9) ~~[(8)]~~ DADS--The Texas Department of Aging and Disability Services.

(10) DBMD--The Deaf Blind with Multiple Disabilities Program operated by DADS as authorized by the Centers for Medicare & Medicaid Services in accordance with §1915(c) of the Social Security Act.

(11) DSHS--Texas Department of State Health Services.

(12) ~~[(9)]~~ Financial Management Services (FMS)--Services including, but not limited to, the following activities for individuals using the CDS option: collect and process timesheets of the individual's attendant care providers; process payroll, withholding, filing, and payment of applicable Federal, State, and local employment related taxes and insurance; separately track budget funds and expenditures for each individual; track and report disbursements and balances of each individual's funds; process and pay invoices for services in the person-centered service plan; and provide individual periodic reports of expenditures and the status of the approved service budget to the individual and to HHSC.

(13) ~~[(10)]~~ Financial management services agency (FMSA)--An entity that is qualified [~~certified~~] by DADS and is contracted with HHSC and/or an MCO to provide financial management services.

(14) ~~[(11)]~~ Health-related tasks--In accordance with 42 CFR §441.505 and state law, specific tasks related to the needs of an individual which include tasks delegated by a registered nurse, health maintenance activities, and extension of therapy.

(15) ~~[(12)]~~ HHSC--The Texas Health and Human Services Commission, or its designee.

(16) ~~[(13)]~~ Home and Community-based Services (HCS) Program--The Home and Community-based Services Program operated by DADS as authorized by the Centers for Medicare & ~~and~~ Medicaid Services in accordance with §1915(c) of the Social Security Act.

~~(17) [(14)]~~ Home and Community Support Services Agency (HCSSA)--Home and Community Support Services Agency [~~community support services agency~~] licensed by DADS in accordance with Texas Health and Safety Code, Chapter 142.

~~(18)~~ Intermediate care facility for individuals with an intellectual disability or related conditions (ICF-IID)--A facility providing care and services to individuals with intellectual disabilities or related conditions as defined in §1905(d) of the Social Security Act.

~~(19) [(15)]~~ Instrumental activities of daily living (IADLs)--Activities [~~As defined in 42 CFR 441.505; activities~~] related to living independently in the community including, but not limited to, 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.

~~(20) [(16)]~~ Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this division, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

~~(21) [(17)]~~ Local Intellectual and Developmental Disability Authority (LIDDA) [~~LA~~]-An entity designated by DADS in accordance with the Texas Health and Safety Code, §533.035(a).

~~(22) [(18)]~~ Managed Care Organization (MCO)--An organization contracted with HHSC in accordance with Chapter 353 [~~§353.1~~] of this title (relating to Medicaid Managed Care [~~Purpose~~]).

~~(23)~~ Medical Assistance Only (MAO)--An individual who qualifies financially and functionally for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits.

~~(24) [(19)]~~ Person-centered service planning--A documented service planning process that includes people chosen by the individual, is directed by the individual to the maximum extent possible, enables the individual to make informed choices and decisions, is timely and occurs at times and locations convenient to the individual, reflects cultural considerations of the individual, includes strategies for solving conflict or disagreement within the process, offers choices to the individual regarding the services and supports they receive and from whom, includes a method for the individual to require updates to the plan, and records alternative settings that were considered by the individual.

~~(25)~~ Service Planning Team--For an individual receiving CFC services, the group of people responsible for creating the individual's person-centered service plan.

~~(26) [(20)]~~ Service responsibility option (SRO)--A service delivery option in which an individual or LAR selects, trains, and provides daily management of a service provider, while the fiscal, personnel, and service back-up plan responsibilities remain with an SRO provider.

~~(27)~~ STAR Health--The managed care program that primarily serves:

(A) children and youth in Texas Department of Family and Protective Services (DFPS) conservatorship;

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

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

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

(29) STAR+PLUS home and community-based services (HCBS)--The program that provides person-centered care services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified clients who are 65 years of age or older, are blind, or have a disability, as cost-effective alternatives to institutional care in nursing facilities.

(30) Supplemental Security Income (SSI)--The federal cash assistance program of direct financial payments to people who are 65 years of age or older, are blind, or have a disability administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

(31) [(24)] Texas Home Living (TxHmL)--The Texas Home Living Program operated by DADS as authorized by the Centers for Medicare & [and] Medicaid Services in accordance with §1915(c) of the Social Security Act.

§354.1363. *Assessment.*

(a) Level of care (LOC) assessment.

(1) To determine nursing facility and hospital LOC, HHSC uses the Medical Necessity/Level of Care (MN/LOC) assessment. MN is the determination that an individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care.

(2) To determine ICF/IID LOC, HHSC uses the Intellectual Disability/Related Condition assessment (ID/RC). The ID/RC assessment includes all factors needed to determine an LOC: diagnostic information that includes age of onset of the qualifying conditions, names of qualifying conditions, the appropriate International Classification of Diseases codes, results of standardized intelligence testing, and the adaptive behavior level as determined by an approved adaptive behavior assessment tool.

(3) To determine psychiatric inpatient LOC for individuals under age 21, and institution for mental disease LOC for individuals age 65 and over, the Child and Adolescent Needs and Strengths assessment (CANS) or Adult Needs and Strengths assessment (ANSA) is completed and entered into a State system which has an automated clinical and diagnostic tool that helps determine an individual's LOC. The system uses CANS or ANSA data to determine whether an individual meets Medicaid inpatient psychiatric admission criteria.

(b) Functional needs assessment. Assessments for CFC services are conducted by existing assessors who are determined to be qualified by the State in a state plan or LTSS program already approved by CMS. Assessments are provided without regard to an individual's age or disability. The functional needs assessment and person-centered service plan development process comply with the requirements set forth in 42 CFR §§441.535 - 441.540.

(1) CFC functional needs assessments are conducted initially and at least annually, unless a change in condition or health status requires reassessment at an earlier date, or the individual requests a reassessment. The assessments are conducted face-to-face and include an assessment of an individual's functional needs, strengths, preferences, and goals for the services and supports provided under CFC.

(2) Individuals are assessed for functional needs by a qualified provider, at a time and location convenient for the individual. The assessment is conducted as part of a person-centered planning process with the individual and anyone else chosen by the individual. Initially and at least annually, in partnership, the assessor, individual, and a service planning team comprised of members chosen by the individual develop a recommended service plan for review and consideration by HHSC or the appropriate MCO.

(3) Qualified assessors of functional needs include LIDDAs [local intellectual and developmental disability] and mental health authorities, MCO service coordinators or service managers, DSHS [Department of State Health Services] case workers, direct service agencies, and case management agencies [managers].

(c) Requirements on entities conducting the assessments. A person or entity conducting the functional needs assessment or facilitating [participating in] the person-centered service plan [planning] for the individual must not:

(1) be related by blood or marriage to the individual, or to any paid caregiver of the individual;

(2) be financially responsible for the individual;

(3) be empowered to make financial or health-related decisions on behalf of the individual;

(4) benefit financially from assessing the individual's needs or providing CFC services to the individual; or

(5) be a provider of CFC services [state plan HCBS] for the individual or have an interest in or be employed by a provider of CFC services [state plan HCBS] for the individual, unless:

(A) HHSC determines that the provider is the only willing and qualified entity able to perform assessments of functional need and develop person-centered service plans in a geographic area; and

(B) the provider adheres to a conflict of interest policy developed by HHSC.

§354.1364. *Services and Limitations.*

(a) Subject to the specifications, conditions, requirements, and limitations established by HHSC, Community First Choice (CFC) services are provided subject to provisions in 42 CFR §§441.500 - 441.590. Services include:

(1) CFC personal assistance services. CFC personal assistance services include:

(A) non skilled assistance with the performance of the ADLs and IADLs through hands-on assistance, supervision, and/or cueing;

(B) household chores necessary to maintain the home in a clean, sanitary, and safe environment;

(C) escort services, which consist of accompanying, but not transporting, and assisting an individual to access personal assistance services or activities in the community; and

(D) assistance with health-related tasks.

(2) CFC habilitation. CFC habilitation is provided to allow an individual to reside successfully in a community setting by assisting the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the individual on ADLs and IADLs. Personal assistance may be a component of CFC habilitation for some individuals. CFC habilitation services include habilitation training, which is interacting face-to-face with an individual, to train the individual in activities such as:

- (A) self-care;
- (B) personal hygiene;
- (C) household tasks;
- (D) mobility;
- (E) money management;
- (F) community integration, including how to get around in the community;
- (G) use of adaptive equipment;
- (H) self-advocacy;
- (I) personal decision making;
- (J) interpersonal communication;
- (K) reduction of challenging behaviors;
- (L) socialization and the development of relationships;
- (M) participating in leisure and recreational activities;
- (N) use of natural supports and typical community services available to the public; and
- (O) self-administration of medication and other health-maintenance activities. ~~;~~ and
- ~~[(P) strategies to restore or compensate for reduced cognitive skills.]~~

(3) CFC emergency response services. CFC emergency response services are available for individuals who live alone, who are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

(4) CFC support management. The CFC support management benefit is available to individuals receiving CFC personal attendant services or CFC habilitation services regardless of service delivery option.

(b) CFC services can only be delivered in a home and community-based setting. These settings do not include:

- (1) a hospital providing long-term services;
- (2) a nursing facility;
- (3) an institution for mental disease;
- (4) an intermediate care facility for individuals with an intellectual disability or related conditions; or
- (5) a setting with the characteristics of an institution as described in 42 CFR §441.530(a)(2)(v).

(c) Individuals receiving services through CFC are not precluded from receiving other home and community-based long-term services and supports through other Medicaid state plan, waiver, grant, or demonstration authorities.

(d) Services are limited by functional need as determined by the assessment described in §354.1363(b) of this division (relating to Assessment).

(e) MCOs are required to offer all CFC services to those MCO members who are eligible and are determined to need the services based on an assessment conducted in accordance with §354.1363 of this division.

§354.1365. *Provider Qualifications.*

(a) Community First Choice (CFC) services are provided by long-term services and supports (LTSS) and state plan service providers determined to be qualified by the State in an existing program.

(b) HHSC ensures that all current qualification standards are maintained.

(c) Providers delivering CFC services include licensed Home and Community Support Services [home and community support services] agencies (HCSSAs), certified Home and Community-based Services (HCS) Program and Texas Home Living (TxHmL) providers, [licensed] personal emergency response services agencies, qualified financial management services agencies, and providers hired by individuals using the Consumer Directed Services (CDS) option who meet qualifications.

§354.1366. *Consumer Directed Services and Service Responsibility Option.*

An individual that is eligible to receive Community First Choice [CFC] services may choose to receive those services through a provider agency or:

(1) the Consumer Directed Services (CDS) option in accordance with 40 TAC Chapter 41 (relating to Consumer Directed Services Option); or

(2) the Service Responsibility Option (SRO) in accordance with 40 TAC Chapter 43 (relating to the Service Responsibility Option).

§354.1367. *Person-Centered Service Plan.*

(a) Compliance with federal law. A person-centered service planning process is provided in accordance with 42 CFR §441.540.

(b) Person-centered service plan facilitators. A person-centered service plan facilitator must complete HHSC-approved training on person-centered service planning by June 1, 2017, or within two years of hire date. Person-centered plan facilitators include:

(1) those that conduct the functional assessment for CFC in the DBMD and CLASS waiver programs;

(2) LIDDAs in the HCS, TxHmL, and STAR+PLUS programs;

(3) MCOs in the STAR+PLUS and STAR Health programs; and

(4) DSHS case workers.

(c) Development of the person-centered service plan. The person-centered service plan is created simultaneously and in conjunction with the functional needs assessment.

(1) The person-centered service planning meeting is conducted face-to-face and occurs at a time and location convenient to the individual receiving services.

(2) The person-centered service plan is developed by the service planning team, which consists of the individual, the individual's LAR, the person-centered service plan facilitator, and any other individuals selected by the individual or the individual's LAR. The provider may be a participant on the person-centered service planning team. Other program rules may require certain other participants (for example, the program director or a registered nurse designated by the program provider in DBMD).

(3) As the individual's functional needs are assessed simultaneously, the person-centered service plan facilitator works with the individual to identify the individual's goals, needs, and preferences with regard to his or her services.

(4) The person-centered service plan facilitator ensures consideration of information from the individual or LAR to determine any risks that might exist to the health and welfare of the individual as a result of living in the community, and identifies and documents in the person-centered service plan those services that are critical to the health and welfare of the individual for which a backup plan must be developed.

(5) The person-centered service plan incorporates cultural considerations of the individual.

(6) The person-centered service plan includes documentation on whether the individual has chosen to receive services through Consumer Directed Services or the Service Responsibility Option.

(7) The person-centered service plan is finalized and agreed to in writing by the individual and signed by all persons and providers responsible for its implementation.

(8) The person-centered service plan and functional needs assessment must be made available to the direct service providers delivering CFC services.

(9) The person-centered service plan reflects that the setting in which the individual lives meets the criteria outlined in 42 CFR §441.530 and is chosen by the individual.

(10) The person-centered service plan is reviewed and revised by the person-centered service planning team:

(A) at least annually;

(B) upon reassessment of functional need;

(C) when the individual's circumstances or needs change significantly; or

(D) at the request of the individual or legally authorized representative through contact with the individual's person-centered plan facilitator.

§354.1368. *Fair Hearing.*

An individual whose request for eligibility for the CFC option is denied or is not acted upon with reasonable promptness, or an individual whose CFC services have been terminated, suspended, denied, or reduced by HHSC has the right to request a fair hearing in accordance with federal and state law.

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

Filed with the Office of the Secretary of State on March 14, 2016.

TRD-201601214

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

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For further information, please call: (512) 424-6900



SUBCHAPTER D. TEXAS HEALTHCARE
TRANSFORMATION AND QUALITY
IMPROVEMENT PROGRAM
DIVISION 5. ACTIONS IN PREPARATION
FOR EXTENSION OF THE DSRIP PROGRAM

1 TAC §§354.1641, 354.1643, 354.1645, 354.1647, 354.1649

The Texas Health and Human Services Commission (HHSC) proposes new Division 5, §§354.1641, 354.1643, 354.1645, 354.1647 and 354.1649, concerning Actions in Preparation for Extension of the DSRIP Program.

BACKGROUND AND JUSTIFICATION

In September 2015, HHSC proposed an extension of the Texas Healthcare Transformation and Quality Improvement Program, a Section 1115 Waiver that expires on September 30, 2016. As part of the extension of the 1115 Waiver, HHSC intends to extend the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP is a program for hospitals and certain other providers to propose and implement transformative projects that increase access to care and quality of care.

To prepare for expected changes in the structure of DSRIP, HHSC proposed a transition year to coincide with the first demonstration year in the extension period (or sixth demonstration year overall). DSRIP performing providers must take certain steps to prepare for the transition year. These proposed new rules describe the steps expected of performing providers.

First, a performing provider may elect to continue, end, or replace their existing projects. Second, a performing provider may request adjustments to certain DSRIP project characteristics. Third, HHSC plans to require the provision of Quantifiable Patient Impact (QPI) data by a particular method and will require that performing providers report Medicaid IDs as a necessary component to getting a DSRIP payment. HHSC is offering exceptions to certain performing providers.

HHSC is currently negotiating with the Centers for Medicare & Medicaid Services (CMS) on the extension of the DSRIP program and the policies surrounding the transition year. HHSC will update these rules, as necessary, in accordance with CMS guidance.

SECTION-BY-SECTION SUMMARY

Proposed §354.1641 provides definitions specific to the new division.

Proposed §354.1643 describes the requirements for a performing provider to categorize an individual as Medicaid and Low-income or Uninsured (MLIU) for purposes of the Quantifiable Patient Impact (QPI) milestone.

Proposed §354.1645 describes the actions that a current performing provider must undertake in preparation for the transition year.

Proposed §354.1647 describes certain methods by which a performing provider may request alterations to current DSRIP projects for the transition year.

Proposed §354.1649 describes requirements for the planned transition year and the manner in which a performing provider may request an exception to those planned requirements.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services for HHSC, has determined that for each year of the first five years the proposed rules will be in effect, there will be no impact to costs or revenues of state government.

There could be a fiscal impact on local governments. HHSC can recoup funds under these proposed rules. In that case, the DSRIP performing provider would return all Medicaid funds

specified in the rule that have been received for the project. HHSC would refund federal funds to CMS and intergovernmental transfers used as the non-federal portion would be returned to the transferring entity. Due to uncertainties regarding which projects would have funds recouped, HHSC lacks sufficient data to provide an estimate of the possible fiscal impact to local governments.

PUBLIC BENEFITS AND COSTS

Gary Jessee, State Medicaid Director, has determined that, for each year of the first five years the proposed rules will be in effect, the public will benefit from adoption of the proposed rules. The anticipated public benefit will be the continued transformation of the Texas healthcare system through more efficient means.

Ms. Rymal has also determined that there are no economic costs to persons required to comply with the proposed rules.

HHSC has determined that the proposed rules will not affect a local economy or local employment.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

HHSC has determined that the proposed rules would have no adverse economic effect on small businesses or micro-businesses. Participation in the DSRIP program and in the DSRIP transition year is voluntary and no small business or micro-business is required to be involved in the program.

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Kim Tucker, Texas Health and Human Services Commission, Brown Heatly Building, 4900 North Lamar Boulevard, Mail Code H-425, Austin, Texas 78751; by fax to (512) 730-7479; or by e-mail to kimberly.tucker@hhsc.state.tx.us, within 30 days after publication of this proposal in the *Texas Register*.

PUBLIC HEARING

A public hearing is scheduled for April 11, 2016, at 9:30 a.m. (central time) at the Brown-Heatly Building, Public Hearing Room, located at 4900 North Lamar Boulevard, Austin, Texas 78751. Persons requiring further information, special assistance, or accommodations should contact Amy Chandler at (512) 487-3419.

STATUTORY AUTHORITY

The new rules are proposed under Texas Government Code §531.0055, which provides the Executive Commissioner of HHSC with rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021, which authorize HHSC to administer the federal medical assistance (Medicaid) program in Texas.

The new rules implement Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§354.1641. Definitions.

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

(1) Extension period--The period of time, as approved by the Centers for Medicare & Medicaid Services (CMS), for which the waiver is extended beyond the initial demonstration period.

(2) Federal poverty level--The household income guidelines issued annually and published in the Federal Register by the United States Department of Health and Human Services.

(3) Initial demonstration period--The first five demonstration years (DYs) of the waiver, or December 12, 2011, through September 30, 2016.

(4) Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI)--The number of MLIU individuals served or encounters provided during the applicable DY that are attributable to a DSRIP project.

(5) MLIU QPI Goal--The number of MLIU individuals that a performing provider intends to serve, or the number of MLIU encounters that a performing provider intends to provide, during the applicable DY that are attributable to a DSRIP project.

(6) Transition year--As it relates to DSRIP, the first DY of the extension period.

§354.1643. Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI).

(a) To qualify as a Medicaid individual for purposes of MLIU QPI, the individual must be enrolled in Medicaid at the time of at least one DSRIP project encounter during the applicable demonstration year (DY).

(b) To qualify as a low-income or uninsured individual for purposes of MLIU QPI, the individual must either be below 200% of the federal poverty level or must not have health insurance at the time of at least one DSRIP project encounter during the applicable DY.

(c) If an individual was enrolled in Medicaid at the time of one DSRIP project encounter during the applicable DY, and was low-income or uninsured at the time of a separate DSRIP project encounter during the applicable DY, that individual is classified as a Medicaid individual for purposes of MLIU QPI.

§354.1645. Electing to Continue a DSRIP Project in the Waiver Extension Period.

(a) If HHSC determines that a DSRIP project is ineligible to continue, that DSRIP project may not participate in the transition year. A performing provider affected by such a determination may be eligible to submit replacement DSRIP projects with the funds associated with the discontinued DSRIP project to begin in DY7.

(b) For each DSRIP project that HHSC determines is eligible to continue, the performing provider must indicate, by a date to be determined by HHSC, whether it chooses to:

(1) discontinue the DSRIP project in the transition year; or

(2) continue the DSRIP project in the transition year.

(c) If a performing provider chooses to discontinue the DSRIP project in the transition year, the performing provider may not propose any new DSRIP projects for the entirety of the extension period with funds associated with the discontinued DSRIP project.

(d) If a performing provider chooses to continue the DSRIP project in the transition year, the performing provider must indicate, by a date to be determined by HHSC, whether it chooses to:

(1) continue the DSRIP project for the remainder of the extension period; or

(2) replace the DSRIP project with a new DSRIP project to commence at the beginning of the second DY of the extension period.

(e) If, after choosing to continue the DSRIP project in the transition year, a performing provider decides not to continue that DSRIP project, or decides not to replace that DSRIP project, HHSC will recoup any transition year payments that the performing provider received for that DSRIP project.

§354.1647. Requests for Adjustments to Certain DSRIP Projects.

(a) Performing providers of certain DSRIP projects may, by a date to be determined by HHSC, request an adjustment to a DSRIP project's transition year MLIU QPI goal. A DSRIP project eligible for such a request includes:

(1) a DSRIP project that is underperforming on MLIU QPI in the initial demonstration period;

(2) a DSRIP project that is reporting on clients that meet the MLIU definition for the initial demonstration period, but will not meet the MLIU definition for the extension period; and

(3) any other DSRIP project that HHSC determines has a strong justification for an adjustment.

(b) Performing providers with a total valuation less than \$250,000 in demonstration year (DY) 5 may increase their total valuation to up to \$250,000 for each subsequent DY across Categories 1-4. Categories 1-4 are each increased proportionately if a performing provider chooses this option. Performing providers eligible for such an option must make this choice by a date to be determined by HHSC.

§354.1649. Certain Requirements for the Planned Transition Year and their Exceptions.

(a) To be eligible for the MLIU QPI milestone payment, beginning in the transition year, performing providers must report for each DSRIP project:

(1) the MLIU individuals served or encounters provided at the individual or encounter level as opposed to the percentage of total QPI; and

(2) the Medicaid IDs for the Medicaid-enrolled individuals served.

(b) There are limited exceptions to these requirements. Performing providers may request an exception to these requirements by a date to be determined by HHSC. DSRIP projects eligible for such a request include:

(1) a DSRIP project for which the performing provider did not assess the DSRIP project participants' health insurance coverage or financial status prior to September 30, 2015, and instead used a proxy to estimate the MLIU population served in their October DY4 QPI Reporting Template, and:

(A) utilizes an intervention site that is a school, non-medical social service office (i.e., shelter), or community health fair;

(B) is in Project Area 1.6 (Enhance Urgent Medical Advice), 2.6 (Implement Evidence-based Health Promotion), or 2.7 (Implement Evidence-based Disease Prevention Programs); or

(C) the performing provider is a Local Health Department that does not bill Medicaid for the types of services provided through the DSRIP project; or

(2) any other DSRIP project that HHSC determines has a strong justification for an exception.

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

Filed with the Office of the Secretary of State on March 9, 2016.

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Karen Ray
Chief Counsel

Texas Health and Human Services Commission

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For further information, please call: (512) 424-6900



CHAPTER 382. WOMEN'S HEALTH SERVICES SUBCHAPTER A. HEALTHY TEXAS WOMEN

1 TAC §§382.1, 382.3, 382.5, 382.7, 382.9, 382.11, 382.13, 382.15, 382.17, 382.19, 382.21, 382.23, 382.25, 382.27, 382.29

The Texas Health and Human Services Commission (HHSC) proposes new Chapter 382, Women's Health Services, Subchapter A, Healthy Texas Women, §382.1, concerning Introduction; §382.3, concerning Non-entitlement and Availability; §382.5, concerning Definitions; §382.7, concerning Client Eligibility; §382.9, concerning Application and Renewal Procedures; §382.11, concerning Financial Eligibility Requirements; §382.13, concerning Denial, Suspension, or Termination of Services and Client Appeals; §382.15, concerning Covered and Non-covered Services; §382.17, concerning Health-Care Providers; §382.19, concerning Prohibition of Abortion; §382.21, concerning Reimbursement; §382.23, concerning Provider's Request for Review of Claim Denial; §382.25, concerning Confidentiality and Consent; §382.27, concerning Audits and Reports; and §382.29, concerning Severability.

BACKGROUND AND JUSTIFICATION

In 2014, the Sunset Advisory Commission reviewed the Texas Health and Human Services agencies, including its women's health programs. The Sunset Advisory Commission issued the recommendation that HHSC consolidate the women's health care programs in order to improve service and efficiency for clients and providers. This included the recommendation to consolidate the existing Texas Women's Health Program at HHSC and the Expanded Primary Healthcare Program at the Department of State Health Services (DSHS) into one program and division at HHSC.

In response to the Sunset Advisory Commission's recommendations, the 84th Texas Legislature enacted Texas Government Code §531.0201(a)(2)(C) to transfer client services functions

performed by DSHS to HHSC. Texas Government Code §531.0204 was also enacted to require the HHSC Executive Commissioner to develop a transition plan which included an outline of HHSC's reorganized structure, and a definition of "client services functions."

Furthermore, the 2016-17 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015, merged the women's health strategies (DSHS Strategy B.1.3., Family Planning Services, and Strategy B.1.4., Community Primary Care Services) into a single strategy within the HHSC Budget (HHSC Strategy D.2.3., Women's Health Services).

The transition plan developed by HHSC pursuant to Texas Government Code §531.0204 included the consolidation of women's health services performed in the HHSC Texas Women's Health Program and DSHS Expanded Primary Health Care Program under HHSC as of September 1, 2015.

On July 1, 2016, HHSC plans to consolidate the Texas Women's Health Program and the Expanded Primary Healthcare Program into a new program fully funded by state general revenue. The new program will be named Healthy Texas Women. The Healthy Texas Women program will be a successor program to the Medicaid Women's Health Program, and therefore subject to Texas Human Resources Code §32.024(c-1). These proposed rules are intended to transition and consolidate the Texas Women's Health Program and the Expanded Primary Healthcare Program into the Healthy Texas Women (HTW) program, which will be operated by HHSC.

SECTION-BY-SECTION SUMMARY

Proposed §382.1 introduces the purpose of the rules and describes the statutory authority for adopting the rules.

Proposed §382.3 states that these rules do not create an entitlement and that the services described in the rules are subject to appropriated funds.

Proposed §382.5 defines certain terms used throughout the HTW subchapter.

Proposed §382.7 describes the eligibility requirements for an HTW client.

Proposed §382.9 details the procedure a woman must follow to apply for HTW services and renew HTW services.

Proposed §382.11 describes the financial eligibility requirements for an HTW client.

Proposed §382.13 describes when HHSC may deny, suspend, or terminate HTW services to a client and the client's fair hearing rights.

Proposed §382.15 lists those services that a client may, and may not, receive through HTW. The list of services is generalized; further detail will be provided in policy.

Proposed §382.17 describes the requirements for HTW providers.

Proposed §382.19 describes the prohibition of abortion procedures provided by HTW providers.

Proposed §382.21 pertains to reimbursement for services covered by HTW.

Proposed §382.23 pertains to an HTW provider's request to HHSC to review a denied claim.

Proposed §382.25 describes the confidentiality and consent policies for HTW.

Proposed §382.27 provides for audits to verify compliance with applicable statutes and rules.

Proposed §382.29 describes the severability provision for the HTW subchapter.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the proposed rules are in effect there will be no impact to costs and revenues of state and local governments.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

HHSC has determined that there will be no adverse economic effect on small businesses or micro-businesses to comply with the proposed rules, as they will not be required to alter current business practices as a result of the proposed rules.

PUBLIC BENEFIT

Lesley French, Associate Commissioner for the Women's Health Program, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be increased access to women's health and family planning services including positively impacting the health and wellbeing of women and their families.

Ms. Rymal has also determined that there are no probable economic costs to persons who are required to comply with the proposed rules. There is no anticipated impact on local economies nor is there an anticipated negative impact on local employment.

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Meagan Kirby, Program Specialist; 1100 W. 49th Street, P.O. Box 149347; Austin, Texas 78714; by fax to (512) 776-7203; or by e-mail to meagan.kirby@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

PUBLIC HEARING

A public hearing is scheduled for April 26, 2016, from 9:00 a.m. to 10:00 a.m. (CST), in the Brown-Healy Public Hearing Room located at 4900 North Lamar Boulevard, Austin, Texas 78751. Persons requiring further information, special assistance, or accommodations should contact Amy Chandler at (512)-487-3419.

STATUTORY AUTHORITY

The new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority to adopt rules necessary to carry out the commission's duties under Chapter 531.

The proposed new rules are authorized generally by Texas Government Code §531.0201(a)(2)(C), which transfers client services functions performed by DSHS to HHSC.

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

§382.1. Introduction.

(a) Governing rules. This subchapter sets out rules governing the administration of the Healthy Texas Women program (HTW).

(b) Authority. This subchapter is authorized generally by Texas Government Code §531.0201(a)(2)(C), which transfers client services functions performed by the Texas Department of State Health Services to HHSC, and Texas Government Code §531.0204, which requires the HHSC Executive Commissioner to develop a transition plan which includes an outline of HHSC's reorganized structure and a definition of client services functions.

(c) Objectives. HTW is established to achieve the following overarching objectives:

(1) to increase access to women's health and family planning services to:

(A) avert unintended pregnancies;

(B) positively affect the outcome of future pregnancies;

and

(C) positively impact the health and wellbeing of women and their families;

(2) to implement the state policy to favor childbirth and family planning services that do not include elective abortion or the promotion of elective abortion within the continuum of care or services;

(3) to ensure the efficient and effective use of state funds in support of these objectives and to avoid the direct or indirect use of state funds to promote or support elective abortion;

(4) to reduce the overall cost of publicly-funded health care (including federally-funded health care) by providing low-income Texans access to safe, effective services that are consistent with these objectives; and

(5) to enforce Texas Human Resources Code §32.024(c-1) and any other state law that regulates the delivery of non-federally funded family planning services, to the extent permitted by the Constitution of the United States.

§382.3. Non-entitlement and Availability.

(a) No entitlement. This subchapter does not establish an entitlement to the services described in this subchapter.

(b) Fund availability. The services described in this subchapter are subject to the availability of appropriated funds.

§382.5. Definitions.

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

(1) Affiliate--

(A) An individual or entity that has a legal relationship with another entity, which relationship is created or governed by at least one written instrument that demonstrates:

(i) common ownership, management, or control;

(ii) a franchise; or

(iii) the granting or extension of a license or other agreement that authorizes the affiliate to use the other entity's brand name, trademark, service mark, or other registered identification mark.

(B) The written instruments referenced in subparagraph (A) of this definition may include a certificate of formation, a franchise agreement, standards of affiliation, bylaws, articles of incorporation or a license, but do not include agreements related to a physician's participation in a physician group practice, such as a hospital group agreement, staffing agreement, management agreement, or collaborative practice agreement.

(2) Applicant--A female applying to receive services under HTW, including a current client who is applying to renew.

(3) Budget group--Members of a household whose needs, income, resources, and expenses are considered in determining eligibility.

(4) Child--An adoptive, step, or natural child who is under 19 years of age.

(5) Client--A female who receives services through HTW.

(6) Contraceptive method--A broad range of birth control options, approved by the United States Food and Drug Administration, with the exception of emergency contraception.

(7) Corporate entity--A foreign or domestic non-natural person, including a for-profit or nonprofit corporation, a partnership, or a sole proprietorship.

(8) Covered service--A medical procedure for which HTW will reimburse an enrolled health-care provider.

(9) Elective abortion--The intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means:

(A) to terminate a pregnancy that resulted from an act of rape or incest;

(B) in a case in which a female suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the female in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or

(C) in a case in which a fetus has a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

(10) Family planning services--Educational or comprehensive medical activities that enable individuals to determine freely the number and spacing of their children and to select the means by which this may be achieved.

(11) Federal poverty level--The household income guidelines issued annually and published in the *Federal Register* by the United States Department of Health and Human Services.

(12) Health-care provider--A physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife, federally qualified health center, family planning agency, health clinic, ambulatory surgical center, hospital ambulatory surgical center, laboratory, or rural health center.

(13) Health clinic--A corporate entity that provides comprehensive preventive and primary health care services to outpatient clients, which must include both family planning services and diagnosis and treatment of both acute and chronic illnesses and conditions in three or more organ systems. The term does not include a clinic specializing in family planning services.

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

(15) HTW--The Healthy Texas Women program administered by HHSC as outlined in this subchapter.

(16) HTW provider--A health-care provider that performs covered services. An HTW provider may be contracted with HHSC to provide additional services.

(17) Medicaid--The Texas Medical Assistance Program, a joint federal and state program provided for in Texas Human Resources Code Chapter 32, and subject to Title XIX of the Social Security Act, 42 U.S.C. §§1396 et seq.

(18) Minor--In accordance with the Texas Family Code, a person under 18 years of age who has never been married and never been declared an adult by a court (emancipated).

(19) Provider--A physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife, federally qualified health center, family planning agency, health clinic, ambulatory surgical, hospital ambulatory surgical center, laboratory, or rural health center that receives funding from HHSC to provide family planning services.

(20) Third-party resource--A person or organization, other than HHSC or a person living with the applicant or client, who may be liable as a source of payment of the applicant's or client's medical expenses (for example, a health insurance company).

(21) Unintended pregnancy--Pregnancy a female reports as either mistimed or undesired at the time of conception.

(22) U.S.C.--United States Code.

§382.7. Client Eligibility.

(a) Criteria. A female is eligible to receive services through HTW if she:

(1) meets the following age requirements:

(A) is 18 through 44 years of age, inclusive; or

(B) is 15 through 17 years of age, inclusive, and has a parent or legal guardian apply, renew, and report changes to her case on her behalf;

(2) is not pregnant;

(3) has countable income (as calculated under §382.11 of this subchapter (relating to Financial Eligibility Requirements) that does not exceed 200 percent of the federal poverty level;

(4) is a United States citizen, a United States national, or an alien who qualifies under §382.9(g) of this subchapter (relating to Application and Renewal Procedures);

(5) resides in Texas;

(6) does not currently receive benefits through a Medicaid program, Children's Health Insurance Program, or Medicare Part A or B; and

(7) does not have creditable health coverage that covers the services HTW provides, except as specified in subsection (c) of this section.

(b) Age. For purposes of subsection (a)(1)(A) of this section, an applicant is considered 18 years of age on the day of her 18th birthday and 44 years of age through the last day of the month of her 45th birthday. For purposes of subsection (a)(1)(B) of this section, an applicant is considered 15 years of age the first day of the month of her 15th birthday and 17 years of age through the day before her 18th birthday. A female is ineligible for HTW if her application is received the month before her 15th birthday or the month after she turns 45 years of age.

(c) Third-party resources. An applicant with creditable health coverage that would pay for all or part of the costs of covered services may be eligible to receive covered services if she affirms, in a manner satisfactory to HHSC, her belief that a party may retaliate against her or cause physical or emotional harm if she assists HHSC (by providing information or by any other means) in pursuing claims against that third party. An applicant with such creditable health coverage who does not comply with this requirement is ineligible to receive HTW benefits.

(d) Period of eligibility. A client is deemed eligible to receive covered services for 12 continuous months after her application is approved, unless:

(1) the client dies;

(2) the client voluntarily withdraws;

(3) the client no longer satisfies criteria set out in subsection (a) of this section;

(4) state law no longer allows the female to be covered; or

(5) HHSC determines the client provided information affecting her eligibility that was false at the time of application.

(e) Transfer of eligibility. A female who received services through the Texas Women's Health Program is automatically enrolled as an HTW client and is eligible to receive covered services for as long as she would have been eligible for the Texas Women's Health Program.

(f) Auto-Enrollment. A female who is receiving Medicaid for pregnant women is enrolled into HTW at the end of her Medicaid for pregnant women certification period. A female enrolled into HTW has the option to opt out of receiving HTW. To be auto-enrolled, a female must:

(1) be 18 to 44 years of age, inclusive, as defined in subsection (b) of this section;

(2) not be receiving active third-party resources at the time of auto-enrollment; and

(3) be ineligible for any other Medicaid or CHIP program.

§382.9. Application and Renewal Procedures.

(a) Application. A female, or a parent or legal guardian acting on her behalf if she is 15 through 17 years of age, inclusive, may apply for HTW services by completing an application form and providing documentation as required by HHSC.

(1) An applicant may obtain an application in the following ways:

(A) from a local benefits office of HHSC, an HTW provider's office, or any other location that makes HTW applications available;

(B) from the HTW or HHSC website;

(C) by calling 2-1-1; or

(D) by any other means approved by HHSC.

(2) HHSC accepts and processes every application received through the following means:

- (A) in person at a local benefits office of HHSC;
- (B) by fax;
- (C) through the mail; or
- (D) by any other means approved by HHSC.

(b) Processing timeline. HHSC processes an HTW application by the 45th day after the date HHSC receives the application.

(c) Start of coverage. Program coverage begins on the first day of the month in which HHSC receives a valid application. For applicants 18 through 44 years of age, inclusive, a valid application has, at a minimum, the applicant's name, address, and signature. For applicants 15 through 17 years of age, inclusive, a valid application has, at a minimum, the applicant's name, address, and the signature of a parent or legal guardian.

(d) Social security number (SSN) required. In accordance with 42 U.S.C. §405(c)(2)(C)(i), HHSC requires an applicant to provide or apply for a social security number. If an applicant is not eligible to receive an SSN, the applicant must provide HHSC with any documents requested by HHSC to verify the applicant's identity. HHSC requests, but does not require, budget group members who are not applying for HTW to provide or apply for an SSN.

(e) Interviews. HHSC does not require an interview for purposes of an eligibility determination. An applicant may, however, request an interview for an initial or renewal application.

(f) Identity. An applicant must verify her identity the first time she applies to receive covered services.

(g) Citizenship. If an applicant is a United States citizen, she must provide proof of citizenship. If the applicant, who is otherwise eligible to receive HTW services, is not an United States citizen, HHSC determines her eligibility in accordance with §366.513 of this title (relating to Citizenship).

(h) Renewal. A female, or a parent or legal guardian acting on her behalf if she is 15 through 17 years of age, inclusive, may renew HTW services by completing a renewal form and providing documentation as required by HHSC.

(1) An HTW client will be sent a renewal packet during the 10th month of her 12-month certification period for HTW.

(2) HHSC accepts and processes every renewal form received through the following means:

- (A) in person at a local benefits office of HHSC;
- (B) by fax;
- (C) through the mail; or
- (D) by any other means approved by HHSC.

§382.11. Financial Eligibility Requirements.

(a) Calculating countable income. Unless an applicant is adjunctively eligible as described in subsection (b) of this section, HHSC determines an applicant's financial eligibility by calculating the applicant's countable income. To determine countable income, HHSC adds the incomes listed in paragraph (1) of this subsection, less any deductions listed in paragraph (2) of this subsection, and exempting any amounts listed in paragraph (3) of this subsection.

(1) To determine income eligibility, HHSC counts the income of the following individuals if living together:

(A) the female age 18 through 44, inclusive, applying for HTW;

- (i) the female's spouse; and
- (ii) the female's children age 18 and younger; or

(B) the female age 15 through 17, inclusive, applying for HTW;

- (i) the female's parent(s);
- (ii) the female's siblings age 18 and younger; and
- (iii) the female's children;

(2) In determining countable income, HHSC deducts the following items:

(A) work-related expense deductions of up to \$120 of earned income;

(B) a dependent care deduction of \$200 per month for each child under two years of age, and \$175 per month for each dependent two years of age or older, including an earned income deduction for the actual costs of unreimbursed payments if the person incurs an expense for the care of a child or incapacitated adult or transportation of a child to and from day care or school;

(C) payments to dependents living outside the home;

(D) alimony;

(E) child support payments; and

(F) up to \$75 per month in received regular child support payments, except HHSC counts all child support payments an applicant received if HHSC determines the applicant has violated an agreement to assign child support to the State.

(3) HHSC exempts from the determination of countable income the following types of income:

(A) any income that federal law excludes;

(B) the earnings of a child:

(i) who is 18 years of age and is a full-time student, including a home-schooled student, or a part-time student employed less than 30 hours a week; or

(ii) who is under 18 years of age and is:

(I) a full-time student, including a home-schooled student; or

(II) a part-time student employment less than 30 hours a week;

(C) up to \$300 per federal fiscal quarter in cash gifts and contributions that are from private, nonprofit organizations and are based on need;

(D) proceeds from claims on insurance policies to compensate for a loss or that are used to pay medical expenses;

(E) payments from federal volunteer programs for volunteer service, such as payments:

(i) for volunteer service in a senior citizen volunteer program, under the Domestic Volunteer Service Act (42 U.S.C. §§5000 et seq.);

(ii) for volunteer service to Volunteers in Service to America (VISTA), (42 U.S.C. §§4951 - 4960); and

(iii) for volunteer service under the National and Community Service Act (42 U.S.C. §§12511 - 12657);

(F) payments under the Workforce Innovation and Opportunity Act (29 U.S.C. §§3101, et seq.);

(G) the value of any benefits received under a government nutrition assistance program that is based on need, including benefits under the Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program)(7 U.S.C. §§2011-2036), the Child Nutrition Act of 1966 (42 U.S.C. §§1771-1793), the National School Lunch Act (42 U.S.C. §§1751-1769), and the Older Americans Act of 1965 (42 U.S.C. §§3056, et seq.);

(H) foster care payments;

(I) payments made under a government housing assistance program based on need;

(J) energy assistance payments;

(K) job training payments that:

(i) are earmarked as reimbursement for training-related expenses; and

(ii) do not duplicate payment for an item that is covered by budgetary needs;

(L) a lump sum provided and used to pay burial, legal, or medical bills, or to replace damaged or lost possessions, except HHSC does not exclude amounts from lump sums used for another purpose;

(M) reimbursements for monies spent on items not covered by budgetary needs;

(N) amounts deducted from royalties for production expenses and severance taxes;

(O) all income of Supplemental Security Income recipients;

(P) third-party funds received and used for a third-party beneficiary who is not a household member;

(Q) vendor payments made from funds not legally obligated to the household;

(R) veterans benefits for special needs that are not items covered by budgetary needs;

(S) workers' compensation payments legally obligated to the recipient that are earmarked and used for medical expenses;

(T) the amount of any nonfarm self-employment income offsetting a tax deduction taken that year for a farm loss, for households with farms generating income of at least \$1,000 annually;

(U) up to \$2,000 of gifts annually from tax-exempt organizations provided to children with life-threatening conditions;

(V) independent living payments to youths who are leaving foster care, as provided by the Social Security Act, Title IV-E (42 U.S.C. §§670 et seq.);

(W) funds from payments of up to \$2,000 to Native Americans made under the federal Old Age Assistance Claims Settlement Act (25 U.S.C. §§2301-2307) or the federal Alaska Native Claims Settlement Act (43 U.S.C. §§1601-1629);

(X) funds from payments made to volunteers under Title I of the Domestic Volunteer Services Act of 1973 (42 U.S.C. §§4950, et seq.);

(Y) funds from adoption subsidy payments made under Title IV-A (42 U.S.C. §§601, et seq.) and Title IV-E (42 U.S.C. §§670, et seq.) of the Social Security Act;

(Z) funds from insurance policy dividends;

(AA) funds from veterans payments earmarked as a housebound allowance or as an aid and attendance allowance;

(BB) earned income tax credit payments;

(CC) federal, state, or local government payments provided to rebuild a home or replace personal possessions damaged in a disaster, including payments under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. §§5121 et seq.), if the recipient is subject to legal sanction if the payment is not used as intended;

(DD) funds from educational assistance payments (but only during the quarter, semester, or applicable period that the payment is intended to cover);

(EE) loans, if the circumstances satisfy HHSC that there exists an understanding that the money will be repaid, and the applicant or client reasonably explains to HHSC how the money will be repaid; and

(FF) crime victim's compensation payments.

(b) Adjunctive eligibility. An applicant or client is considered adjunctively eligible at an initial or renewal application, and therefore automatically financially eligible, if:

(1) a member in her budget group receives benefits under the Women, Infants, and Children (WIC) supplemental nutrition program;

(2) she is a member of a certified Supplemental Nutrition Assistance Program (SNAP) household;

(3) she is in a Children's Medicaid budget group for someone receiving Medicaid; or

(4) she is receiving Temporary Assistance for Needy Families (TANF) cash or is in a TANF budget group for someone receiving TANF cash.

§382.13. Denial, Suspension, or Termination of Services and Client Appeals.

(a) Notice and opportunity for hearing. HHSC may deny, suspend, or terminate services to an applicant or client if it determines that the applicant or client is ineligible to participate in HTW.

(b) Notice and opportunity for a fair hearing. Before HHSC finalizes the denial, suspension, or termination under subsection (a) of this section, the applicant or client is notified and provided an opportunity for a fair hearing in accordance with Chapter 357, Subchapter A, of this title (relating to Uniform Fair Hearing Rules).

(c) Appeal procedures. An applicant or client who is aggrieved by the denial, suspension, or termination of services under subsection (a) of this section may appeal the decision in accordance with Chapter 357, Subchapter A of this title. An applicant or client may not appeal a decision to deny, suspend, or terminate services if the decision is the result of a decision by the State to reduce or stop funding the program.

§382.15. Covered and Non-covered Services.

(a) Covered services. Services provided through HTW include:

(1) health history and physical;

- (2) counseling and education;
- (3) laboratory testing;
- (4) provision of a contraceptive method;
- (5) referrals for additional services, as needed;
- (6) immunizations; and
- (7) breast and cervical cancer screening and diagnostic ser-

services.

(b) Non-covered services. Services not provided through HTW include:

- (1) counseling on and provision of abortion services;
- (2) counseling on and provision of emergency contracep-
tives; and
- (3) other services that cannot be appropriately billed with
a permissible procedure code.

§382.17. Health-Care Providers.

(a) Procedures. An HTW provider must:

(1) be enrolled as a Medicaid provider in accordance with
Chapter 352 of this title (relating to Medicaid and Children's Health
Insurance Program Provider Enrollment);

(2) complete the HTW certification process as described in
subsection (e) of this section; and

(3) comply with the requirements set out in Chapter 354,
Subchapter A, Division 1 of this title (relating to Medicaid Procedures
for Providers).

(b) Requirements. An HTW provider must ensure that:

(1) the provider does not perform or promote elective abor-
tions outside the scope of HTW and is not an affiliate of an entity that
performs or promotes elective abortions; and

(2) in offering or performing an HTW service, the provider:

(A) does not promote elective abortion within the scope
of HTW;

(B) maintains physical and financial separation be-
tween its HTW activities and any elective abortion-performing or
abortion-promoting activity, as evidenced by the following:

(i) physical separation of HTW services from any
elective abortion activities, no matter what entity is responsible for the
activities;

(ii) a governing board or other body that controls the
HTW health care provider has no board members who are also mem-
bers of the governing board of an entity that performs or promotes elec-
tive abortions;

(iii) accounting records that confirm that none of the
funds used to pay for HTW services directly or indirectly support the
performance or promotion of elective abortions by an affiliate; and

(iv) display of signs and other media that identify
HTW and the absence of signs or materials promoting elective abortion
in the provider's location or in the provider's public electronic commu-
nications; and

(C) does not use, display, or operate under a brand
name, trademark, service mark, or registered identification mark of an
organization that performs or promotes elective abortions.

(c) Defining "promote." For purposes of subsection (b) of this
section, the term "promote" means advancing, furthering, advocating,
or popularizing elective abortion by, for example:

(1) taking affirmative action to secure elective abortion ser-
vices for an HTW client (such as making an appointment, obtaining
consent for the elective abortion, arranging for transportation, nego-
tiating a reduction in an elective abortion provider fee, or arranging
or scheduling an elective abortion procedure); however, the term does
not include providing upon the patient's request neutral, factual infor-
mation and nondirective counseling, including the name, address, tele-
phone number, and other relevant information about a provider;

(2) furnishing or displaying to an HTW client information
that publicizes or advertises an elective abortion service or provider; or

(3) using, displaying, or operating under a brand name,
trademark, service mark, or registered identification mark of an
organization that performs or promotes elective abortions.

(d) Compliance information. Upon request, an HTW provider
must provide HHSC with all information HHSC requires to determine
the provider's compliance with this section.

(e) Certification. Upon initial application for enrollment in
HTW, a provider must certify its compliance with subsection (b) of this
section and any other requirement specified by HHSC. Each provider
enrolled in HTW must annually certify that the provider complies with
subsection (b) of this section.

(f) Provider disqualification. If HHSC determines that an
HTW provider fails to comply with subsection (b) of this section,
HHSC disqualifies the provider from HTW.

(g) Client assistance and recoupment. If an HTW provider is
disqualified, HHSC takes appropriate action to:

(1) assist an HTW client to find an alternate provider; and

(2) recoup any funds paid to a disqualified provider for
HTW services performed during the period of disqualification.

(h) Exemption from initial certification. The initial applica-
tion requirement of subsection (g) of this section does not apply to a
provider that certified and was determined to be in compliance with the
requirements of the Texas Women's Health Program administered by
HHSC pursuant to Texas Human Resources Code §32.024(c-1).

§382.19. Prohibition of Abortion.

Abortion is not considered a method of family planning, and no state
funds appropriated for HTW family planning services are used to pay
the direct or indirect costs (including overhead, rent, phones, equip-
ment, and utilities) of abortion procedures.

§382.21. Reimbursement.

(a) Reimbursement.

(1) Covered services provided through HTW are re-
imbursed in accordance with Chapter 355 of this title (relating to
Reimbursement Rates).

(2) Entities that contract with HHSC to provide additional
services related to HTW that are separate from services referenced in
paragraph (1) of this subsection are reimbursed by HHSC in compli-
ance with program standards, policy and procedures, and contract re-
quirements unless payment is prohibited by law.

(b) Claims procedures. An HTW provider must comply with
Chapter 354, Subchapter A, Divisions 1 and 5 of this title (relating
to Medicaid Procedures for Providers and relating to Physician and
Physician Assistant Services).

(c) Improper use of reimbursement. An HTW provider may not use any HTW funds received to pay the direct or indirect costs (including overhead, rent, phones, equipment, and utilities) of elective abortions.

§382.23. Provider's Request for Review of Claim Denial.

(a) Review of denied claim. An HTW provider may request a review of a denied claim. The request must be submitted as an administrative appeal under Chapter 354, Subchapter I, Division 3 of this title (relating to Appeals).

(b) Appeal procedures. An administrative appeal is subject to the timelines and procedures set out in Chapter 354, Subchapter I, Division 3 of this title and all other procedures and timelines applicable to a provider's appeal of a Medicaid claim denial.

§382.25. Confidentiality and Consent.

(a) Confidentiality required. An HTW provider must maintain all health care information as confidential to the extent required by law.

(b) Written release authorization. Before an HTW provider may release any information that might identify a particular client, that client must authorize the release in writing. If the client is 15 through 17 years of age, inclusive, the client's parent, managing conservator, or guardian, as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations, must authorize the release.

(c) Confidentiality training. An HTW provider's staff (paid and unpaid) must be informed during orientation of the importance of keeping client information confidential.

(d) Records monitoring. An HTW provider must monitor client records to ensure that only appropriate staff and HHSC may access the records.

(e) Assurance of confidentiality. An HTW provider must verbally assure each client that her records are confidential and must explain the meaning of confidentiality.

(f) Consent for minors. HTW services must be provided with consent from the minor's parent, managing conservator, or guardian only as authorized by Texas Family Code, Chapter 32, or by federal law or regulations.

§382.27. Audits and Reports.

(a) Compliance audits. HHSC may audit any HTW provider to verify compliance with any applicable law or regulation.

(b) Reporting duties. An HTW provider must submit information to HHSC as HHSC requires.

§382.29. Severability.

(a) Legislative intent. The Texas Legislature, in enacting Texas Human Resources Code §32.024(c-1), confirmed its intent that the Healthy Texas Women program, as successor to the Medicaid Women's Health Program, must be operated only in a manner that ensures that no funds spent under the program are:

(1) spent to perform or promote elective abortions; or

(2) used to contract with entities that perform or promote elective abortions or affiliates of such entities.

(b) Limitation on administration. HHSC, as the agency responsible for administering HTW, is subject to the conditions specified in Texas Human Resources Code §32.024(c-1). Its authority to operate the program is thus strictly limited, and HHSC has no authority to operate the HTW program except in compliance with such conditions.

(c) Nonseverable provisions.

(1) Section 382.5(1) of this subchapter (relating to Definitions) and §382.17 of this subchapter (relating to Health Care Providers) are necessary and integral to the implementation of the requirements of Texas Human Resources Code §32.024(c-1), the fulfillment of legislative intent, and the achievement of the objectives of HTW. As such, HHSC regards the provisions and application of these sections as essential aspects of HHSC's compliance with state law and, therefore, not severable from the other provisions of this subchapter.

(2) Accordingly, to the extent that §382.5(1), §382.17, or this section is determined by a court of competent jurisdiction to be unconstitutional or unenforceable, or to the degree an official or employee of HHSC or the State of Texas is enjoined from enforcing these sections, HHSC will regard this entire subchapter as invalid and unenforceable and will cease operation of the program.

(d) Severable provisions. To the extent that any part of this subchapter other than §382.5(1), §382.17, or this section are enjoined, HHSC may enforce the parts of the subchapter not affected by such injunctive relief to the extent that HHSC determines it can do so consistent with legislative intent and the objectives of this subchapter.

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

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 424-6900



SUBCHAPTER B. FAMILY PLANNING PROGRAM

1 TAC §§382.101, 382.103, 382.105, 382.107, 382.109, 382.111, 382.113, 382.115, 382.117, 382.119, 382.121, 382.123, 382.125, 382.127, 382.129

The Texas Health and Human Services Commission (HHSC) proposes new Chapter 382, Women's Health Services, Subchapter B, Family Planning Program, §382.101, concerning Introduction; §382.103, concerning Non-entitlement and Availability; §382.105, concerning Definitions; §382.107, concerning Client Eligibility; §382.109, concerning Financial Eligibility Requirements; §382.111, concerning Denial, Suspension, or Termination of Services and Client Appeals; §382.113, concerning Covered and Non-covered Services; §382.115, concerning Health-Care Providers; §382.117, concerning Prohibition of Abortion; §382.119, concerning Reimbursement; §382.121, concerning Provider's Request for Review of Claim Denial; §382.123, concerning Records Retention; §382.125, concerning Confidentiality and Consent; §382.127, concerning FPP Services for Minors; and §382.129, concerning Severability.

BACKGROUND AND JUSTIFICATION

The HHSC Family Planning Program (FPP) provides statewide family planning services to low-income women and men who do

not have other sources of payment for services. A male or female is eligible to receive services through the FPP if he or she is 64 years of age or younger, resides in Texas, and is at or below 250 percent of the federal poverty level for the household. Family planning services include preventive health, medical services, counseling, and educational services.

In 2014, the Sunset Advisory Commission reviewed the Texas Health and Human Services agencies, including the Family Planning Program. The Sunset Advisory Commission issued the recommendation that the FPP transfer from the Texas Department of State Health Services (DSHS) to HHSC. In response to the Sunset Advisory Commission's recommendation, the 84th Texas Legislature enacted Texas Government Code §531.0201(a)(2)(C) to transfer client services functions performed by DSHS to HHSC. Texas Government Code §531.0204 was also enacted to require the HHSC Executive Commissioner to develop a transition plan which included an outline of HHSC's reorganized structure, and a definition for "client services functions."

The 2016-17 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015, merged the women's health strategies (DSHS Strategy B.1.3., Family Planning Services, and Strategy B.1.4., Community Primary Care Services) into a single strategy within the HHSC Budget (HHSC Strategy D.2.3., Women's Health Services).

The transition plan developed by HHSC pursuant to Texas Government Code §531.0204 included the transfer of the FPP from DSHS to HHSC as of September 1, 2015. On July 1, 2016, HHSC plans to begin a new procurement period for the FPP, which is funded by state general revenue for client services and some federal funds for administrative costs.

SECTION-BY-SECTION SUMMARY

Proposed §382.101 sets out rules governing the administration of the HHSC FPP, including the statutory authority for adopting the rules, and the program objectives. This program is separate from family planning services provided through Medicaid.

Proposed §382.103 states that the rules in this subchapter do not create an entitlement and that the services described are subject to appropriated funds.

Proposed §382.105 provides definitions for terms used in this subchapter.

Proposed §382.107 describes client eligibility requirements, including point of service eligibility determination.

Proposed §382.109 describes financial eligibility requirements.

Proposed §382.111 describes when HHSC may deny, suspend, or terminate services to a client and the client's fair hearing rights.

Proposed §382.113 lists covered and non-covered services.

Proposed §382.115 describes health-care provider requirements.

Proposed §382.117 clarifies that abortion is not considered a method of family planning.

Proposed §382.119 pertains to reimbursement for services.

Proposed §382.121 describes claim denial procedures for providers.

Proposed §382.123 outlines record retention requirements.

Proposed §382.125 describes provider confidentiality and client consent requirements.

Proposed §382.127 describes the provision of family planning services for minors.

Proposed §382.129 sets out the legislative intent for the operation of the Family Planning Program, the limitation on administration, and non-severable provisions.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the proposed rules are in effect, there will be no impact to costs and revenues of state and local governments.

SMALL BUSINESSES AND MICRO-BUSINESS IMPACT ANALYSIS

HHSC anticipates no adverse economic effect on small businesses or micro-businesses to comply with the proposed rules, as there is no requirement to alter current business practices.

PUBLIC BENEFIT AND COSTS

Lesley French, Associate Commissioner for the Women's Health Program, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The public benefit anticipated as a result of enforcing or administering the rules will be continued access to family planning services for eligible, low-income men and women in Texas.

Ms. Rymal has also determined that there are no probable economic costs to persons who are required to comply with the proposed rules. The proposed rules are not anticipated to affect a local economy, nor is there any anticipated negative impact on local employment.

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Claudia Himes-Crayton, Nurse Consultant, P.O. Box 149347, Austin, Texas 78714, MC 0224; by fax to (512) 776-7203; or by e-mail to famplan@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

PUBLIC HEARING

A public hearing is scheduled for April 26, 2016, from 9:00 a.m. to 10:00 a.m. (CST), in the Brown-Heatly Public Hearing Room located at 4900 North Lamar Boulevard, Austin, Texas 78751.

Persons requiring further information, special assistance, or accommodations should contact Amy Chandler at (512) 487-3419.

STATUTORY AUTHORITY

The new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority to carry out the Commission's duties under Chapter 531.

The proposed new rules are authorized generally by Texas Government Code §531.0201(a)(2)(C), which transfers client services functions performed by DSHS to HHSC.

The proposed new rules implement Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§382.101. Introduction.

(a) Governing rules. This subchapter sets out rules governing the administration of the HHSC Family Planning Program. This program is separate from family planning services provided through Medicaid.

(b) Authority. This subchapter is authorized generally by Texas Government Code §531.0201(a)(2)(C), which transfers client services functions performed by the Texas Department of State Health Services to HHSC, and Texas Government Code §531.0204 which requires the HHSC Executive Commissioner to develop a transition plan which includes an outline of HHSC's reorganized structure and a definition of client services functions.

(c) Objectives. The HHSC Family Planning Program is established to achieve the following overarching objectives:

(1) to increase access to health and family planning services to:

(A) avert unintended pregnancies;

(B) positively affect the outcome of future pregnancies;

and

(C) positively impact the health and well-being of women and their families;

(2) to implement the state policy to favor childbirth and family planning services that do not include elective abortion or the promotion of elective abortion within the continuum of care or services;

(3) to ensure the efficient and effective use of state funds in support of these objectives and to avoid the direct or indirect use of state funds to promote or support elective abortion;

(4) to reduce the overall cost of publicly-funded health care (including federally-funded health care) by providing low-income Texans access to safe, effective services that are consistent with these objectives; and

(5) to enforce any state law that regulates the delivery of non-federally funded family planning services, to the extent permitted by the Constitution of the United States.

§382.103. Non-entitlement and Availability.

(a) No entitlement. This subchapter does not establish an entitlement to the services described in this subchapter.

(b) Fund availability. The services described in this subchapter are subject to the availability of appropriated funds.

§382.105. Definitions.

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

(1) Affiliate--

(A) An individual or entity that has a legal relationship with another entity, which relationship is created or governed by at least one written instrument that demonstrates:

(i) common ownership, management, or control;

(ii) a franchise; or

(iii) the granting or extension of a license or other agreement that authorizes the affiliate to use the other entity's brand name, trademark, service mark, or other registered identification mark.

(B) The written instruments referenced in subparagraph (A) of this definition may include a certificate of formation, a franchise agreement, standards of affiliation, bylaws, articles of incorporation or a license, but do not include agreements related to a physician's participation in a physician group practice, such as a hospital group agreement, staffing agreement, management agreement, or collaborative practice agreement.

(2) Applicant--An individual applying to receive services under FPP, including a current client who is applying to renew.

(3) Budget group--Members of a household whose needs, income, resources, and expenses are considered in determining eligibility.

(4) Client--Any individual seeking assistance from an FPP provider to meet their family planning goals.

(5) Contraceptive method--A broad range of birth control options, approved by the United States Food and Drug Administration, with the exception of emergency contraception.

(6) Contractor--An entity that HHSC has contracted with to provide services. The contractor is the responsible entity, even if a subcontractor provides the service.

(7) Corporate entity--A foreign or domestic non-natural person, including a for-profit or nonprofit corporation, a partnership, or a sole proprietorship.

(8) Covered service--A medical procedure for which FPP will reimburse a contracted health-care provider.

(9) Elective abortion--The intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means:

(A) to terminate a pregnancy that resulted from an act of rape or incest;

(B) in a case in which a female suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the female in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or

(C) in a case in which a fetus has a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

(10) Family Planning Program (FPP)--The non-Medicaid program administered by HHSC as outlined in this subchapter.

(11) Family planning services--Educational or comprehensive medical activities that enable individuals to determine freely the

number and spacing of their children and to select the means by which this may be achieved.

(12) Federal poverty level--The household income guidelines issued annually and published in the *Federal Register* by the United States Department of Health and Human Services.

(13) Health-care provider--A physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife, federally qualified health center, family planning agency, health clinic, ambulatory surgical center, hospital ambulatory surgical center, laboratory, or rural health center.

(14) Health clinic--A corporate entity that provides comprehensive preventive and primary health care services to outpatient clients, which must include both family planning services and diagnosis and treatment of both acute and chronic illnesses and conditions in three or more organ systems. The term does not include a clinic specializing in family planning services.

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

(16) Medicaid--The Texas Medical Assistance Program, a joint federal and state program provided for in Texas Human Resources Code Chapter 32, and subject to Title XIX of the Social Security Act, 42 U.S.C. §§1396 et seq.

(17) Minor--In accordance with the Texas Family Code, a person under 18 years of age who has never been married and never been declared an adult by a court (emancipated).

(18) Point of Service--The location where an individual can receive FPP services.

(19) Provider--A physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife, federally qualified health center, family planning agency, health clinic, ambulatory surgical, hospital ambulatory surgical center, laboratory, or rural health center that receives funding from HHSC to provide family planning services.

(20) Third-party resource--A person or organization, other than HHSC or a person living with the applicant or client, who may be liable as a source of payment of the applicant's or client's medical expenses (for example, a health insurance company).

(21) Unintended pregnancy--Pregnancy a female reports as either mistimed or undesired at the time of conception.

(22) U.S.C.--United States Code.

§382.107. Client Eligibility.

(a) Criteria. A male or female is eligible to receive services through FPP if:

(1) he or she is 64 years of age or younger;

(2) he or she resides in Texas; and

(3) has countable income (as calculated under §382.109 of this subchapter (relating to Financial Eligibility Requirements) that does not exceed 250 percent of the federal poverty level (FPL).

(b) Contractors determine eligibility at the point of service in accordance with program policy and procedures.

(c) Adjunctive eligibility--An applicant is considered adjunctively (automatically) eligible for FPP services at an initial or renewal eligibility screening if the applicant can provide proof of active enrollment in one of the following programs:

(1) Children's Health Insurance Program (CHIP) Perinatal;

(2) Medicaid for Pregnant Women;

(3) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); or

(4) Supplement Nutrition Assistance Program (SNAP).

§382.109. Financial Eligibility Requirements.

Calculating countable income. FPP determines an applicant's financial eligibility by calculating the applicant's countable income. To determine countable income, FPP adds the incomes listed in paragraph (1) of this section, less any deductions listed in paragraph (2) of this section, and exempting any amounts listed in paragraph (3) of this section.

(1) To determine income eligibility, FPP counts the income of the following individuals if living together:

(A) the individual age 18 through 64, inclusive, applying for FPP;

(i) the individual's spouse; and

(ii) the individual's children age 18 and younger; or

(B) the individual age 17 or younger, inclusive, applying for FPP;

(i) the individual's parent(s);

(ii) the individual's siblings age 18 and younger; and

(iii) the individual's children;

(2) In determining countable income, FPP deducts the following items:

(A) a dependent care deduction of up to \$200 per month for each child under two years of age, and up to \$175 per month for each dependent two years of age or older;

(B) a deduction of up to \$175 per month for each dependent adult with a disability; and

(C) child support payments.

(3) FPP exempts from the determination of countable income the following types of income:

(A) the earnings of a child;

(B) up to \$300 per federal fiscal quarter in cash gifts and contributions that are from private, nonprofit organizations and are based on need;

(C) Temporary Assistance to Needy Families (TANF);

(D) the value of any benefits received under a government nutrition assistance program that is based on need, including benefits under the Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program) (7 U.S.C. §§2011-2036), the Child Nutrition Act of 1966 (42 U.S.C. §§1771-1793), the National School Lunch Act (42 U.S.C. §§1751-1769), and the Older Americans Act of 1965 (42 U.S.C. §§3056, et seq.);

(E) foster care payments;

(F) payments made under a government housing assistance program based on need;

(G) energy assistance payments;

(H) job training payments;

(I) lump sum payments;

(J) Supplemental Security Income;

(K) adoption payments;

(L) dividends, interest and royalties;

(M) Veteran's Administration;

(N) earned income tax credit payments;

(O) federal, state, or local government payments provided to rebuild a home or replace personal possessions damaged in a disaster, including payments under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. §§5121 et seq.), if the recipient is subject to legal sanction if the payment is not used as intended;

(P) educational assistance payments; and

(Q) crime victim's compensation payments.

§382.111. Denial, Suspension, or Termination of Services and Client Appeals.

(a) Notice and opportunity for hearing. HHSC may deny, suspend, or terminate services to an applicant or client if it determines that the applicant or client is ineligible to participate in FPP.

(b) Notice and opportunity for a fair hearing. Before HHSC finalizes the denial, suspension, or termination under subsection (a) of this section, the applicant or client is notified and provided an opportunity for a fair hearing in accordance with Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules).

(c) Appeal procedures. An applicant or client who is aggrieved by the denial, suspension, or termination of services under subsection (a) of this section may appeal the decision in accordance with Chapter 357, Subchapter A of this title. An applicant or client may not appeal a decision to deny, suspend, or terminate services if the decision is the result of a decision by the State to reduce or stop funding the program.

§382.113. Covered and Non-covered Services.

(a) Covered services. Services provided through FPP include:

(1) health history and physical;

(2) counseling and education;

(3) laboratory testing;

(4) provision of a contraceptive method;

(5) referrals for additional services, as needed;

(6) immunizations;

(7) breast and cervical cancer screening and diagnostic services; and

(8) prenatal services.

(b) Non-covered services. Services not provided through FPP include:

(1) counseling on and provision of abortion services;

(2) counseling on and provision of emergency contraceptives; and

(3) other services that cannot be appropriately billed with a permissible procedure code.

§382.115. Health-Care Providers.

(a) Procedures. An FPP provider must:

(1) be enrolled as a Medicaid provider in accordance with Chapter 352 of this title (relating to Medicaid and Children's Health Insurance Program Provider Enrollment);

(2) must complete the FPP certification process as described in subsection (g) of this section; and

(3) must comply with the requirements set out in Chapter 354, Subchapter A, Division 1 of this title (relating to Medicaid Procedures for Providers).

(b) Requirements. An FPP provider must ensure that:

(1) the provider does not perform or promote elective abortions outside the scope of FPP and is not an affiliate of an entity that performs or promotes elective abortions; and

(2) in offering or performing an FPP service, the provider:
(A) does not promote elective abortion within the scope of FPP;

(B) maintains physical and financial separation between its FPP activities and any elective abortion-performing or abortion-promoting activity, as evidenced by the following:

(i) physical separation of FPP services from any elective abortion activities, no matter what entity is responsible for the activities;

(ii) a governing board or other body that controls the FPP health care provider has no board members who are also members of the governing board of an entity that performs or promotes elective abortions;

(iii) accounting records that confirm that none of the funds used to pay for FPP services directly or indirectly support the performance or promotion of elective abortions by an affiliate; and

(iv) display of signs and other media that identify FPP services and the absence of signs or materials promoting elective abortion in the provider's location or in the provider's public electronic communications; and

(C) does not use, display, or operate under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

(c) Defining "promote." For purposes of subsection (b) of this section, the term "promote" means advancing, furthering, advocating, or popularizing elective abortion by, for example:

(1) taking affirmative action to secure elective abortion services for an FPP client (such as making an appointment, obtaining consent for the elective abortion, arranging for transportation, negotiating a reduction in an elective abortion provider fee, or arranging or scheduling an elective abortion procedure); however, the term does not include providing upon the patient's request neutral, factual information and nondirective counseling, including the name, address, telephone number, and other relevant information about a provider;

(2) furnishing or displaying to an FPP client information that publicizes or advertises an elective abortion service or provider; or

(3) using, displaying, or operating under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

(d) Compliance information. Upon request, an FPP provider must provide HHSC with all information HHSC requires to determine the provider's compliance with this section.

(e) Certification. Upon initial application for enrollment in FPP, an FPP contractor must certify its compliance with subsection (b) of this section and any other requirement specified by HHSC. Each FPP

contractor must annually certify that the contractor complies with subsection (b) of this section.

(f) Provider disqualification. If HHSC determines that an FPP provider fails to comply with subsection (b) of this section, HHSC disqualifies the provider from providing FPP services under this subchapter.

(g) Client assistance and recoupment. If an FPP provider is disqualified from providing FPP services under this subchapter, HHSC takes appropriate action to:

(1) assist an FPP client to find an alternate provider; and

(2) recoup any funds paid to a disqualified provider for FPP services performed during the period of disqualification.

§382.117. Prohibition of Abortion.

Abortion is not considered a method of family planning, and no state funds appropriated for the FPP are used to pay the direct or indirect costs (including overhead, rent, phones, equipment, and utilities) of abortion procedures.

§382.119. Reimbursement.

(a) Reimbursement.

(1) Covered services provided through FPP are reimbursed in accordance with Chapter 355 of this title (relating to Reimbursement Rates).

(2) Entities that contract with HHSC to provide additional services related to family planning that are separate from services referenced in paragraph (1) of this subsection are reimbursed by HHSC in compliance with program standards, policy and procedures, and contract requirements unless payment is prohibited by law.

(b) Claims procedures. An FPP provider must comply with Chapter 354, Subchapter A, Divisions 1 and 5 of this title (relating to Medicaid Procedures for Providers and relating to Physician and Physician Assistant Services).

(c) Improper use of reimbursement. An FPP provider may not use any FPP funds received to pay the direct or indirect costs (including overhead, rent, phones, equipment, and utilities) of elective abortions.

§382.121. Provider's Request for Review of Claim Denial.

(a) Review of denied claim. An FPP provider may request a review of a denied claim. The request must be submitted as an administrative appeal under Chapter 354, Subchapter I, Division 3 of this title (relating to Appeals).

(b) Appeal procedures. An administrative appeal is subject to the timelines and procedures set out in Chapter 354, Subchapter I, Division 3 of this title and all other procedures and timelines applicable to a provider's appeal of a Medicaid claim denial.

§382.123. Records Retention.

(a) FPP contractors must maintain, for the time period specified by the HHSC, all records pertaining to client services, contracts, and payments.

(b) FPP contractors must comply with the Medicaid record retention requirements found in §354.1004 of this title (relating to Retention of Records).

(c) All records relating to services must be accessible for examination at any reasonable time to representatives of HHSC and as required by law.

§382.125. Confidentiality and Consent.

(a) Confidentiality required. A provider must maintain all health care information as confidential to the extent required by law.

(b) Written release authorization. Before a provider may release any information that might identify a particular client, that client must authorize the release in writing. If the client is a minor, the client's parent, managing conservator, or guardian, as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations, must authorize the release.

(c) Confidentiality training. A provider's staff (paid and unpaid) must be informed during orientation of the importance of keeping client information confidential.

(d) Records monitoring. A provider must monitor client records to ensure that only appropriate staff and HHSC may access the records.

(e) Assurance of confidentiality. A provider must verbally assure each client that her records are confidential and must explain the meaning of confidentiality.

(f) Consent for minors. FPP services must be provided with consent from the minor's parent, managing conservator, or guardian only as authorized by Texas Family Code, Chapter 32, or by federal law or regulations.

§382.127. FPP Services for Minors.

(a) Minors must be provided individualized family planning counseling and family planning medical services that meet their specific needs as soon as possible.

(b) The provider must ensure that:

(1) counseling for minors seeking family planning services is provided with parental consent;

(2) counseling for minors includes information on use and effectiveness of all medically approved birth control methods, including abstinence; and

(3) appointment schedules are flexible enough to accommodate access for minors requesting services.

§382.129. Severability.

(a) Legislative intent. It is the intent of the Texas Legislature that FPP must be operated only in a manner that ensures that no funds spent under the program are used to:

(1) perform or promote elective abortions; or

(2) contract with entities that perform or promote elective abortions or affiliates of such entities.

(b) Limitation on administration. HHSC, as the agency responsible for administering FPP, is subject to the conditions specified in state law and legislative appropriations. Its authority to operate the program is thus strictly limited, and HHSC has no authority to operate FPP except in compliance with such conditions.

(c) Nonseverable provisions.

(1) Section 382.105(1) of this subchapter (relating to Definitions) and §382.115 of this subchapter (relating to Health-Care Providers) are necessary and integral to the implementation of the requirements of state law and legislative appropriations and the achievement of the objectives of FPP. As such, HHSC regards the provisions and application of these sections as essential aspects of HHSC's compliance with state law and, therefore, not severable from the other provisions of this subchapter.

(2) Accordingly, to the extent that §382.105(1), §382.115, or this section is determined by a court of competent jurisdiction to be unconstitutional or unenforceable, or to the degree an official or employee of HHSC or the State of Texas is enjoined from enforcing

these sections, HHSC will regard this entire subchapter as invalid and unenforceable and will cease operation of the program.

(d) Severable provisions. To the extent that any part of this subchapter other than §382.105(1), §382.115, or this section are enjoined, HHSC may enforce the parts of the subchapter not affected by such injunctive relief to the extent that HHSC determines it can do so consistent with legislative intent and the objectives of this subchapter.

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

Filed with the Office of the Secretary of State on March 14, 2016.

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 424-6900



TITLE 22. EXAMINING BOARDS

PART 9. TEXAS MEDICAL BOARD

CHAPTER 183. ACUPUNCTURE

22 TAC §§183.2, 183.4, 183.5, 183.18, 183.20

The Texas Medical Board (Board) proposes amendments to §183.2, concerning Definitions; §183.4, concerning Licensure; §183.5, concerning Annual Renewal of License; §183.18, concerning Administrative Penalties; and §183.20, concerning Continuing Acupuncture Education.

The amendment to §183.2 adds definitions for "Military service member," "Military spouse," "Military veteran," "Active duty," and "Armed forces of the United States." These amendments are in accordance with the passage of SB 1307 (84th Legislature, Regular Session) which amended Chapter 55 of the Texas Occupations Code.

The amendment to §183.4 adds language to subsection (a)(10), Alternative Licensing Procedure, expanding subsection (a)(10) to include military service members and military veterans. The amendment also includes language allowing the executive director to waive any prerequisite to obtaining a license for an applicant described in subsection (a)(10) after reviewing the applicant's credentials. These amendments are in accordance with the passage of SB 1307 (84th Legislature, Regular Session), which amended Chapter 55 of the Texas Occupations Code. Subsection (a)(10)(F) adds a provision for recognizing certain training for Applicants with military experience, based on the passage of SB 0162 (83rd Legislature, Regular Session). The change to subsection (c)(2)(A) deletes the word "either" to make the sentence grammatically correct.

The amendment to §183.5 adds new subsection (h) providing that military service members who hold a license to practice in Texas are entitled to two years of additional time to complete any other requirement related to the renewal of the military service member's license. This amendment is in accordance with the passage of SB 1307 (84th Legislature, Regular Session) which amended Chapter 55 of the Texas Occupations Code.

The amendment to §183.18 deletes subsection (g) due to redundancy, as Chapters 187 and 189 relating to Procedural Rules and Compliance already address Administrative Penalties.

The amendment to §183.20 adds new subsection (w) providing that an acupuncturist, who is a military service member, may request an extension of time, not to exceed two years, to complete any continuing education requirements. This amendment is in accordance with the passage of SB 1307 (84th Legislature, Regular Session) which amended Chapter 55 of the Texas Occupations Code.

Elsewhere in this issue of the *Texas Register*, the Board contemporaneously proposes the rule review for Chapter 183.

Scott Freshour, General Counsel for the Board, has determined that for each year of the first five years the amendments as proposed are in effect the public benefit anticipated as a result of enforcing this proposal will be to have rules that are grammatically correct; clear and consistent with current processes, without being confusing or redundant; and to have rules that are consistent with statutes.

Mr. Freshour has also determined that for the first five-year period the amendments are in effect there will be no fiscal implication to state or local government as a result of enforcing the amendments as proposed. There will be no effect to individuals required to comply with the rules as proposed. There will be no effect on small or micro-businesses.

Comments on the proposal may be submitted to Rita Chapin, P.O. Box 2018, Austin, Texas 78768-2018 or e-mail comments to: rules.development@tmb.state.tx.us. A public hearing will be held at a later date.

The amendments are proposed under the authority of the Texas Occupations Code Annotated, §205.101, which provides authority for the Board to recommend rules to establish licensing and other fees and recommend rules necessary to administer and enforce this chapter.

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

§183.2. Definitions.

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

(1) - (34) (No change.)

(35) Military service member--A person who is on active duty.

(36) Military spouse--A person who is married to a military service member.

(37) Military veteran--A person who served on active duty and who was discharged or released from active duty.

(38) Active duty--A person who is currently serving as full-time military service member in the armed forces of the United States or active duty military service as a member of the Texas military forces, as defined by §437.001, Government Code, or similar military service of another state.

(39) Armed forces of the United States--Army, Navy, Air Force, Coast Guard, or Marine Corps of the United States or a reserve unit of one of those branches of the armed forces.

§183.4. Licensure.

(a) Qualifications. An applicant must present satisfactory proof to the acupuncture board that the applicant:

(1) is at least 21 years of age;

(2) is of good professional character as defined in §183.2 of this ~~chapter~~ [title] (relating to Definitions);

(3) has successfully completed 60 semester hours of general academic college level courses, other than in acupuncture school, that are not remedial and would be acceptable at the time they were completed for credit on an academic degree at a two or four year institution of higher education within the United States accredited by an agency recognized by the Higher Education Coordinating Board or its equivalent in other states as a regional accrediting body. Coursework completed as a part of a degree program in acupuncture or Oriental medicine may be accepted by the acupuncture board if, in the opinion of the acupuncture board, such coursework is substantially equivalent to the required hours of general academic college level coursework;

(4) is a graduate of an acceptable approved acupuncture school;

(5) has taken and passed, within five attempts, each component of the full National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) examination. If an applicant submits to multiple attempts on a component before and on or after June 1, 2004, the number of attempts shall be combined based on the subject matter tested;

(6) has taken and passed the CCAOM (Council of Colleges of Acupuncture and Oriental Medicine) Clean Needle Technique (CNT) course and practical examination;

(7) for applicants who apply for a license on or after September 1, 2007, passes a jurisprudence examination ("JP exam"), which shall be conducted on the licensing requirements and other laws, rules, or regulations applicable to the acupuncture profession in this state. The jurisprudence examination shall be developed and administered as follows:

(A) Questions for the JP Exam shall be prepared by agency staff with input from the Acupuncture board and the agency staff shall make arrangements for a facility by which applicants can take the examination.

(B) Applicants must pass the JP exam with a score of 75 or better within three attempts, unless the Board allows an additional attempt based upon a showing of good cause. An applicant who is unable to pass the JP exam within three attempts must appear before the Licensure Committee of the board to address the applicant's inability to pass the examination and to re-evaluate the applicant's eligibility for licensure. It is at the discretion of the committee to allow an applicant additional attempts to take the JP exam.

(C) An examinee shall not be permitted to bring medical books, compends, notes, medical journals, calculators or other help into the examination room, nor be allowed to communicate by word or sign with another examinee while the examination is in progress without permission of the presiding examiner, nor be allowed to leave the examination room except when so permitted by the presiding examiner.

(D) Irregularities during an examination such as giving or obtaining unauthorized information or aid as evidenced by observation or subsequent statistical analysis of answer sheets, shall be sufficient cause to terminate an applicant's participation in an examination, invalidate the applicant's examination results, or take other appropriate action.

(E) A person who has passed the JP Exam shall not be required to retake the Exam for another or similar license, except as a specific requirement of the board.

(8) is able to communicate in English as demonstrated by one of the following:

(A) passage of the NCCAOM examination taken in English;

(B) passage of the TOEFL (Test of English as a Foreign Language) with a score of at least "intermediate" on the Reading and Listening sections and a score of at least "fair" on the Speaking and Writing sections of the Internet Based Test (iBT®), or a score of 550 or higher on the paper based test (PBT);

(C) passage of the TSE (Test of Spoken English) with a score of 45 or higher;

(D) passage of the TOEIC (Test of English for International Communication) with a score of 500 or higher;

(E) graduation from an acceptable approved school of acupuncture located in the United States or Canada; or

(F) at the discretion of the acupuncture board, passage of any other similar, validated exam testing English competency given by a testing service with results reported directly to the acupuncture board or with results otherwise subject to verification by direct contact between the testing service and the acupuncture board.

(9) can demonstrate current competence through the active practice of acupuncture.

(A) All applicants for licensure shall provide sufficient documentation to the board that the applicant has, on a full-time basis, actively treated persons, been a student at an acceptable approved acupuncture school, or been on the active teaching faculty of an acceptable approved acupuncture school, within either of the last two years preceding receipt of an application for licensure.

(B) The term "full-time basis," for purposes of this section, shall mean at least 20 hours per week for 40 weeks duration during a given year.

(C) Applicants who do not meet the requirements of subparagraphs (A) and (B) of this paragraph may, in the discretion of the executive director or board, be eligible for an unrestricted license or a restricted license subject to one or more of the following conditions or restrictions:

(i) limitation of the practice of the applicant to specified components of the practice of acupuncture and/or exclusion of specified components of the practice of acupuncture;

(ii) remedial education; or

(iii) such other remedial or restrictive conditions or requirements that, in the discretion of the board, are necessary to ensure protection of the public and minimal competency of the applicant to safely practice acupuncture.

(10) Alternative License Procedure for Military Service Members, Military Veterans and Military Spouses [Spouse].

(A) An applicant who is a military service member, military veteran or military [the] spouse [of a member of the armed forces of the United States assigned to a military unit headquartered in Texas] may be eligible for alternative demonstrations of competency for certain licensure requirements. Unless specifically allowed in this subsection, an applicant must meet the requirements for licensure as specified in this chapter.

(B) To be eligible, an applicant must be a military service member, military veteran or military [the] spouse [of a person serv-

ing on active duty as a member of the armed forces of the United States] and meet one of the following requirements:

(i) holds an active unrestricted acupuncture [medical] license issued by another state that has licensing requirements that are substantially equivalent to the requirements for a Texas acupuncture license; or

(ii) within the five years preceding the application date held an acupuncture license in this state, [that expired and was cancelled for nonpayment while the applicant lived in another state for at least six months.]

(C) The executive director may waive any prerequisite to obtaining a license for an applicant described by this subsection after reviewing the applicant's credentials.

(D) [(C)] Applications for licensure from applicants qualifying under [paragraph (9)(A) and (B) of] this subsection shall be expedited by the board's licensure division.

(E) [(D)] Alternative Demonstrations of Competency Allowed. Applicants qualifying under [paragraph (9)(A) and (B) of] this subsection:

(i) are not required to comply with subsection (c)(1) of this section; and

(ii) notwithstanding the one year expiration in subsection (b)(1)(B) of this section, are allowed an additional 6 months to complete the application prior to it becoming inactive; and

(iii) notwithstanding the 60 day deadline in subsection (b)(1)(G) of this section, may be considered for permanent licensure up to 5 days prior to the board meeting.

(F) Applicants with Military Experience.

(i) For applications filed on or after March 1, 2014, the board shall, with respect to an applicant who is a military service member or military veteran as defined in §183.2 of this chapter, credit verified military service, training, or education toward the licensing requirements, other than an examination requirement, for a license issued by the board.

(ii) This section does not apply to an applicant who:

(I) has had an acupuncture license suspended or revoked by another state or a Canadian province;

(II) holds an acupuncture license issued by another state or a Canadian province that is subject to a restriction, disciplinary order, or probationary order; or

(III) has an unacceptable criminal history.

(b) Procedural rules for licensure applicants. The following provisions shall apply to all licensure applicants.

(1) Applicants for licensure:

(A) whose documentation indicates any name other than the name under which the applicant has applied must furnish proof of the name change;

(B) whose applications have been filed with the board in excess of one year will be considered expired. Any fee previously submitted with that application shall be forfeited unless otherwise provided by §175.5 of this title (relating to Payment of Fees or Penalties). Any further request for licensure will require submission of a new application and inclusion of the current licensure fee. An extension to an application may be granted under certain circumstances, including:

(i) Delay by board staff in processing an application;

(ii) Application requires Licensure Committee review after completion of all other processing and will expire prior to the next scheduled meeting;

(iii) Licensure Committee requires an applicant to meet specific additional requirements for licensure and the application will expire prior to deadline established by the Committee;

(iv) Applicant requires a reasonable, limited additional period of time to obtain documentation after completing all other requirements and demonstrating diligence in attempting to provide the required documentation;

(v) Applicant is delayed due to unanticipated military assignments, medical reasons, or catastrophic events;

(C) who in any way falsify the application may be required to appear before the acupuncture board. It will be at the discretion of the acupuncture board whether or not the applicant will be issued a Texas acupuncture license;

(D) on whom adverse information is received by the acupuncture board may be required to appear before the acupuncture board. It will be at the discretion of the acupuncture board whether or not the applicant will be issued a Texas license;

(E) shall be required to comply with the acupuncture board's rules and regulations which are in effect at the time the completed application form and fee are filed with the board;

(F) may be required to sit for additional oral, written, or practical examinations or demonstrations that, in the opinion of the acupuncture board, are necessary to determine competency of the applicant;

(G) must have the application for licensure completed and legible in every detail 60 days prior to the acupuncture board meeting in which they are to be considered for licensure unless otherwise determined by the acupuncture board based on good cause.

(2) Applicants for licensure who wish to request reasonable accommodation due to a disability must submit the request at the time of filing the application.

(3) Applicants who have been licensed in any other state, province, or country shall complete a notarized oath or other verified sworn statement in regard to the following:

(A) whether the license, certificate, or authority has been the subject of proceedings against the applicant for the restriction for cause, cancellation for cause, suspension for cause, or revocation of the license, certificate, or authority to practice in the state, province, or country, and if so, the status of such proceedings and any resulting action; and

(B) whether an investigation in regard to the applicant is pending in any jurisdiction or a prosecution is pending against the applicant in any state, federal, national, local, or provincial court for any offense that under the laws of the state of Texas is a felony, and if so, the status of such prosecution or investigation.

(4) An applicant for a license to practice acupuncture may not be required to appear before the acupuncture board or any of its committees unless the application raises questions about the applicant's:

(A) physical or mental impairment;

(B) criminal conviction; or

(C) revocation of a professional license.

(c) Licensure documentation.

(1) Original documents/interview. Upon request, any applicant must appear for a personal interview at the board offices and present original documents to a representative of the board for inspection. Original documents may include, but are not limited to, those listed in paragraph (2) of this subsection.

(2) Required documentation. Documentation required of all applicants for licensure shall include the following:

(A) Birth certificate/proof of age. Each applicant for licensure must provide a copy of [either] a birth certificate, and translation^[5] if necessary, to prove that the applicant is at least 21 years of age. In instances where a birth certificate is not available, the applicant must provide copies of a passport or other suitable alternate documentation.

(B) Name change. Any applicant who submits documentation showing a name other than the name under which the applicant has applied must present copies of marriage licenses, divorce decrees, or court orders stating the name change. In cases where the applicant's name has been changed by naturalization the applicant must submit the original naturalization certificate by hand delivery or by certified mail to the board office for inspection.

(C) Examination scores. Each applicant for licensure must have a certified transcript of grades submitted directly from the appropriate testing service to the acupuncture board for all examinations used in Texas for purposes of licensure in Texas.

(D) Dean's certification. Each applicant for licensure must have a certificate of graduation submitted directly from the school of acupuncture on a form provided by the acupuncture board. The applicant shall attach to the form a recent photograph, meeting United States Government passport standards, before submitting it to the school of acupuncture. The school shall have the Dean or the designated appointee sign the form attesting to the information on the form and placing the school seal over the photograph.

(E) Diploma or certificate. All applicants for licensure must submit a copy of their diploma or certificate of graduation.

(F) Evaluations. All applicants must provide, on a form furnished by the acupuncture board, evaluations of their professional affiliations for the past ten years or since graduation from acupuncture school, whichever is the shorter period.

(G) Preacupuncture school transcript. Each applicant must have the appropriate school or schools submit a copy of the record of their undergraduate education directly to the acupuncture board. Transcripts must show courses taken and grades obtained. If determined that the documentation submitted by the applicant is not sufficient to show proof of the completion of 60 semester hours of college courses other than in acupuncture school, the applicant must obtain coursework verification by submitting documentation to the acupuncture board for a determination as to the adequacy of such education or to a two or four year institution of higher education within the United States. The institution must be preapproved by the board's executive director and accredited by an agency recognized as a regional accrediting body by the Texas Higher Education Coordinating Board or its equivalent in another state.

(H) School of acupuncture transcript. Each applicant must have his or her acupuncture school submit a transcript of courses taken and grades obtained directly to the acupuncture board. Transcripts must clearly demonstrate completion of 1,800 instructional hours, with at least 450 hours of herbal studies.

(I) Fingerprint card. Each applicant must submit his or her fingerprints according to the procedure prescribed by the board.

(J) Other verification. For good cause shown, with the approval of the acupuncture board, verification of any information required by this subsection may be made by a means not otherwise provided for in this subsection.

(3) Additional documentation. Applicants may be required to submit other documentation, including but not limited to the following:

(A) Translations. An accurate certified translation of any document that is in a language other than the English language must be submitted along with the original document or a certified copy of the original document which has been translated.

(B) Arrest Records. If an applicant has ever been arrested, a copy of the arrest and arrest disposition from the arresting authority and must be submitted by that authority directly to the acupuncture board.

(C) Malpractice. If an applicant has ever been named in a malpractice claim filed with any liability carrier or if an applicant has ever been named in a malpractice suit, the applicant shall submit the following:

(i) a completed liability carrier form furnished by the acupuncture board regarding each claim filed against the applicant's insurance;

(ii) for each claim that becomes a malpractice suit, a letter from the attorney representing the applicant directly to this board explaining the allegation, dates of the allegation, and current status of the suit. If the suit has been closed, the attorney must state the disposition of the suit, and if any money was paid, the amount of the settlement, unless release of such information is prohibited by law or an order of a court with competent jurisdiction. If such letter is not available, the applicant will be required to furnish a notarized affidavit explaining why this letter cannot be provided; and

(iii) a statement, composed by the applicant, explaining the circumstances pertaining to patient care in defense of the allegations.

(D) Inpatient treatment for alcohol/substance abuse or mental illness. Each applicant that has been admitted to an inpatient facility within the last five years for the treatment of alcohol/substance abuse or mental illness must submit the following:

(i) an applicant's statement explaining the circumstances of the hospitalization;

(ii) an admitting summary and discharge summary, submitted directly from the inpatient facility;

(iii) a statement from the applicant's treating physician/psychologist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(iv) a copy of any contracts or agreements signed with any licensing authority.

(E) Outpatient treatment for alcohol/substance abuse or mental illness. Each applicant that has been treated on an outpatient basis within the last five years for alcohol/substance abuse or mental illness must submit the following:

(i) an applicant's statement explaining the circumstances of the outpatient treatment;

(ii) a statement from the applicant's treating physician/psychologist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(iii) a copy of any contracts or agreements signed with any licensing authority.

(F) Additional documentation. Additional documentation as is deemed necessary to facilitate the investigation of any application for licensure.

(G) DD214. A copy of the DD214 indicating separation from any branch of the United States military must be submitted.

(H) Other verification. For good cause shown, with the approval of the acupuncture board, verification of any information required by this subsection may be made by a means not otherwise provided for in this subsection.

(I) False documentation. Falsification of any affidavit or submission of false information to obtain a license may subject an acupuncturist to denial of a license or to discipline pursuant to the Act, §205.351.

(4) Substitute documents/proof. The acupuncture board may, at its discretion, allow substitute documents where proof of exhaustive efforts on the applicant's part to secure the required documents is presented. These exceptions are reviewed by the acupuncture board, a board committee, or the board's executive director on an individual case-by-case basis.

(d) Temporary license.

(1) Issuance. The acupuncture board may, through the executive director of the agency, issue a temporary license to a licensure applicant who:

(A) appears to meet all the qualifications for an acupuncture license under the Act, but is waiting for the next scheduled meeting of the acupuncture board for review and for the license to be issued; or

(B) has not, on a full-time basis, actively practiced as an acupuncturist as defined under subsection (a)(9) of this section but meets all other requirements for licensure.

(2) Duration/renewal. A temporary license shall be valid for 100 days from the date issued and may be extended only for another 30 days after the date the initial temporary license expires. Issuance of a temporary license may be subject to restrictions at the discretion of the executive director and shall not be deemed dispositive in regard to the decision by the acupuncture board to grant or deny an application for a permanent license.

(e) Distinguished professor temporary license.

(1) Issuance. The acupuncture board may issue a distinguished professor temporary license to an acupuncturist who:

(A) holds a substantially equivalent license, certificate, or authority to practice acupuncture in another state, province, or country;

(B) agrees to and limits any acupuncture practice in this state to acupuncture practice for demonstration or teaching purposes for acupuncture students and/or instructors, and in direct affiliation with an acupuncture school that is a candidate for accreditation or has accreditation through the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) at which the students are trained and/or the instructors teach;

(C) agrees to and limits practice to demonstrations or instruction under the direct supervision of a licensed Texas acupuncturist who holds an unrestricted license to practice acupuncture in this state;

(D) pays any required fees for issuance of the distinguished professor temporary license; and

(E) passes the JP Exam, as provided in subsection (a)(7) of this section.

(2) Duration. The distinguished professor temporary license shall be valid for a continuous one-year period; however, the permit is revocable at any time the board deems necessary. The distinguished professor temporary license shall automatically expire one year after the date of issuance. The distinguished professor temporary license may not be renewed or reissued.

(3) Disciplinary action. A distinguished professor temporary license may be denied, terminated, canceled, suspended, or revoked for any violation of acupuncture board rules or the Act, Subchapter H.

(f) Relicensure. If an acupuncturist's license has been expired for one year, it is considered to have been canceled, and the acupuncturist may not renew the license. The acupuncturist may submit an application for relicensure and must comply with the requirements and procedures for obtaining an original license.

§183.5. Annual Renewal of License.

(a) Acupuncturists licensed under the Act shall register annually and pay a fee. An acupuncturist may renew an unexpired license by submitting the required form and by paying the required renewal fee to the acupuncture board on or before the expiration date each year. The fee shall accompany a written application which legibly sets forth the licensee's name, mailing address, the place or places where the licensee is engaged in the practice of acupuncture, and other necessary information prescribed by the acupuncture board.

(b) Falsification of an affidavit or submission of false information to obtain renewal of a license shall subject an acupuncturist to denial of a license renewal or to discipline pursuant to §205.351 of the Act.

(c) If the renewal fee and completed application form are not received on or before the expiration date, penalty fees will be imposed as outlined in §175.3(3) of this title (relating to Penalties).

(d) If a acupuncturist's permit has been expired for 90 days or less, the acupuncturist may obtain a new permit by submitting to the board a completed permit application, the registration fee, as defined in §175.2(3) of this title (relating to Registration and Renewal Fees) and the penalty fee, as defined in §175.3(3)(A) of this title.

(e) If a acupuncturist's permit has been expired for more than 90 days but less than one year, the acupuncturist may obtain a new permit by submitting to the board a completed permit application, the registration fee, as defined in §175.2(3) of this title and the penalty fee, as defined in §175.3(3)(B) of this title.

(f) If a acupuncturist's registration permit has been expired for one year or longer, the acupuncturist's license is automatically canceled, unless an investigation is pending, and the acupuncturist may not register for a new permit.

(g) Practicing acupuncture after a acupuncturist's permit has expired under subsection (c) of this section without obtaining a new registration permit for the current registration period has the same effect as, and is subject to all penalties of, practicing acupuncture without a license.

(h) A military service member who holds an acupuncture license in Texas is entitled to two years of additional time to complete any other requirement related to the renewal of the military service member's license.

§183.18. *Administrative Penalties.*

(a) Pursuant to §205.352 of the Act and Chapter 165 of the Medical Practice Act, the board by order may impose an administrative penalty, subject to the provisions of the APA, against a person licensed or regulated under the Act who violates the Act or a rule or order adopted under the Act. The imposition of such a penalty shall be consistent with the requirements of the Act and the APA.

(b) The penalty for a violation may be in an amount not to exceed \$5,000. Each day a violation continues or occurs is a separate violation for purposes of imposing a penalty.

(c) Prior to the imposition of an administrative penalty by board order, a person must be given notice and opportunity to respond and present evidence and argument on each issue that is the basis for the proposed administrative penalty at a show compliance proceeding.

(d) The amount of the penalty shall be based on the factors set forth under Chapter 190 of this title (relating to Disciplinary Guidelines).

(e) If the board by order determines that a violation has occurred and imposes an administrative penalty on a person licensed or regulated under the Act, the board shall give notice to the person of the board's order which shall include a statement of the right of the person to seek judicial review of the order.

(f) An administrative penalty may be imposed under this section for the following:

(1) failure to timely comply with a board subpoena issued by the board shall be grounds for the imposition of an administrative penalty of no less than \$100 and no more than \$5,000 for each separate violation;

(2) failure to timely comply with the terms, conditions, or requirements of a board order shall be grounds for imposition of an administrative penalty of no less than \$100 and no more than \$5,000 for each separate violation;

(3) failure to timely report a change of address to the board shall be grounds for imposition of an administrative penalty of no less than \$100 and no more than \$5,000 for each separate violation;

(4) failure to timely respond to a patient's communications shall be grounds for imposition of an administrative penalty of no less than \$100 and no more than \$5,000 for each separate violation;

(5) failure to comply with the complaint procedure notification requirements as set forth in §183.11 of this chapter [title] (relating to Complaint Procedure Notification) shall be grounds for imposition of an administrative penalty of no less than \$100 and no more than \$5,000 for each separate violation;

(6) failure to provide show compliance proceeding information in the prescribed time shall be grounds for imposition of an administrative penalty of no less than \$100 and no more than \$5,000 for each separate violation; and

(7) for any other violation other than quality of care that the board deems appropriate shall be grounds for imposition of an administrative penalty of no less than \$100 and no more than \$5,000 for each separate violation.

~~[(g) In the case of untimely compliance with a board order, the board staff shall not be authorized to impose an administrative penalty without an informal show compliance proceeding if the person licensed or regulated under the Act has not first been brought into compliance with the terms, conditions, and requirements of the order other than the time factors involved.]~~

~~(g) [(h)] Any order proposed under this section shall be subject to final approval by the board.~~

~~(h) [(i)] Failure to pay an administrative penalty imposed through an order shall be grounds for disciplinary action by the board pursuant to the Act, §205.351(a)(10), regarding unprofessional or dishonorable conduct likely to deceive or defraud, or injure the public, and shall also be grounds for the executive director to refer the matter to the attorney general for collection of the amount of the penalty.~~

~~(i) [(j)] A person who becomes financially unable to pay an administrative penalty after entry of an order imposing such a penalty, upon a showing of good cause by a writing executed by the person under oath and at the discretion of the Discipline and Ethics Committee of the board, may be granted an extension of time or deferral of no more than one year from the date the administrative penalty is due. Upon the conclusion of any such extension of time or deferral, if payment has not been made in the manner and in the amount required, action authorized by the terms of the order or subsection (h) [(i)] of this section.~~

§183.20. *Continuing Acupuncture Education.*

(a) - (c) (No change.)

(d) Grounds for Exemption from Continuing Acupuncture Education. An acupuncturist may request in writing and may be exempt from the annual minimum continuing acupuncture education requirements for one or more of the following reasons:

(1) the licensee's catastrophic illness;

(2) the licensee's military service of longer than one year in duration;

(3) the licensee's acupuncture practice and residence of longer than one year in duration outside the United States; and/or

(4) good cause shown on written application of the licensee which gives satisfactory evidence to the board that the licensee is unable to comply with the requirements of continuing acupuncture education.

(e) - (v) (No change.)

(w) An acupuncturist, who is a military service member, may request an extension of time, not to exceed two years, to complete any CAE requirements.

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

Filed with the Office of the Secretary of State on March 14, 2016.

TRD-201601217

Mari Robinson, J.D.

Executive Director

Texas Medical Board

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 305-7016



CHAPTER 188. PERFUSIONISTS

22 TAC §§188.1 - 188.15, 188.17 - 188.24, 188.26, 188.28, 188.29

The Texas Medical Board (Board), and the Perfusionist Licensure Advisory Committee (Advisory Committee), propose new §§188.1 - 188.15, 188.17 - 188.24, 188.26, 188.28 and 188.29, concerning Perfusionists. The proposed rules establish quali-

fications, procedures, requirements and processes that enable the Board to regulate the practice of perfusion and perform the various functions, including licensing, compliance, and enforcement, as it relates to the practice of perfusion in Texas.

The Texas Legislature enacted Senate Bill 202 (S.B. 202), 84th Legislature, Regular Session (2015), which transferred the Perfusionist licensing program, under Chapter 603 of the Texas Occupations Code, from the Department of State Health Services (DSHS) to the Texas Medical Board (Board). The statutory amendments transferring regulation of Perfusionists from DSHS to the Board took effect on September 1, 2015.

The proposed new rules under 22 TAC Chapter 188 are proposed in accordance with the changes to Chapter 603 of the Texas Occupations Code, as enacted by S.B. 202, and are necessary to enable the Board to regulate the practice of perfusion and perform the various functions, including licensing, compliance, and enforcement relating to the practice of perfusion.

The Advisory Committee met on February 12, 2016, to consider a draft of these rules and recommended proposing them in the *Texas Register* for public comment.

Scott Freshour, General Counsel for the Board, has determined that for each year of the first five years the rules as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be to implement the new statutory provisions of Chapter 603 of the Texas Occupations Code, as enacted by S.B. 202, which transfers the primary responsibility of licensing and regulating the practice of perfusion to the Board and the Advisory Committee. The proposed rules align processes and procedures, related to licensing and regulating the practice of perfusion, with the Board's current processes and procedures and further enable the Board to perform the various functions, including licensing, compliance, and enforcement, as it relates to the practice of perfusion in Texas. Additionally, the proposed rules benefit the public by setting forth practice and licensing requirements, as well as describe the disciplinary process and procedures as it pertains to perfusionists. The rules clarify the Board's authority and help insure the safe practice of properly trained and qualified perfusionists in Texas. Moreover, the proposed rules provide a mechanism for licensees to obtain treatment through the Texas Physician Health Program for health conditions that impair, or may impair, a licensee's practice of perfusion. The proposed rules are organized to assist the public and the regulated community in easily locating rules and regulations specific to licensing, compliance, and enforcement, as it relates to the practice of perfusion in Texas. Finally, the proposed rules are streamlined so as to not duplicate provisions that are already located in the statute under Chapter 603 of the Occupations Code and other applicable rules in 22 TAC Part 9, which apply uniformly to licensees regulated by the Board.

Mr. Freshour has also determined that for the first five-year period the rules are in effect there will be no fiscal implication to state or local government as a result of enforcing the sections as proposed. The effect to individuals required to comply with the sections, as proposed, will be the fees associated with licensure and registration. There will be no effect on small or micro businesses.

Comments on the proposal may be submitted to Rita Chapin, P.O. Box 2018, Austin, Texas 78768-2018 or e-mail comments to: rules.development@tmb.state.tx.us. A public hearing will be held at a later date.

The new rules are proposed under the authority of the Texas Occupations Code Annotated, §603.152, which provide authority for the Board to adopt rules as necessary to: regulate the practice of perfusion; enforce Chapter 603 of the Texas Occupations Code; and perform its duties under Chapter 603 of the Texas Occupations Code.

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

§188.1. Purpose.

These rules are promulgated under the authority Medical Practice Act Title 3, Subtitle B, Tex. Occ. Code and the Licensed Perfusionist Act, Texas Occupations Code Annotated Chapter 603. The purpose of these rules is to establish procedures and standards for the training, education, licensing, and discipline of persons performing perfusion in this state so as to establish an orderly system of regulating the practice of perfusion in a manner which protects the health, safety, and welfare of the public. Nothing in these rules and regulations shall be construed to relieve the supervising or ordering physician of the professional or legal responsibility for the care and treatment of his or her patients. In addition, nothing in these rules and regulations shall be construed to require licensure as a perfusionist for those individuals who are exempted, under §603.004 of the Act.

§188.2. Definitions.

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

(1) Act--The Licensed Perfusionists Act, Title 3, Subtitle K, Texas Occupations Code Annotated Chapter 603.

(2) Active duty--A person who is currently serving as full-time military service member in the armed forces of the United States or active duty military service as a member of the Texas military forces, as defined by §437.001, Government Code, or similar military service of another state.

(3) Address of record--The mailing address of each licensee or applicant as provided to the agency pursuant to the Act.

(4) Advisory committee--The Perfusionist Licensure Advisory Committee, an informal advisory committee to the board whose purpose is to advise the board regarding rules relating to the licensure, enforcement, and discipline of perfusionists.

(5) APA--Administrative Procedure Act, Texas Government Code, Chapter 2001 as amended.

(6) Applicant--A person seeking a perfusionist license from the board.

(7) Armed forces of the United States--Army, Navy, Air Force, Coast Guard, or Marine Corps of the United States or a reserve unit of one of those branches of the armed forces.

(8) Board--The Texas Medical Board.

(9) Delegating physician--A physician licensed by the board who delegates, to a licensed perfusionist, the practice of perfusion.

(10) Health care professional--A licensed perfusionist, provisional licensed perfusionist, or any person licensed, certified, or registered by the state in a health-related profession.

(11) Military service member--A person who is on active duty.

(12) Military spouse--A person who is married to a military service member.

(13) Military veteran--A person who served on active duty and who was discharged or released from active duty.

(14) Perfusion--The function necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, or respiratory system, or a combination of those activities, and to ensure the safe management of physiologic functions by monitoring the parameters of the system under an order and under the supervision of a licensed physician, including:

(A) the use of extracorporeal circulation, cardiopulmonary support techniques, and other therapeutic and diagnostic technologies;

(B) counterpulsation, ventricular assistance, or autotransfusion (including blood conservation techniques), administration of cardioplegia, and isolated limb perfusion;

(C) the use of techniques involving blood management, advanced life support, and other related functions; and

(D) in the performance of the acts described in this subsection:

(i) the administration of:

(I) pharmacological and therapeutic agents; or

(II) blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician;

(ii) the performance and use of:

(I) anticoagulation analysis;

(II) physiologic analysis;

(III) blood gas and chemistry analysis;

(IV) hematocrit analysis;

(V) hypothermia;

(VI) hyperthermia;

(VII) hemoconcentration; and

(VIII) hemodilution; and

(iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

(15) Perfusionist--A person licensed as a perfusionist by the board.

(16) Perfusion protocols--Perfusion-related policies and protocols developed or approved by a licensed health facility or a physician through collaboration with administrators, licensed perfusionists, and other health professionals.

(17) Provisional licensed perfusionist--A person provisionally licensed as a perfusionist by the board.

(18) Submit--The term used to indicate that a completed item has been actually received and date-stamped by the board along with all required documentation and fees, if any.

(19) Supervision--Supervision of a provisionally licensed perfusionist by a licensed perfusionist or a physician who is licensed by the Texas Medical Board and certified by the American Board of Thoracic Surgery or certified in cardiovascular surgery by the American Osteopathic Board of Surgery. Supervision includes overseeing

the activities of, and accepting responsibility for, the perfusion services rendered by a provisionally licensed perfusionist.

§188.3. Meetings.

(a) The advisory committee shall meet as requested by the board to carry out the mandates of the Act.

(b) A meeting may be held by telephone conference call.

(c) Special meetings may be called by the president of the board, by resolution of the board, or upon written request to the presiding officer of the board signed by at least three members of the board.

(d) Advisory committee meetings shall, to the extent possible, be conducted pursuant to the provisions of Robert's Rules of Order Newly Revised unless, by rule, the board adopts a different procedure.

(e) All issues requiring a vote of the committee shall be decided by a simple majority of the members present.

§188.4. Qualifications for Licensure.

(a) Except as otherwise provided in this section, an individual applying for licensure must:

(1) submit an application on forms approved by the board;

(2) pay the appropriate application fee;

(3) certify that the applicant is mentally and physically able to function safely as a perfusionist;

(4) not have a license, certification, or registration in this state or from any other licensing authority or certifying professional organization that is currently revoked, suspended, or subject to probation or other disciplinary action for cause;

(5) have no proceedings that have been instituted against the applicant for the restriction, cancellation, suspension, or revocation of certificate, license, or authority to practice perfusion in the state, territory, Canadian province, country, or uniformed service of the United States in which it was issued;

(6) have no prosecution pending against the applicant in any state, federal, or Canadian court for any offense that under the laws of this state is a felony;

(7) be of good professional character;

(8) not have violated any provision of any federal or state statute relating to confidentiality of patient communications or records;

(9) not have been convicted of a felony or a crime involving moral turpitude;

(10) not use drugs or alcohol to an extent that affects the applicant's professional competency;

(11) not have engaged in fraud or deceit in applying for a license;

(12) pass an independently evaluated perfusionist examination approved by the board;

(13) have successfully completed an educational program as set forth in subparagraphs (A) and (B) of this paragraph:

(A) a perfusion education program that is accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) at the time of graduation; or

(B) a substantially equivalent program with requirements as stringent as those established by the Accreditation Committee for Perfusion Education (AC-PE) and approved by the board.

(i) Degrees and course work received in international countries shall be acceptable only if the degree or coursework has educational standards that are as stringent as those established by the AC-PE and approved by CAAHEP or their successors.

(ii) An international training program shall be acceptable only if it has educational standards as stringent as those established by the AC-PE and approved by the CAAHEP or their successors.

(14) submit a complete and legible set of fingerprints, on a form prescribed by the medical board, to the medical board or to the Department of Public Safety for the purpose of obtaining criminal history record information from the Department of Public Safety and the Federal Bureau of Investigation, as required by §603.2571 of the Act.

(15) submit to the board any other information the board considers necessary to evaluate the applicant's qualifications.

(b) Competency Examination. An individual applying for licensure must submit proof of passage of the required perfusion examination administered by the American Board of Cardiovascular Perfusion (ABCP).

(1) If an applicant has already successfully completed the required examination administered by the ABCP, the applicant shall not be required to be reexamined, provided that the applicant furnishes the board with a copy of the test results indicating that the applicant passed the examination and proof that he or she has been certified by the ABCP for some time period within three years immediately preceding date of application.

(2) An applicant who fails the required competency examination administered by the ABCP four times may not reapply as a provisional licensed perfusionist.

(3) The board shall waive the examination requirement for an applicant who, at the time of application:

(A) is licensed or certified by another state that has licensing or certification requirements that the board determines to be substantially equivalent to the requirements of this chapter; or

(B) holds a certificate as a certified clinical perfusionist issued by the ABCP before January 1, 1994, authorizing the holder to practice perfusion in a state that does not license or certify perfusionists.

(c) Jurisprudence Examination. Applicants for licensure must pass a jurisprudence examination ("JP exam"), which shall be conducted on the licensing requirements and other laws, rules, or regulations applicable to the perfusionist profession in this state. The jurisprudence examination shall be developed and administered as follows:

(1) Questions for the JP Exam shall be prepared by agency staff with input from the Advisory Committee and board and the agency staff shall make arrangements for a facility by which applicants can take the examination.

(2) Applicants must pass the JP exam with a score of 75 or better within three attempts, unless the board allows an additional attempt based upon a showing of good cause. An applicant who is unable to pass the JP exam within three attempts must appear before the Licensure Committee of the board to address the applicant's inability to pass the examination and to re-evaluate the applicant's eligibility for licensure. It is at the discretion of the committee to allow an applicant additional attempts to take the JP exam.

(3) An examinee shall not be permitted to bring books, compends, notes, journals, calculators or other help into the ex-

amination room, nor be allowed to communicate by word or sign with another examinee while the examination is in progress without permission of the presiding examiner, nor be allowed to leave the examination room except when so permitted by the presiding examiner.

(4) Irregularities during an examination such as giving or obtaining unauthorized information or aid as evidenced by observation or subsequent statistical analysis of answer sheets, shall be sufficient cause to terminate an applicant's participation in an examination, invalidate the applicant's examination results, or take other appropriate action.

(5) A person who has passed the JP Exam shall not be required to retake the Exam for another or similar license, except as a specific requirement of the board.

(6) The JP examination must be taken and passed no more than two years prior to the date of the application for licensure.

(d) Alternative License Procedures for Military Service Members, Military Veterans, and Military Spouses.

(1) An applicant who is a military service member, military veteran, or military spouse may be eligible for alternative demonstrations of competency for certain licensure requirements. Unless specifically allowed in this subsection, an applicant must meet the requirements for licensure as specified in this chapter.

(2) To be eligible, an applicant must be a military service member, military veteran, or military spouse and meet one of the following requirements:

(A) holds an active unrestricted perfusionist license issued by another state that has licensing requirements that are substantially equivalent to the requirements for a Texas perfusionist license; or

(B) within the five years preceding the application date held a perfusionist license in this state.

(3) The executive director may waive any prerequisite to obtaining a license for an applicant described by this subsection after reviewing the applicant's credentials.

(4) Applications for licensure from applicants qualifying under this section, shall be expedited by the board's licensure division. Such applicants shall be notified, in writing or by electronic means, as soon as practicable, of the requirements and process for renewal of the license.

(5) Alternative Demonstrations of Competency Allowed. Applicants qualifying under this section, notwithstanding:

(A) the one year expiration in §188.5 of this chapter (relating to Procedural Rules for Licensure Applicants), are allowed an additional six months to complete the application prior to it becoming inactive; and

(B) the requirement to produce a copy of a valid and current certificate demonstrating completion of an educational program as described in this section and required in §188.6 of this chapter (relating to Licensure Documentation), may substitute certification from the ABCP if it is made on a valid examination transcript.

(e) Applicants with Military Experience.

(1) The board shall, with respect to an applicant who is a military service member or military veteran as defined in §188.2 of this chapter (relating to Definitions), credit verified military service, training, or education toward the licensing requirements, other than an examination requirement, for a license issued by the board.

(2) This section does not apply to an applicant who:

(A) has had a perfusionist license suspended or revoked by another state, territory, Canadian province or country;

(B) holds a perfusionist license issued by another state, territory, Canadian province or country that is subject to a restriction, disciplinary order, or probationary order; or

(C) has an unacceptable criminal history.

§188.5. Procedural Rules for Licensure Applicants.

(a) An applicant for licensure:

(1) whose documentation indicates any name other than the name under which the applicant has applied must furnish proof of the name change;

(2) whose applications have been filed with the board in excess of one year will be considered expired. Any fee previously submitted with that application shall be forfeited unless otherwise provided by §175.5 of this title (relating to Payment of Fees or Penalties). Any further request for licensure will require submission of a new application and inclusion of the current licensure fee. An extension to an application may be granted under certain circumstances, including:

(A) Delay by board staff in processing an application;

(B) Application requires Licensure Committee review after completion of all other processing and will expire prior to the next scheduled meeting;

(C) Licensure Committee requires an applicant to meet specific additional requirements for licensure and the application will expire prior to deadline established by the Committee;

(D) Applicant requires a reasonable, limited additional period of time to obtain documentation after completing all other requirements and demonstrating diligence in attempting to provide the required documentation;

(E) Applicant is delayed due to unanticipated military assignments, medical reasons, or catastrophic events;

(3) who in any way falsifies the application may be required to appear before the board. It will be at the discretion of the board whether or not the applicant will be issued a license;

(4) on whom adverse information is received by the board may be required to appear before the board. It will be at the discretion of the board whether or not the applicant will be issued a license;

(5) shall be required to comply with the board's rules and regulations which are in effect at the time the completed application form and fee are received by the board; and

(6) must complete an oath swearing that the applicant has submitted an accurate and complete application.

(b) Review and Recommendations by the Executive Director.

(1) The executive director or designee shall review applications for licensure and may determine whether an applicant is eligible for licensure or refer an application to a committee of the board for review.

(2) If the executive director or designee determines that the applicant clearly meets all licensing requirements, the executive director or designee, may issue a license to the applicant, to be effective on the date issued without formal board approval, as authorized by §603.151 of the Act.

(3) If the executive director determines that the applicant does not clearly meet all licensing requirements as prescribed by the Act and this chapter, a license may be issued only upon action by the

board following a recommendation by the Licensure Committee, in accordance with §603.151 and §603.255 of the Act and §187.13 of this title (relating to Informal Board Proceedings Relating to Licensure Eligibility). Not later than the 20th day after the date the applicant receives notice of the executive director's determination the applicant shall:

(A) request a review of the executive director's recommendation by a committee of the board conducted in accordance with §187.13 of this title; or

(B) withdraw his or her application.

(C) If an applicant fails to take timely action, as provided under this subsection, such inaction shall be deemed a withdrawal of his or her application.

(4) To promote the expeditious resolution of any licensure matter, the executive director, with the approval of the board, may recommend that an applicant be eligible for a license, but only under certain terms and conditions and present a proposed agreed order or remedial plan to the applicant. Not later than the 20th day after the date the applicant receives notice of the executive director's recommendation, the applicant shall do one of the following:

(A) sign the order/remedial plan and the order/remedial plan shall be presented to the board for consideration and acceptance without initiating a Disciplinary Licensure Investigation (as defined in §187.13 of this title) or appearing before a committee of the board concerning issues relating to licensure eligibility; or

(B) request a review of the executive director's recommendation by a committee of the board conducted in accordance with §187.13 of this title; or

(C) withdraw his or her application.

(D) If an applicant fails to take timely action, as provided under this subsection, such inaction shall be deemed a withdrawal of his or her application

(c) Committee Referrals. An applicant who has either requested to appear before the licensure committee of the board or has elected to be referred to the licensure committee of the board due to a determination of ineligibility by the Executive Director in accordance with section, in lieu of withdrawing the application for licensure, may be subject to a Disciplinary Licensure Investigation as defined in §187.13 of this title. Review of the executive director's determination by a committee of the board shall be conducted in accordance with §187.13 of this title.

§188.6. Licensure Documentation.

(a) Original documents include, but are not limited to, those listed in subsections (b) and (c) of this section.

(b) Documentation required of all applicants for licensure.

(1) Birth Certificate/Proof of Age. Each applicant for licensure must provide a copy of a birth certificate and translation if necessary to prove that the applicant is at least 21 years of age. In instances where a birth certificate is not available the applicant must provide copies of a passport or other suitable alternate documentation.

(2) Name change. Any applicant who submits documentation showing a name other than the name under which the applicant has applied must present copies of marriage licenses, divorce decrees, or court orders stating the name change. In cases where the applicant's name has been changed by naturalization, the applicant should send the original naturalization certificate by certified mail to the board office for inspection.

(3) Examination verification. Each applicant for licensure must have the appropriate testing service that administered the required perfusionist competency examination, described in §188.4 of this chapter (relating to Qualifications of Licensure), submit verification of the applicant's passage of the examination directly to the board or verification of current certification by the ABCP.

(4) Certificate from Educational Program or other State License. All applicants must submit:

(A) a certificate of successful completion of an educational program as described in §188.4 of this chapter, unless the applicant qualifies for the special eligibility provision regarding education under §188.4 of this chapter;

(B) If an applicant is or has been licensed, certified, or registered in another state, territory, or jurisdiction, the applicant must submit information required by the board concerning that license, certificate or registration on official board forms.

(5) Transcripts. Each applicant must have his or her educational program(s) submit a transcript of courses taken and grades obtained to demonstrate compliance with curriculum requirements under §188.4 of this chapter.

(6) Evaluations.

(A) All applicants must provide evaluations, on forms provided by the board, of their professional affiliations for the past three years or since graduation from an educational program, in compliance with §188.4 of this chapter (relating to Qualifications for Licensure), whichever is the shorter period.

(B) The evaluations must come from at least three supervisors or instructors who are either licensed perfusionists or licensed physicians and have each supervised the applicant's work experience.

(C) An exception to subparagraph (B) of this paragraph may be made for those applicants who provide adequate documentation that they have not been supervised by at least three licensed physicians or licensed perfusionists for the three years preceding the board's receipt of application or since graduation, whichever is the shorter period.

(7) License verifications. Each applicant for licensure who is licensed, registered, or certified in another state must have that state submit, directly to the board, proof that the applicant's license, registration, or certification is current and in full force and that the license, registration, or certification has not been restricted, suspended, revoked or otherwise subject to disciplinary action. The other state shall also include a description of any sanctions imposed by or disciplinary matters pending in the state.

(c) Applicants may be required to submit other documentation, which may include the following:

(1) Translations. Any document that is in a language other than the English language will need to have a certified translation prepared and a copy of the translation submitted with the translated document.

(A) An official translation from the school or appropriate agency attached to the foreign language transcript or other document is acceptable.

(B) If a foreign document is received without a translation, the board will send the applicant a copy of the document to be translated and returned to the board.

(C) Documents must be translated by a translation agency who is a member of the American Translation Association or a United States college or university official.

(D) The translation must be on the translator's letterhead, and the translator must verify that it is a "true word for word translation" to the best of his/her knowledge, and that he/she is fluent in the language translated, and is qualified to translate the document.

(E) The translation must be signed in the presence of a notary public and then notarized. The translator's name must be printed below his/her signature. The notary public must use the phrase: "Subscribed and Sworn this _____ day of _____, 20____." The notary must then sign and date the translation, and affix his/her notary seal to the document.

(2) Arrest records. If an applicant has ever been arrested, the applicant must request that the arresting authority submit to the board copies of the arrest and arrest disposition.

(3) Inpatient treatment for alcohol/substance disorder or mental illness. An inpatient facility shall include a hospital, ambulatory surgical center, nursing home, and rehabilitation facility. Each applicant that has been admitted to an inpatient facility within the last five years for treatment of alcohol/substance disorder or mental illness (recurrent or severe major depressive disorder, bipolar disorder, schizophrenia, schizoaffective disorder, or any severe personality disorder), or a physical illness that impairs or has impaired the applicant's ability to practice perfusion, shall submit documentation must submit the following:

(A) applicant's statement explaining the circumstances of the inpatient treatment/hospitalization;

(B) all records, submitted directly from the inpatient facility;

(C) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(D) a copy of any contracts signed with any licensing authority, professional society or impaired practitioner committee.

(4) Outpatient treatment for alcohol/substance disorder or mental illness. Each applicant that has been treated on an outpatient basis within the past five years for alcohol/substance disorder or mental illness (recurrent or severe major depressive disorder, bipolar disorder, schizophrenia, schizoaffective disorder, or any severe personality disorder), or a physical illness that impairs or has impaired the applicant's ability to practice perfusion, shall submit documentation to include, but not limited to the following:

(A) applicant's statement explaining the circumstances of the outpatient treatment;

(B) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(C) a copy of any contracts signed with any licensing authority, professional society or impaired practitioners committee.

(5) Malpractice. If an applicant has ever been named in a malpractice claim filed with any liability carrier or if an applicant has ever been named in a malpractice suit, the applicant must:

(A) have each liability carrier complete a form furnished by this board regarding each claim filed against the applicant's insurance;

(B) for each claim that becomes a malpractice suit, have the attorney representing the applicant in each suit submit a letter to the board explaining the allegation, relevant dates of the allegation, and current status of the suit. If the suit has been closed, the attorney must state the disposition of the suit and, if any money was paid, the amount of the settlement. If such letter is not available, the applicant will be required to furnish a notarized affidavit explaining why this letter cannot be provided; and

(C) provide a statement composed by the applicant, explaining the circumstances pertaining to patient care in defense of the allegations.

(6) Additional documentation. Additional documentation may be required as is deemed necessary to facilitate the investigation of any application for licensure.

(d) The board may, in unusual circumstances, allow substitute documents where proof of exhaustive efforts on the applicant's part to secure the required documents is presented. These exceptions are reviewed by the board's executive director on a case-by-case basis.

§188.7. Provisional Licensed Perfusionists.

(a) The board may issue a provisional license to an applicant who:

(1) files an application and pays the application fee as specified in Chapter 175 of this title (relating to Fees and Penalties);

(2) meets all the qualifications for a license under the Act and this chapter, with the exception of passage of the required competency examination described in §188.4 of this chapter (relating to Qualifications for Licensure); and

(3) practices under the supervision and direction of a licensee while performing perfusion, as described in this section.

(b) Supervision.

(1) A provisional licensed perfusionist shall be under the supervision and direction of a currently licensed perfusionist who resides in Texas.

(2) Supervision and direction shall be defined as procedural guidance provided by a licensed perfusionist.

(3) The supervising licensed perfusionist must sign the application for a provisional license and the application for renewal of the provisional license.

(4) The supervising licensee must:

(A) have an unrestricted license in Texas;

(B) not have an investigation or proceeding pending for the restriction, cancellation, suspension, revocation, or other discipline of the supervisor's license, permit, or authority to practice medicine or perfusion; and

(C) not have been the subject of a disciplinary order, unless the order was administrative in nature.

(5) An applicant or provisional licensee may request the board to approve that supervision and direction be performed by a licensed physician in lieu of a licensed perfusionist.

(A) The request for a variance must be in writing and must include the following:

(i) the individual's name and address;

(ii) the reason(s) why a licensed perfusionist is not reasonably available to provide supervision and direction; and

(iii) the name, address, and copies of the credentials for verification that the physician is licensed by the Texas Medical Board and certified and/or eligible for certification by the American Board of Thoracic Surgeons, Inc., or certified and/or eligible for certification in cardiovascular surgery by the American Osteopathic Board of Surgery.

(B) The applicant will be notified of approval or denial of the request in writing.

(c) Termination. The supervising licensee must submit written notification of termination of supervision to the board and the supervisee within 14 days of when supervision has ceased. The provisional licensed perfusionist shall make a good faith effort to ensure that the supervising licensee submits an appropriate notification.

(d) Changes. Any change in the supervision shall be submitted in writing to the Executive Director. The signature of the supervising licensee shall be included in the written notice.

(e) Required supervisor. A provisional licensed perfusionist must have a supervising licensed perfusionist or licensed physician at all times whether or not the provisional licensed perfusionist is actively employed.

(f) An applicant shall be determined ineligible for a provisional license if the applicant:

(1) has had a perfusionist license or certificate suspended or revoked by another state, territory, Canadian province or country;

(2) holds a perfusionist license or certificate issued by another state, territory, Canadian province or country that is subject to a restriction, disciplinary order, or probationary order; or

(3) has an unacceptable criminal history.

(g) A provisional license expires on the earlier of:

(1) the date the board issues the provisional license holder a full Texas perfusionist license or denies the provisional license holder's application for a full license;

(2) one year after the date the provisional license was issued; or

(3) upon determination by the Executive Director that the provisional license holder is ineligible for licensure pursuant to the Act or this chapter.

(h) An individual may not renew a provisional license more than five times.

§188.8. Temporary Licensure.

(a) The executive director of the board may issue a temporary license to an applicant:

(1) whose completed application has been filed, processed, and found to be in order; and

(2) who has met all other requirements for licensure under the Act, but is waiting for the next scheduled meeting of the board for the license to be issued.

(b) A temporary license is valid for 100 days from the date issued and may be extended for not more than an additional 30 days after the expiration date of the initial temporary license.

§188.9. License Renewal.

(a) Perfusionists licensed by the board shall register biennially and pay a fee. A perfusionist may, on notification from the board, renew an unexpired licensed by submitting a required form and paying the

required renewal fee to the board on or before the expiration date of the license. The fee shall accompany a written application that sets forth the licensee's name, mailing address, the address of each of the licensee's offices, and other necessary information prescribed by the board.

(b) An applicant renewing a license shall submit a complete and legible set of fingerprints for purposes of performing a criminal history check of the applicant if required, as provided by §603.3031 of the Act.

(c) The board may prorate the length of the initial perfusionist registration and registration fees, so that registrations expire on a single date, regardless of the board meeting at which the perfusionist is licensed.

(d) The board shall provide written notice to each practitioner at the practitioner's address of record at least 30 days prior to the expiration date of the license.

(e) Within 30 days of a perfusionist's change of mailing or office address from the address on file with the board, a perfusionist shall notify the board in writing of such change.

(f) A licensee shall furnish a written explanation of his or her affirmative answer to any question asked on the application for license renewal, if requested by the board. This explanation shall include all details as the board may request and shall be furnished within 14 days of the date of the board's request.

(g) The board may deny renewal of a license, pursuant to §603.401 of the Act, under the following circumstances:

(1) A licensee's falsification of an affidavit or submission of false information to obtain renewal of a license;

(2) A licensee's violation of the Act or rules;

(3) A licensee's default on a student loan as provided by the Education Code, §57.491 relating to student loan default; or

(4) A licensee's default on a child support obligation as provided by the Texas Family Code, Title 5, Subtitle D, Chapter 232.

(h) The board shall deny renewal of the license of a person for whom a contested case is pending until resolution of the case, but such individual remains licensed pending resolution of the contested case, if timely application for renewal is made.

(i) The board may refuse to renew the license of a person who fails to pay an administrative penalty imposed under the Act, unless enforcement of the penalty is stayed or a court has ordered that the administrative penalty is not owed.

(j) Expired Annual Registration License.

(1) If a perfusionist's license has been expired for 90 days or less, the perfusionist may obtain a new license by submitting to the board a completed license application and fee, and the penalty fee, as defined in §175.3 of this title (relating to Penalties).

(2) If a perfusionist's license has been expired for longer than 90 days, but less than one year, the perfusionist may obtain a new license by submitting a completed application and fee, and a penalty fee as defined in §175.3 of this title.

(3) If a perfusionist's license has been expired for one year or longer, the perfusionist's license is automatically canceled, unless an investigation is pending, and the perfusionist may not obtain a new license.

(4) A perfusionist may not hold himself out as a licensed perfusionist if he holds an expired license. Practicing perfusion after a

perfusionist's license has expired under this subsection without obtaining a new registration license for the current registration period has the same effect as, and is subject to all penalties of, practicing perfusion without a license.

(k) A military service member who holds a perfusionist license in Texas is entitled to two years of additional time to complete any other requirement related to the renewal of the military service member's license.

(l) Renewal of Expired License by Out-Of-State Practitioner.

(1) The board may renew, without reexamination, an expired license of a person who was licensed as a perfusionist in this state, moved to another state, and is licensed or certified and has been in practice in the other state for the two years preceding the date the person applies for renewal of the expired license in this state.

(2) The person must pay to the board a fee that is equal to the amount of the renewal fee for the license.

§188.10. Code of Ethics.

(a) The rules in this chapter shall constitute a code of ethics as authorized by the Act, §603.151.

(b) Perfusionists are obligated to maintain ethical and professional responsibilities and shall be expected to conform to all state and federal laws, rules, ethical and professional standards, including those set forth in Chapter 603 of the Act and this title.

§188.11. Perfusionist Scope of Practice.

The practice of perfusion is limited to perfusion performed as described under §603.003 of the Act.

§188.12. Supervision.

(a) Perfusionists shall perform perfusion under an order and under the supervision of a licensed physician and in accordance with §603.003 of the Act and this chapter.

(b) Perfusion-related policies and protocols shall be developed or approved by a licensed health facility or a physician through collaboration with administrators, licensed perfusionists, and other health professionals as required by §603.003 of the Act and this chapter.

(c) A provisionally licensed perfusionist under §188.7 of this chapter (relating to Provisional Licensed Perfusionists), shall be supervised by a perfusionist or physician who has an active and unrestricted license to practice as a perfusionist or physician in Texas.

§188.13. Grounds for Denial of Licensure and for Disciplinary Action.

The board may refuse to issue a license to any person and may, following notice of hearing as provided for in the APA, take disciplinary action against any perfusionist that:

(1) fraudulently or deceptively obtains or attempts to obtain a license;

(2) fraudulently or deceptively uses a license or misrepresents his or her qualifications or credentials;

(3) falsely represents that the person is a physician;

(4) violates the Act, Code of Ethics, Code of Ethics promulgated by the ABCP or any rule relating to the practice of perfusion;

(5) is convicted of a felony, or has imposition of deferred adjudication or pre-trial diversion;

(6) habitually uses drugs or alcohol to the extent that, in the opinion of the board, the person cannot safely perform as a perfusionist;

(7) has been adjudicated as mentally incompetent or has a mental or physical condition that renders the person unable to safely perform as a perfusionist;

(8) has acted in an unprofessional or dishonorable manner that is likely to deceive, defraud, or injure any member of the public;

(9) has failed to practice as a perfusionist in an acceptable manner consistent with public health and welfare;

(10) has committed any act that is in violation of the laws of this state if the act is connected with practice as a perfusionist; a complaint, indictment, or conviction of a law violation is not necessary for the enforcement of this provision. Proof of the commission of the act while in practice as a perfusionist or under the guise of practice as a perfusionist is sufficient for action by the board under this section;

(11) has had the person's license or other authorization to practice as a perfusionist suspended, revoked, or restricted or who has had other disciplinary action taken by another state, territory, Canadian province or country regarding practice as a perfusionist or had disciplinary action taken by the uniformed services of the United States. A certified copy of the record of the state, territory, Canadian province, country or uniformed services of the United States taking the action is conclusive evidence of it;

(12) unlawfully advertises in a false, misleading, or deceptive manner as defined by §101.201 of the Texas Occupations Code or promotes or endorses products in a false or misleading manner;

(13) alters, with fraudulent intent, any perfusionist license, certificate, or diploma;

(14) uses any perfusionist license, certificate, or diploma that has been fraudulently purchased, issued, or counterfeited or that has been materially altered;

(15) is removed or suspended or has disciplinary action taken by his peers in any professional association or society, whether the association or society is local, regional, state, or national in scope, or is being disciplined by a licensed hospital or medical staff of a hospital, including removal, suspension, limitation of privileges, or other disciplinary action, if that action, in the opinion of the board, was based on unprofessional conduct or professional incompetence that was likely to harm the public. This action does not constitute state action on the part of the association, society, or hospital medical staff;

(16) has repeated or recurring meritorious health care liability claims that in the opinion of the board evidence professional incompetence likely to harm the public;

(17) sexually abuses or exploits another person through the licensee's practice as a perfusionist;

(18) provides medically unnecessary services to a patient or submitting a billing statement to a patient or a third party payer that the licensee knew or should have known was improper, as further provided by §311.0025 of the Texas Health and Safety Code and §101.203 of the Texas Occupations Code. "Improper" means the billing statement is false, fraudulent, misrepresents services provided, or otherwise does not meet professional standards;

(19) violates a board order;

(20) fails to comply with a board subpoena or request for information or action;

(21) provides false information to the board;

(22) fails to cooperate with board staff;

(23) refers a patient to a facility, laboratory, or other health-care establishment without disclosing the existence of the licensee's ownership interest in the entity to the patient;

(24) behaving in an abusive or assaultive manner towards a patient or the patient's family or representatives that interferes with patient care or could be reasonably expected to adversely impact the quality of care rendered to a patient;

(25) fails to timely respond to communications from a patient;

(26) fails to complete the required amounts of CE;

(27) fails to maintain the confidentiality of a patient;

(28) behaves in a disruptive manner toward licensees, hospital personnel, other medical personnel, patients, family members or others that interferes with patient care or could be reasonably expected to adversely impact the quality of care rendered to a patient;

(29) enters into any agreement whereby a licensee, peer review committee, hospital, medical staff, or medical society is restricted in providing information to the board;

(30) contacts or attempt to contact a complainant, witness, medical peer review committee member, or professional review body regarding statements used in an active investigation by the board for purposes of intimidation. It is not a violation for a licensee under investigation to have contact with a complainant, witness, medical peer review committee member, or professional review body if the contact is in the normal course of business and unrelated to the investigation.

(31) defaults on student loans;

(32) fails to pay child support as required by court order;

(33) aids or abets, directly or indirectly, the practice of perfusion by any person not duly licensed to practice as a perfusionist by the board;

(34) fails to practice in an acceptable professional manner consistent with public health and welfare, including, but not limited to, failing to treat a patient according to the generally accepted standard of care, negligence in performing perfusion services, failing to use proper diligence in one's professional practice, failing to safeguard against potential complications;

(35) fails to adequately supervise the provisionally licensed perfusionist according to Act or rules adopted by the board; or

(36) lacks the competency, skill or ability to provide perfusion services according to the standard of care.

§188.14. Discipline of Perfusionists.

(a) The board, upon finding a perfusionist has committed any of the acts set forth in §188.13 of this chapter (relating to Grounds for Denial of Licensure and for Disciplinary Action), may enter an order imposing one or more of the allowable actions set forth under §603.151 and §603.401 of the Act including:

(1) deny the person's application for a license or other authorization to practice as a perfusionist;

(2) administer a public reprimand;

(3) order revocation, suspension, limitation, or restriction of a perfusionist's license, or other authorization to practice as a perfusionist, including limiting the practice of the person to, or excluding from the practice, one or more specified activities of the practice as a perfusionist or stipulating periodic board review;

- (4) require a perfusionist to submit to care, counseling, or treatment by a health care practitioner designated by the board;
- (5) order the perfusionist to perform public service;
- (6) require the perfusionist to complete additional training;
- (7) require the perfusionist to participate in continuing education programs; or
- (8) assess an administrative penalty against the perfusionist.

(b) The board may stay enforcement of any order and place the perfusionist on probation. The board shall retain the right to vacate the probationary stay and enforce the original order for noncompliance with the terms of probation or to impose any other remedial measures or sanctions authorized by subsection (a) of this section in addition to or instead of enforcing the original order.

(c) The time period of an order shall be extended for any period of time in which the person subject to an order subsequently resides or practices outside this state or for any period during which the person's license is subsequently cancelled for nonpayment of licensure fees.

§188.15. Disciplinary Guidelines.

(a) Chapter 190 of this title (relating to Disciplinary Guidelines) shall apply to perfusionists regulated under this chapter to be used as guidelines for the following areas as they relate to the denial of licensure or disciplinary action of a licensee:

- (1) practice inconsistent with public health and welfare;
- (2) unprofessional and dishonorable conduct;
- (3) disciplinary actions by state boards and peer groups;
- (4) repeated and recurring meritorious health care liability claims;
- (5) aggravating and mitigating factors; and
- (6) criminal convictions.

(b) If the provisions of Chapter 190 of this title conflict with the Act or rules under this chapter, the Act and provisions of this chapter shall control.

(c) Pursuant to §603.151 of the Act, §187.9 of this title (relating to Board Actions), and §187.13 of this title (relating to Informal Board Proceedings Relating to Licensure Eligibility) the Board may impose a nondisciplinary remedial plan to resolve an investigation of a complaint or as a condition for licensure.

§188.17. Complaint Procedure Notification.

Pursuant to §603.202 of the Act, §178.3 of this title (relating to Complaint Procedure Notification) shall govern perfusionists with regard to methods of notification for filing complaints with the agency. If the provisions of §178.3 of this title conflict with the Act or rules under this chapter, the Act and provisions of this chapter shall control.

§188.18. Investigations.

(a) Investigation of complaints shall be conducted in accordance with Chapter 178 of this title (relating to Complaints) and Chapter 179 of this title (relating to Investigations) and referred to an informal settlement conference in accordance with Chapter 187 of this title (relating to Procedural Rules), if appropriate. If the provisions of Chapters 178, 179 or 187 of this title conflict with the Act or rules under this chapter, the Act and provisions of this chapter shall control.

(b) Confidentiality. All complaints, adverse reports, monitoring reports, investigation files, investigation materials, investigative re-

ports, and other investigative information in the possession of, or received, or gathered by the board or its employees or agents relating to a person, licensee, an application for license, or a criminal investigation or proceeding are privileged and confidential and are not subject to discovery, subpoena, or other means of legal compulsion for their release to anyone other than the board or its employees or agents involved in the investigation or discipline of a person or license holder.

(c) Permitted disclosure of investigative information. Investigative information in the possession of the board or its employees or agents that relates to discipline of a licensee and information contained in such files may not be disclosed except in the following circumstances:

(1) to the appropriate licensing or regulatory authorities in other states or the District of Columbia or a territory or country where the perfusionist is licensed, registered, or certified or has applied for a license;

(2) to a peer assistance program approved by the board under Chapter 467, Health and Safety Code;

(3) to appropriate law enforcement agencies if the investigative information indicates a crime may have been committed and the board shall cooperate with and assist all law enforcement agencies conducting criminal investigations of licensees by providing information relevant to the criminal investigation to the investigating agency and any information disclosed by the board to an investigative agency shall remain confidential and shall not be disclosed by the investigating agency except as necessary to further the investigation; or

(4) persons engaged in bona fide research, if all individual-identifying information has been deleted.

§188.19. Third Party Reports to the Board.

(a) Any medical peer review committee in this state, any perfusionist licensed to practice in this state shall report relevant information to the board related to the acts of any perfusionist in this state if, in the opinion of the medical peer review committee, the perfusionist poses a continuing threat to the public welfare through his practice as a perfusionist. The duty to report under this section shall not be nullified through contract.

(b) Professional Review Actions. A written report of a professional review action taken by a peer review committee or a health-care entity provided to the board must contain the results and circumstances of the professional review action. Such results and circumstances shall include:

(1) the specific basis for the professional review action, whether or not such action was directly related to the care of individual patients; and

(2) the specific limitations imposed upon the perfusionist's clinical privileges, upon membership in the professional society or association, and the duration of such limitations.

(c) Reporting a Perfusionist's Continuing Threat to the Public.

(1) Relevant information shall be reported to the board indicating that a perfusionist's practice poses a continuing threat to the public welfare and shall include a narrative statement describing the time, date, and place of the acts or omissions on which the report is based.

(2) A report that a perfusionist's practice constitutes a continuing threat to the public welfare shall be made to the board as soon as possible after the peer review committee reaches that conclusion and is able to assemble the relevant information.

(d) Reporting Professional Liability Claims.

(1) Reporting responsibilities. The reporting form must be completed and forwarded to the board for each defendant perfusionist against whom a professional liability claim or complaint has been filed. The information is to be reported by insurers or other entities providing professional liability insurance for a perfusionist. If a non-admitted insurance carrier does not report or if the perfusionist has no insurance carrier, reporting shall be the responsibility of the perfusionist.

(2) In addition, as part of the registration process, each licensee shall report:

(A) the name and address of any entity that provides the licensee coverage for health care liability claims;

(B) any health care liability lawsuits that have been filed since the last registration, including the date that the licensee was served with the lawsuit, the cause number, court, and county of suit; and

(C) any settlements of health care liability claims or lawsuits that have been made since the last registration, including the date of the settlement, the amount paid by or on behalf of the licensee, and, if a lawsuit had been filed on the claim, the cause number, court, and county of suit.

(3) Separate reports required and identifying information. One separate report shall be filed for each defendant perfusionist insured. When Part II is filed, it shall be accompanied by the completed Part I or other identifying information as described in paragraph (4) of this subsection.

(4) Time frames and attachments. The information in Part I of the form must be provided within 30 days of receipt of the claim or suit. A copy of the claim letter or petition and expert report must be attached. If the expert report is not filed with the Court at the time the lawsuit is filed, the expert report shall be filed with the board, together with an updated Part I of the form, not later than the 30th day after receipt of the expert report. Part II of the form, reporting the settlement of a health care liability claim, shall be filed not later than the 30th day after the date of settlement of a health care liability claim, whether or not a lawsuit has been filed..

(5) Penalty. Failure by a licensed insurer to report under this section shall be referred to the Texas Department of Insurance.

(6) Definition. For the purposes of this subsection a professional liability claim or complaint shall be defined as a cause of action against a perfusionist for treatment, lack of treatment, or other claimed departure from accepted standards of health care or safety which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.

(7) Claims not required to be reported. Examples of claims that are not required to be reported under this chapter but which may be reported include, but are not limited to, the following:

(A) product liability claims (i.e. where a perfusionist invented a device which may have injured a patient, but the perfusionist has had no patient relationship with the specific patient claiming injury by the device);

(B) antitrust allegations;

(C) allegations involving improper peer review activities;

(D) civil rights violations; or

(E) allegations of liability for injuries occurring on a perfusionist's property, but not involving a breach of duty to the patient (i.e. slip and fall accidents).

(8) Voluntary Reporting. Claims that are not required to be reported under this chapter may, however, be voluntarily reported.

(9) Reporting Form. The reporting form shall be as follows:

Figure: 22 TAC §188.19(d)(9)

(10) Professional Liability Suits and Claims. Following receipt of a notice of claim letter or a complaint filed in court against a licensee that is reported to the board, the licensee shall furnish to the board the following information within 14 days of the date of receipt of the board's request for said information:

(A) a completed questionnaire to provide summary information concerning the suit or claim;

(B) a completed questionnaire to provide information deemed necessary in assessing the licensee's competency;

(C) information on the status of any suit or claim previously reported to the board.

(e) Immunity and Reporting Requirements. A person, health care entity, medical peer review committee, or other entity that without malice furnishes records, information, or assistance to the board is immune from any civil liability arising from such act.

§188.20. Impaired Perfusionists.

(a) Mental or physical examination requirement. The board may require a licensee to submit to a mental and/or physical examination by a physician or physicians designated by the board if the board has probable cause to believe that the licensee is impaired. Impairment is present if one appears to be unable to practice with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material; or as a result of any mental or physical condition. Probable cause may include, but is not limited to, any one of the following:

(1) sworn statements from two people, willing to testify before the board or the State Office of Administrative Hearings that a certain licensee is impaired;

(2) evidence that a licensee left a treatment program for alcohol or chemical dependency before completion of that program;

(3) evidence that a licensee has engaged in the intemperate use of drugs or alcohol;

(4) evidence of repeated arrests of a licensee for intoxication or drug use;

(5) evidence of recurring temporary commitments of a licensee to a mental institution; or

(6) medical records indicating that a licensee has an illness or condition which results in the inability to function properly in his or her practice.

(b) Chapter 180 of this title (relating to Texas Physician Health Program and Rehabilitation Orders) shall be applied to perfusionists who are believed to be impaired and eligible for the Texas Physician Health Program.

§188.21. Procedure.

Chapter 187 of this title (relating to Procedural Rules) shall govern procedures relating to perfusionists where applicable. If the provisions of Chapter 187 of this title conflict with the Act or rules under this chapter, the Act and provisions of this chapter shall control.

§188.22. Compliance.

Chapter 189 of this title (relating to Compliance Program) shall be applied to perfusionists who are under board orders. If the provisions of

Chapter 189 of this title conflict with the Act or rules under this chapter, the Act and provisions of this chapter shall control.

§188.23. Construction.

The provisions of this chapter shall be construed and interpreted so as to be consistent with the statutory provisions of the Act and the Medical Practice Act. In the event of a conflict between this chapter and the provisions of the Acts, the provisions of the Acts shall control; however, this chapter shall be construed so that all other provisions of this chapter which are not in conflict with the Acts shall remain in effect.

§188.24. Continuing Education.

(a) Completion of continuing education (CE) requirements by licensee with current certification by the ABCP or its successor agency. Completion of continuing education requirements may be documented by demonstrating current certification by the ABCP annual license renewal.

(b) Completion of CE requirements by licensee without current certification by the ABCP. A licensee without current certification by the ABCP at the time of license renewal must meet the following criteria.

(1) Document a minimum of 30 continuing education credit (CEUs) every 24 months (24 month timeline is in relation to the biennial registration period, not the calendar year). A licensee must report during registration if she or he has completed the required CE. Documentation of CE courses shall be made available to the Board upon request, but should not be mailed with the registration payment. Random audits will be made to assure compliance. A minimum of 15 hours of CEU must be earned in Category I. The activity period covered in the professional activity report is from the date of licensure to the third licensure renewal date and every subsequent third license renewal date.

(2) Document a minimum of 40 clinical perfusion cases in a two-year period by submitting a clinical activity report upon renewal, on the approved form, demonstrating completion of 40 cases each biennial as the Primary Perfusionist for Cardiopulmonary bypass (instructor or primary), ECMO, VAD, Isolated Limb Perfusion, or VENO-VENO bypass.

(3) One CEU or contact hour activity is defined as 50 minutes spent in an organized, structured or unstructured learning experience. Categories of CEU activities are:

(A) Category I--Perfusion Meetings and Other Perfusion Related Activity--Perfusion meetings are those programs and seminars in which a minimum of 75% of the contact hours consist of perfusion related material. Only those meetings approved by the ABCP will qualify for Category 1 hours. Examples:

(i) International, national regional, and state perfusion meetings.

(ii) Publication of perfusion related book chapter or paper in a professional journal.

(iii) Presentation at an international, national, regional or state perfusion journal.

(B) Category II--Non-Accredited Perfusion Meetings and Other Medical Meetings--This category includes international, national, regional, and state meetings that have not been approved by the ABCP, local perfusion meetings and all other medically related meetings. Examples:

(i) International, National, Regional, and State, perfusion meetings that have not been accredited by the ABCP.

(ii) Local perfusion meetings (do not require ABCP accreditation). Any perfusion meeting NOT EQUALLY ACCESSIBLE to the general CCP community, this includes manufacturer-specific and company-sponsored educational activities.

(iii) International, National, Regional, or Local medically-related meetings.

(C) Category III--Individual Education and Other Self-Study Activities Credit in this category is acquired on an hour for hour basis of the time spent in these non-accredited or non-supervised activities. Examples:

(i) Reading or viewing medical journals, audio-visual, or other educational material.

(ii) Participation in electronic forums.

(iii) Participation in a Journal Club.

(iv) Participation in degree-oriented, professional-related course work.

(v) Presentation of perfusion topic at a non-perfusion meeting.

(4) Documentation of activities. Licensees are responsible for reporting completion of their professional activities. This information must be reported to the board at the time of registration and renewal and documentation must be submitted to the board upon request. Credit will not be granted for activities that are not documented. The suitable documentation is outlined as follows:

(A) Category I--Perfusion meetings--Approved perfusion meetings held before June 30, 1998, may be documented by copies of registration receipts or official meeting name tags. For approved perfusion meetings held after June 30, 1998, an official document from the meeting sponsor documenting attendance and the number of hours received must be provided.

(i) Perfusion Publications must have complete reference of book or article (authors, title, journal and date/volume of journal.

(ii) Perfusion Presentations must have copy of program agenda.

(B) Category II--International, national, regional, and state perfusion meetings not accredited by the ABCP, local perfusion meetings and all other medical meetings--must provide an official document stating CEUs awarded and copy of the meeting program.

(C) Category III--All self-study activities will require an official record of completion or written summary of the activity.

(D) Submission of a clinical activity report upon renewal, on the approved form, demonstrating completion of 40 cases each biennial as the Primary Perfusionist for Cardiopulmonary bypass (instructor or primary), ECMO, VAD, Isolated Limb Perfusion, or VENO-VENO bypass.

(c) A licensee may request in writing an exemption for the following reasons:

(1) the licensee's catastrophic illness;

(2) the licensee's military service of longer than one year's duration outside the state;

(3) the licensee's residence of longer than one year's duration outside the United States; or

(4) good cause shown submitted in writing by the licensee that gives satisfactory evidence to the board that the licensee is unable to comply with the requirement for continuing education.

(d) Exemptions are subject to the approval of the executive director of the board and must be requested in writing at least 30 days prior to the expiration date of the license.

(e) An exception under subsection (c) of this section may not exceed one year but may be requested annually, subject to the approval of the executive director of the board.

(f) This section does not prevent the board from taking board action with respect to a licensee or an applicant for a license by requiring additional hours of continuing education or of specific course subjects.

(g) The board may require written verification of both formal and informal credits from any licensee within 30 days of request. Failure to provide such verification may result in disciplinary action by the board.

(h) Unless exempted under the terms of this section, a licensee's apparent failure to obtain and timely report the number of hours of CE as required annually and provided for in this section shall result in the denial of licensure renewal until such time as the licensee obtains and reports the required CE hours.

(i) CE hours that are obtained to comply with the CE requirements for the preceding year as a prerequisite for obtaining licensure renewal, shall first be credited to meet the CE requirements for the previous year. Once the previous year's CE requirement is satisfied, any additional hours obtained shall be credited to meet the CE requirements for the current year.

(j) A false report or statement to the board by a licensee regarding CE hours reportedly obtained shall be a basis for disciplinary action by the board pursuant to §603.401 of the Act. A licensee who is disciplined by the board for such a violation may be subject to the full range of actions authorized by the Act including suspension or revocation of the perfusionist's license, but such action shall not be less than an administrative penalty of \$500.

(k) A perfusionist, who is a military service member, may request an extension of time, not to exceed two years, to complete any CE requirements.

§188.26. Exemption from Registration Fee for Retired Perfusionists Providing Voluntary Charity Care.

(a) A retired perfusionist licensed by the board whose only practice is the provision of voluntary charity care shall be exempt from the registration fee.

(b) As used in this section:

(1) "voluntary charity care" means perfusion services provided for no compensation to:

- (A) indigent populations;
- (B) in medically underserved areas; or
- (C) for a disaster relief organization.

(2) "compensation" means direct or indirect payment of anything of monetary value, except payment or reimbursement of reasonable, necessary, and actual travel and related expenses.

(c) To qualify for and obtain such an exemption, a perfusionist must truthfully certify under oath, on a form approved by the board that the following information is correct:

(1) the perfusionist's practice of perfusion does not include the provision of perfusion services for either direct or indirect compensation which has monetary value of any kind;

(2) the perfusionist's practice is limited to voluntary charity care for which the perfusionist receives no direct or indirect compensation of any kind for perfusion services rendered; and

(3) the perfusionist's practice does not include the provision of perfusion services to members of the perfusionist's family.

(d) A perfusionist who qualifies for and obtains an exemption from the registration fee authorized under this section shall obtain and report continuing education as required under the Act and §188.24 of this chapter (relating to Continuing Education), except that the number of credits of CE required shall be equal to two-thirds of the number of continuing education hours required for renewal for a licensed perfusionist.

(e) A retired perfusionist who has obtained an exemption from the registration fee as provided for under this section, may be subject to disciplinary action under the Act based on unprofessional or dishonorable conduct likely to deceive, defraud, or injure the public if the perfusionist engages in the compensated practice of perfusion or the provision of perfusion services to members of the perfusionist's family.

(f) A perfusionist who attempts to obtain an exemption from the registration fee under this section by submitting false or misleading statements to the board shall be subject to disciplinary action pursuant to the Act in addition to any civil or criminal actions provided for by state or federal law.

(g) A perfusionist may return to active status by applying to the board, paying an application fee equal to an application fee for a perfusionist license, complying with the requirements for license renewal under the Act, and submitting professional evaluations from each employment held before the license was placed on retired status, demonstrate any formal or informal continuing education obtained during the period of retired status, provide a description of all voluntary charity care provided during the period of retired status, and complying with paragraph (h) of this section.

(h) The request of a perfusionist seeking a return to active status whose license has been placed on official retired status for two years or longer shall be submitted to the Licensure Committee of the board for consideration and a recommendation to the full board for approval or denial of the request. After consideration of the request and the recommendation of the Licensure Committee, the board shall grant or deny the request. If the request is granted, it may be granted without conditions or subject to such conditions which the board determines are necessary to adequately protect the public including but not limited to:

(1) completion of specified continuing education hours approved for Category 1 credits by a CE sponsor approved by the ABCP;

(2) limitation and/or exclusion of the practice of the applicant to specified activities of the practice as a perfusionist;

(3) remedial education; and/or

(4) such other remedial or restrictive conditions or requirements which, in the discretion of the board are necessary to ensure protection of the public and minimal competency of the applicant to safely practice as a perfusionist.

(i) The request of a perfusionist seeking a return to active status whose license has been placed on retired status providing voluntary charity care for less than two years may be approved by the executive director of the board or submitted by the executive director to the Li-

censure Committee for consideration and a recommendation to the full board for approval or denial of the request. In those instances in which the executive director submits the request to the Licensure Committee of the board, the Licensure Committee shall make a recommendation to the full board for approval or denial. After consideration of the request and the recommendation of the Licensure Committee, the board shall grant or deny the request subject to such conditions which the board determines are necessary to adequately protect the public including, but not limited to, those options provided in subsection (h) of this section.

(j) In evaluating a request of a perfusionist seeking a return to active status whose license has been placed on retired status providing voluntary charity care, the Licensure Committee or the full board may require a personal appearance by the requesting perfusionist at the offices of the board, and may also require a physical or mental examination by one or more perfusionists or other health care providers approved in advance in writing by the executive director, the secretary-treasurer, the Licensure committee, or other designee(s) determined by majority vote of the board.

§188.28. Exemption from Registration Fee for Retired Perfusionists.

(a) The registration fee shall not apply to retired perfusionists. To become exempt from the registration fee due to retirement:

(1) the perfusionist's current license must not be under an investigation or order with the board or otherwise have a restricted license; and

(2) the perfusionist must request in writing on a form prescribed by the board for his or her license to be placed on official retired status.

(b) The following restrictions shall apply to perfusionists whose licenses are on official retired status:

(1) the perfusionist must not engage in clinical activities or practice perfusion in any state; and

(2) the perfusionist's license may not be endorsed to any other state.

(c) A perfusionist may return to active status by applying to the board, paying an application fee equal to an application fee for a perfusionist license, complying with the requirements for license renewal under the Act, and submitting professional evaluations from each employment held before the license was placed on retired status, demonstrate any formal or informal continuing education obtained during the period of retired status and complying with paragraph (d) of this section.

(d) The request of a perfusionist seeking a return to active status whose license has been placed on official retired status for two years or longer shall be submitted to the Licensure Committee of the board for consideration and a recommendation to the full board for approval or denial of the request. After consideration of the request and the recommendation of the Licensure Committee, the board shall grant or deny the request. If the request is granted, it may be granted without conditions or subject to such conditions which the board determines are necessary to adequately protect the public including but not limited to:

(1) completion of specified continuing education hours approved for Category I credits by a CE sponsor approved by the ABCP;

(2) limitation and/or exclusion of the practice of the applicant to specified activities of the practice as a perfusionist;

(3) remedial education; and/or

(4) such other remedial or restrictive conditions or requirements which, in the discretion of the board are necessary to ensure pro-

tection of the public and minimal competency of the applicant to safely practice as a perfusionist.

(e) The request of a perfusionist seeking a return to active status whose license has been placed on official retired status for less than two years may be approved by the executive director of the board or submitted by the executive director to the Licensure Committee for consideration and a recommendation to the full board for approval or denial of the request. In those instances in which the executive director submits the request to the Licensure Committee of the board, the Licensure Committee shall make a recommendation to the full board for approval or denial. After consideration of the request and the recommendation of the Licensure Committee, the board shall grant or deny the request subject to such conditions which the board determines are necessary to adequately protect the public including but not limited to those options provided in subsection (d)(1) - (4) of this section.

(f) In evaluating a request to return to active status, the Licensure Committee or the full board may require a personal appearance by the requesting perfusionist at the offices of the board, and may also require a physical or mental examination by one or more physicians or other health care providers approved in advance in writing by the executive director, the secretary-treasurer, the Licensure Committee, or other designee(s) determined by majority vote of the board.

(g) A perfusionist applying for retired status under subsections (a) and (b) of this section may be approved for emeritus retired status, a subgroup of "official retired status," provided that the perfusionist has:

(1) never received a remedial plan or been the subject of disciplinary action by the Texas Medical Board;

(2) no criminal history, including pending charges, indictment, conviction and/or deferred adjudication in Texas; and

(3) never held a license, registration or certification that has been restricted for cause, canceled for cause, suspended for cause, revoked or subject to another form of discipline in a state, or territory of the United States, a province of Canada, a uniformed service of the United States or other regulatory agency.

§188.29. Voluntary Relinquishment or Surrender of a License.

Chapter 196 of this title (relating to Voluntary Relinquishment or Surrender of a Medical License) shall govern procedures relating to perfusionists where applicable. If the provisions of Chapter 196 of this title conflict with the Licensed Perfusionist Act or rules under this chapter, the Licensed Perfusionist Act and provisions of this chapter shall control.

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

Filed with the Office of the Secretary of State on March 11, 2016.

TRD-201601209

Mari Robinson, J.D.

Executive Director

Texas Medical Board

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 305-7016



TITLE 25. HEALTH SERVICES

PART 11. CANCER PREVENTION AND RESEARCH INSTITUTE OF TEXAS

CHAPTER 703. GRANTS FOR CANCER PREVENTION AND RESEARCH

25 TAC §703.12, §703.21

The Cancer Prevention and Research Institute of Texas (Institute) proposes amendments to §703.12 and §703.21, regarding authorized grant expenses and a process to appeal a waiver of reimbursement of project costs. The proposed changes affect financial reimbursement paid to grant recipients.

Background and Justification

The proposed change to §703.12 clarifies that expenses associated with acquiring or maintaining a visa are not authorized expenses to be paid with grant funds. The proposed change to §703.21 provides a process for a grant recipient to appeal to the Institute a waiver of reimbursement costs. Currently, there is no process in place for a grant recipient to appeal a waiver of costs caused when the grant recipient fails to receive a deferral or submit a required financial status report (FSR) within 30 days of the FSR due date. Pursuant to the proposed change, a grant recipient may provide a written appeal that demonstrates good cause for not submitting the FSR within the required timeframe. The Chief Executive Officer will review the appeal, and if approved, must notify the Oversight Committee.

Fiscal Note

Kristen Pauling Doyle, General Counsel for the Cancer Prevention and Research Institute of Texas, has determined that for the first five-year period the rule changes are in effect there will be no foreseeable implications relating to costs or revenues for state or local government as a result of enforcing or administering the rules.

Public Benefit and Costs

Ms. Doyle has determined that for each year of the first five years the rule changes are in effect the public benefit anticipated as a result of enforcing the rules will be clarification of policies and procedures the Institute will follow to implement its statutory duties.

Small Business and Micro-business Impact Analysis

Ms. Doyle has determined that the rule changes shall not have an effect on small businesses or on micro businesses.

Written comments on the proposed rule changes may be submitted to Ms. Doyle, Cancer Prevention and Research Institute of Texas, P.O. Box 12097, Austin, Texas 78711, no later than April 25, 2016. Parties filing comments are asked to indicate whether or not they support the rule revisions proposed by the Institute and, if a change is requested, to provide specific text proposed to be included in the rule. Comments may be submitted electronically to kdoyle@cpr.it.texas.gov. Comments may be submitted by facsimile transmission to (512) 475-2563.

Statutory Authority

The rule changes are proposed under the authority of the Texas Health and Safety Code Annotated, §102.108, which provides the Institute with broad rule-making authority to administer the chapter. Ms. Doyle, the Institute's General Counsel, has reviewed the proposed amendment and certifies the proposal to be within the Institute's authority to adopt.

There is no other statute, article or code that is affected by these rules.

§703.12. Limitation on Use of Funds.

(a) A Grant Recipient may use Grant Award funds only for Cancer Research and Cancer Prevention projects consistent with the purpose of the Act, and in accordance with the Grant Contract. Grant Award funds may not be used for purposes other than those purposes for which the grant was awarded. The Institute may require a Grant Recipient to repay Grant Award funds if the Grant Recipient fails to expend the Grant Award funds in accordance with the terms and conditions of the Grant Contract and the provisions of this chapter.

(b) Grant Award funds must be used for Authorized Expenses.

(1) Expenses that are not authorized and shall not be paid from Grant Award funds, include, but are not limited to:

(A) Bad debt, such as losses arising from uncollectible accounts and other claims and related costs.

(B) Contributions to a contingency reserve or any similar provision for unforeseen events.

(C) Contributions and donations made to any individual or organization.

(D) Costs of entertainment, amusements, social activities, and incidental costs relating thereto, including tickets to shows or sports events, meals, alcoholic beverages, lodging, rentals, transportation and gratuities.

(E) Costs relating to food and beverage items, unless the food item is related to the issue studied by the project that is the subject of the Grant Award.

(F) Fines, penalties, or other costs resulting from violations of or failure to comply with federal, state, local or Indian tribal laws and regulations.

(G) An honorary gift or a gratuitous payment.

(H) Interest and other financial costs related to borrowing and the cost of financing.

(I) Legislative expenses such as salaries and other expenses associated with lobbying the state or federal legislature or similar local governmental bodies, whether incurred for purposes of legislation or executive direction.

(J) Liability insurance coverage.

(K) Benefit replacement pay or legislatively-mandated pay increases for eligible general revenue-funded state employees at Grant Recipient state agencies or universities.

(L) Professional association fees or dues for the Grant Recipient or an individual.

(M) Promotional items and costs relating to items such as T-shirts, coffee mugs, buttons, pencils, and candy that advertise or promote the project or Grant Recipient.

(N) Patient support services costs relating to services such as personal care items and financial assistance for low-income clients.

(O) Fees for visa services.

(2) Additional guidance regarding Authorized Expenses for a specific program may be provided by the terms of the Grant Contract and by the Uniform Grant Management Standards (UGMS) adopted by the Comptroller's Office. If guidance from UGMS on a particular issue conflicts with a specific provision of the Grant Contract, Chapter 102, Texas Health and Safety Code, or the Institute's

administrative rules, then the Grant Contract, statute, or Institute administrative rule shall prevail.

(3) The Institute is responsible for making the final determination regarding whether an expense shall be considered an Authorized Expense.

(c) A Grant Recipient of Grant Award funds for a Cancer Research or Cancer Prevention project may not spend more than five percent (5%) of the Grant Award funds for Indirect Costs.

(d) The Institute may not award more than five percent (5%) of the total Grant Award funds for each fiscal year to be used for facility purchase, construction, remodel, or renovation purposes during any year. Any Grant Award funds that are to be expended by a Grant Recipient for facility purchase, construction, remodel, or renovations are subject to the following conditions:

(1) The use of Grant Award funds must be specifically approved by the Chief Executive Officer with notification to the Oversight Committee;

(2) Grant Award funds spent on facility purchase, construction, remodel, or renovation projects must benefit Cancer Prevention and Research;

(3) If Grant Award funds are used to build a capital improvement, then the state retains a lien or other interest in the capital improvement in proportion to the percentage of the Grant Award funds used to pay for the capital improvement. If the capital improvement is sold, then the Grant Recipient agrees to repay to the state the Grant Award funds used to pay for the capital improvement, with interest, and share with the state a proportionate amount of any profit realized from the sale.

(e) The Institute may not award more than ten percent (10%) of the money awarded from the Cancer Prevention and Research Fund or from the proceeds of bonds issued on behalf of the Institute to be used for Cancer Prevention and Control programs during any year. Grant Awards for Cancer Prevention research projects shall not be counted toward the Grant Award amount limit for Cancer Prevention and Control Programs. For purposes of this subsection, the Institute is presumed to award the full amount of funds available. At the first regular Oversight Committee meeting of the fiscal year, the Chief Executive Officer shall report that full amount of Grant Award funds available to be awarded for the fiscal year subject to periodic updates announced at regular meetings of the Oversight Committee.

§703.21. Monitoring Grant Award Performance and Expenditures.

(a) The Institute, under the direction of the Chief Executive Officer, shall monitor Grant Awards to ensure that Grant Recipients comply with applicable financial, administrative, and programmatic terms and conditions and exercise proper stewardship over Grant Award funds. Such terms and conditions include requirements set forth in statute, administrative rules, and the Grant Contract.

(b) Methods used by the Institute to monitor a Grant Recipient's performance and expenditures may include:

(1) Financial Status Reports Review - Quarterly financial status reports shall be submitted to the Institute within 90 days of the end of the state fiscal quarter (based upon a September 1 - August 31 fiscal year). The Institute shall review expenditures and supporting documents to determine whether expenses charged to the Grant Award are:

(A) Allowable, allocable, reasonable, necessary, and consistently applied regardless of the source of funds; and

(B) Adequately supported with documentation such as cost reports, receipts, third party invoices for expenses, or payroll information.

(2) Timely submission of Financial Status Reports - Except as provided herein, the [The] Grant Recipient waives the right to reimbursement of project costs incurred during the reporting period if the financial status report (FSR) for that quarter is not submitted to the Institute within 30 days of the FSR due date. Waiver of reimbursement of project costs incurred during the reporting period also applies to Grant Recipients that have received advancement of Grant Award funds.

(A) For purposes of this rule, the "FSR due date" is 90 days following the end of the state fiscal quarter.

(B) The Chief Executive Officer may approve a Grant Recipient's request to defer submission of the reimbursement request for the current fiscal quarter until the next fiscal quarter if, on or before the original FSR due date, the Grant Recipient submits a written explanation for the Grant Recipient's inability to complete a timely submission of the FSR.

(C) A Grant Recipient may appeal the waiver of its right to reimbursement of project costs.

(i) The appeal shall be in writing, provide good cause for failing to submit the FSR within 30 days of the FSR due date, and be submitted through CPRIT's Grant Management System.

(ii) The Chief Executive Officer may approve the appeal for good cause. The decision by the Chief Executive Officer to approve or deny the grant recipient's appeal shall be in writing and provided through CPRIT's Grant Management System.

(iii) The Chief Executive Officer's decision to approve or deny the Grant Recipient's appeal is final, unless the Grant Recipient timely seeks reconsideration of the Chief Executive Officer's decision by the Oversight Committee.

(iv) The Grant Recipient may request that the Oversight Committee reconsider the Chief Executive Officer's decision regarding the Grant Recipient's appeal. The request for reconsideration shall be in writing and submitted to the Chief Executive Officer within 10 days of the date that the Chief Executive Officer notifies the Grant Recipient of the decision regarding the appeal as noted in clause (iii) of this subparagraph.

(v) The Chief Executive Officer shall notify the Oversight Committee in writing of the decision to approve or deny the Grant Recipient's appeal. The notice should provide justification for the Chief Executive Officer's decision. In the event that the Grant Recipient timely seeks reconsideration of the Chief Executive Officer's decision, the Chief Executive Officer shall provide the Grant Recipient's written request to the Oversight Committee at the same time.

(vi) The Grant Recipient's request for reconsideration is deemed denied unless three or more Oversight Committee members request that the Chief Executive Officer add the Grant Recipient's request for reconsideration to the agenda for action at the next regular Oversight Committee meeting. The decision made by the Oversight Committee is final.

(vii) If the Grant Recipient's appeal is approved by the Chief Executive Officer or the Oversight Committee, the Grant Recipient shall report the project costs and provide supporting documentation for the costs incurred during the reporting period covered by the appeal on the next available financial status report to be filed by the Grant Recipient.

(viii) Approval of the waiver appeal does not con-
note approval of the expenditures; the expenditures and supporting doc-
umentation shall be reviewed according to paragraph (1) of this subsec-
tion.

(ix) This subsection applies to any waivers of its re-
imbursement decided by the Institute on or after September 1, 2015.

(D) [(C)] Notwithstanding paragraph (2) of this subsec-
tion [subsection (2)], in the event that the Grant Recipient and Institute
execute the Grant Contract after the effective date of the Grant Con-
tract, the Chief Program Officer may approve additional time for the
Grant Recipient to prepare and submit the outstanding FSR(s). The
approval shall be in writing and maintained in the Institute's electronic
Grants Management System. The Chief Program Officer's approval
may cover more than one FSR and more than one fiscal quarter.

(E) [(D)] In order to receive disbursement of grant
funds, the most recently due FSR must be approved by CPRIT.

(3) Grant Progress Reports - The Institute shall review
Grant Progress Reports to determine whether sufficient progress is
made consistent with the scope of work and timeline set forth in the
Grant Contract.

(A) The Grant Progress Reports shall be submitted at
least annually, but may be required more frequently pursuant to Grant
Contract terms or upon request and reasonable notice of the Institute.

(B) The annual Grant Progress Report shall be submit-
ted within sixty (60) days after the anniversary of the effective date of
the Grant Contract. The annual Grant Progress Report shall include at
least the following information:

(i) An affirmative verification by the Grant Reci-
pient of compliance with the terms and conditions of the Grant Contract;

(ii) A description of the Grant Recipient's progress
made toward completing the scope of work specified by the Grant Con-
tract, including information, data, and program metrics regarding the
achievement of project goals and timelines;

(iii) The number of new jobs created and the number
of jobs maintained for the preceding twelve month period as a result of
Grant Award funds awarded to the Grant Recipient for the project;

(iv) An inventory of the equipment purchased for the
project in the preceding twelve month period using Grant Award funds;

(v) A verification of the Grant Recipient's efforts to
purchase from suppliers in this state more than 50 percent goods and
services purchased for the project with grant funds;

(vi) A Historically Underutilized Businesses report;

(vii) Scholarly articles, presentations, and educa-
tional materials produced for the public addressing the project funded
by the Institute;

(viii) The number of patents applied for or issued ad-
dressing discoveries resulting from the research project funded by the
Institute;

(ix) A statement of the identities of the funding
sources, including amounts and dates for all funding sources support-
ing the project;

(x) A verification of the amounts of Matching Funds
dedicated to the research that is the subject of the Grant Award for the
period covered by the annual report, which shall be submitted pursuant
to the timeline in §703.11. In order to receive disbursement of grant

funds, the most recently due verification of the amount of Matching
Funds must be approved by CPRIT;

(xi) All financial information necessary to support
the calculation of the Institute's share of revenues, if any, received by
the Grant Recipient resulting from the project; and

(xii) A single audit determination form.

(C) Notwithstanding subparagraph (B) of this para-
graph [subsection (B)], in the event that the Grant Recipient and
Institute execute the Grant Contract after the effective date of the Grant
Contract, the Chief Program Officer may approve additional time for
the Grant Recipient to prepare and submit the outstanding reports. The
approval shall be in writing and maintained in the Institute's electronic
Grants Management System. The Chief Program Officer's approval
may cover more than one report and more than one fiscal quarter.

(D) In addition to annual Grant Progress Reports, a final
Grant Progress Report shall be filed no more than ninety (90) days af-
ter the termination date of the Grant Contract. The final Grant Progress
Report shall include a comprehensive description of the Grant Reci-
pient's progress made toward completing the scope of work specified by
the Grant Contract, as well as other information specified by the Insti-
tute.

(E) The Grant Progress Report will be evaluated by a
grant manager pursuant to criteria established by the Institute. The
evaluation shall be conducted under the direction of the Chief Pre-
vention Officer, the Chief Product Development Officer, or the Chief
Scientific Officer, as may be appropriate. Required financial reports
associated with the Grant Progress Report will be reviewed by the In-
stitute's financial staff. In order to receive disbursement of grant funds,
the final progress report must be approved by CPRIT.

(F) If the Grant Progress Report evaluation indicates
that the Grant Recipient has not demonstrated progress in accordance
with the Grant Contract, then the Chief Program Officer shall notify the
Chief Executive Officer and the General Counsel for further action.

(i) The Chief Program Officer shall submit written
recommendations to the Chief Executive Officer and General Counsel
for actions to be taken, if any, to address the issue.

(ii) The recommended action may include termina-
tion of the Grant Award pursuant to the process described in §703.14
of this chapter (relating to Termination, Extension, and Close Out of
Grant Contracts).

(G) If the Grant Recipient fails to submit required finan-
cial reports associated with the Grant Progress Report, then the Institute
financial staff shall notify the Chief Executive Officer and the General
Counsel for further action.

(H) In order to receive disbursement of grant funds, the
most recently due progress report must be approved by CPRIT.

(I) If a Grant Recipient fails to submit the Grant
Progress Report within 60 days of the anniversary of the effective date
of the Grant Contract, then the Institute shall not disburse any Grant
Award funds as reimbursement or advancement of Grant Award funds
until such time that the delinquent Grant Progress Report is approved.

(J) In addition to annual Grant Progress Reports, Prod-
uct Development Grant Recipients shall submit a Grant Progress Re-
port at the completion of specific tranches of funding specified in the
Award Contract. For the purpose of this subsection, a Grant Progress
Report submitted at the completion of a tranche of funding shall be
known as "Tranche Grant Progress Report."

(i) The Institute may specify other required reports, if any, that are required to be submitted at the time of the Tranche Grant Progress Report.

(ii) Grant Funds for the next tranche of funding specified in the Grant Contract shall not be disbursed until the Tranche Grant Progress Report has been reviewed and approved pursuant to the process described in this section.

(4) Desk Reviews - The Institute may conduct a desk review for a Grant Award to review and compare individual source documentation and materials to summary data provided during the Financial Status Report review for compliance with financial requirements set forth in the statute, administrative rules, and the Grant Contract.

(5) Site Visits and Inspection Reviews - The Institute may conduct a scheduled site visit to a Grant Recipient's place of business to review Grant Contract compliance and Grant Award performance issues. Such site visits may be comprehensive or limited in scope.

(6) Audit Reports - The Institute shall review audit reports submitted pursuant to §703.13 of this chapter (relating to Audits and Investigations).

(A) If the audit report findings indicate action to be taken related to the Grant Award funds expended by the Grant Recipient or for the Grant Recipient's fiscal processes that may impact Grant Award expenditures, the Institute and the Grant Recipient shall develop a written plan and timeline to address identified deficiencies, including any necessary Grant Contract amendments.

(B) The written plan shall be retained by the Institute as part of the Grant Contract record.

(c) All required Grant Recipient reports and submissions described in this section shall be made via an electronic grant portal designated by the Institute, unless specifically directed to the contrary in writing by the Institute.

(d) The Institute shall document the actions taken to monitor Grant Award performance and expenditures, including the review, approvals, and necessary remedial steps, if any.

(1) To the extent that the methods described in subsection (b) of this section are applied to a sample of the Grant Recipients or Grant Awards, then the Institute shall document the Grant Contracts reviewed and the selection criteria for the sample reviewed.

(2) Records will be maintained in the electronic Grant Management System as described in §703.4 of this chapter (relating to Grants Management System).

(e) The Chief Compliance Officer shall be engaged in the Institute's Grant Award monitoring activities and shall notify the General Counsel and Oversight Committee if a Grant Recipient fails to meaningfully comply with the Grant Contract reporting requirements and deadlines, including Matching Funds requirements.

(f) The Chief Executive Officer shall report to the Oversight Committee at least annually on the progress and continued merit of each Grant Program funded by the Institute. The written report shall also be included in the Annual Public Report. The report should be presented to the Oversight Committee at the first meeting following the publication of the Annual Public Report.

(g) The Institute may rely upon third parties to conduct Grant Award monitoring services independently or in conjunction with Institute staff.

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

Filed with the Office of the Secretary of State on March 9, 2016.

TRD-201601195

Heidi McConnell

Chief Operating Officer

Cancer Prevention and Research Institute of Texas

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 463-3190



TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER O. TEXAS COMMERCIAL LINES STATISTICAL PLAN

28 TAC §5.9501

The Texas Department of Insurance proposes amendments to 28 TAC §5.9501, concerning the Texas Commercial Lines Statistical Plan (Plan). The proposed amendments adopt by reference a revised Plan, effective April 1, 2017. These amendments are necessary to effectively implement Insurance Code Chapter 38, Subchapter E, relating to statistical data collection; put the Plan's requirements for surety and fidelity risks in line with reporting requirements in other states; allow for better experience comparison by the department, the designated statistical agent, and the industry in general; and provide accurate contact information.

EXPLANATION. The revised Plan proposed to be adopted by reference in the amended section incorporates the same requirements and instructions for the reporting of direct commercial lines insurance premium and loss data to the designated statistical agent as the existing Plan, with the exception of a new class code and two new indicators for insurers who write surety bonds, and updated contact information for the department and the statistical agent.

The department proposes changes to the Plan to require surety insurers to report a small business indicator, an expedited underwriting indicator, and add a new class code identifying public-private partnerships. The proposed changes to surety risk reporting are for the purpose of standardizing the manner in which those insurers report premium and loss experience. When the Plan was last updated, effective January 1, 2010, the department revised the fields and codes used for reporting premium or loss experience for surety and fidelity risks to be consistent with the standard fields and codes required in the statistical plan used in all other states. In 2015, that statistical plan added a new class code and indicators. The proposed updates to the Plan are necessary to keep its reporting requirements in line with those in the statistical plan used in all other states, which will ease reporting for insurers who write in multiple states; potentially lower compliance costs; and allow for better experience comparison by the department, the designated statistical agent, and the industry in

general. Under the proposed amendments to §5.9501, insurers would be required to begin reporting under the revised Plan by April 1, 2017. Insurers could voluntarily begin reporting under the revised Plan beginning July 1, 2016.

The department also proposes changes to the Plan to update contact information for the department and the designated statistical agent. The changes are necessary to avoid confusion and facilitate communication among insurers, the department, and the designated statistical agent by ensuring that insurers have accurate and current contact information. Insurers should begin using the updated contact information to communicate with the department and the designated statistical agent immediately, if they are not already doing so.

Proposed amendments to §5.9501(b) adopt by reference the revised Plan. Proposed amendments to §5.9501(a)(4) provide that insurers must use the revised version of the Plan beginning April 1, 2017. These amendments are necessary to implement the revised Plan and set the effective date by which insurers must report under the revised Plan.

Nonsubstantive changes to §5.9501 are also necessary to correct grammar errors and conform to the department's writing guidelines, and nonsubstantive changes to the Plan are necessary to make corrections to page cross-references.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. J'ne Byckovski, director and chief actuary, Property and Casualty Actuarial Office, has determined that for each year of the first five years the proposed section will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. Ms. Byckovski has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of the proposed amendments will be an updated Plan that is consistent with surety and fidelity risk reporting standards in other states, which will ease reporting for insurers who write in multiple states; potentially lower compliance costs; and allow for better experience comparison by the department, the designated statistical agent, and the industry in general. The updated Plan will also avoid confusion and facilitate communication by ensuring that insurers have accurate contact information for the department and the statistical agent.

The department does not anticipate costs to insurers associated with the proposed update of contact information for the department and the designated statistical agent in the Plan; however, the department does anticipate some costs associated with complying with the new requirements for reporting of surety risks.

Under the proposed revisions to the Plan, surety and fidelity insurers will be required to report a small business indicator and expedited underwriting indicator, if the insurer already collects this information. The cost for insurers that write surety and fidelity bonds in states other than Texas will be negligible, or may result in savings, since the proposed revisions will align reporting requirements in Texas with the national reporting requirements of the Surety and Fidelity Association of America. Insurers that only write this business in Texas and that collect this information will need to reprogram their data reporting systems to include the extra indicators and possibly translate the company's unique indicators to the Plan codes. The department estimates that it

will take a computer programmer approximately two to five hours to perform this task. For Texas-only insurers that do not collect information on small businesses or expedited underwriting, the addition of the indicators may involve a small initial cost in order to report the correct "not available" code in the small business indicator and expedited underwriting indicator positions. These insurers will have to reprogram their data reporting systems to include the extra indicators using the "not available" code. The department estimates that it will take a computer programmer approximately one to two hours to perform this task. While it is not feasible to determine the actual cost of any employees needed to comply with the small business indicator and expedited underwriting indicator requirements, the latest *State Occupational Employment and Wage Estimates for Texas* published by the United States Department of Labor, Bureau of Labor Statistics (May 2014) indicates that the mean hourly wage for a computer programmer in Texas is \$38.85 (see: www.bls.gov/oes/current/oes_tx.htm).

Under the proposed revisions to the Plan, insurers who write surety bonds for public-private partnerships will have to begin reporting these surety bonds with a new class code. The department expects that insurers that write surety bonds for public-private partnerships are larger insurers that write surety in multiple states, and already report this new class code in other states. The cost for insurers that write these bonds in states other than Texas will be negligible, or may result in savings since the proposed revisions to the Plan align reporting requirements in Texas with the national reporting requirements of the Surety and Fidelity Association of America; however, any Texas-only insurers that write these bonds will need to amend their classification system in order to identify these risks and report this information to the designated statistical agent. To comply, affected insurers will have to determine if the principal's project is a public-private partnership through the underwriting process. Affected insurers will also have to update their classification tables and policy processing systems for the new class code, and will need to change their systems to accept an alphanumeric class code instead of a numeric class code. Affected insurers will also have to change their data reporting systems to accept the new class code. It is not feasible at this time for the department to accurately approximate the cost for affected insurers to make these changes. The exact cost to an affected insurer will depend on the number of surety bonds for public-private partnerships the affected insurer writes and how modern the affected insurer's policy processing, claims, and data reporting systems are.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. As required by Government Code §2006.002(c), the department has determined that the proposal may have an adverse economic effect on approximately four insurers that are small or micro businesses required to comply with the proposed rules.

Adverse economic impact may result from costs associated with reporting a new class code and indicators for surety and fidelity risks. The cost of compliance will not vary between large businesses and small or micro businesses, and the department's cost analysis in the public benefit or cost note portion of this proposal is equally applicable to small or micro businesses. The total cost of compliance is not dependent on the size of the business, but rather is dependent on whether the insurer writes surety bonds in other states, whether the insurer collects the additional information to be reported, and the insurer's existing systems and staff.

In accordance with Government Code §2006.002(c-1), the department has considered other regulatory methods to accomplish the objectives of the proposal that will also minimize any adverse impact on small and micro businesses. The primary objective of the proposal is to align surety and fidelity reporting requirements with those in other states and to provide current and accurate contact information for the department and the designated statistical agent. The other regulatory methods considered by the department include: (i) not adopting the proposed rule, (ii) adopting different reporting requirements, and (iii) exempting small or micro businesses from the revised reporting requirements.

Not adopting the proposed rule. Without adopting the proposed rule, surety insurers would face different requirements for reporting in Texas than for the rest of the nation, resulting in potentially higher compliance costs over time and certain Texas data being unavailable for comparison or other informational purposes. This option has been rejected.

Adopting different reporting requirements. Adopting different reporting requirements for small and micro businesses would not alleviate adverse economic impact from compliance with this proposal because it would still require adjustments to insurers' computer systems in order to accommodate the new requirements. In fact, the adverse economic impact could be increased because alternate requirements would not be in line with those in other states in which the insurer also writes business. In addition, multiple sets of reporting requirements are not feasible. Having different requirements for insurers of different sizes would be burdensome for the department, the designated statistical agent, and the insurers. The department does not expect any small or micro businesses to write surety bonds for private-public partnerships, and the adjustment to reporting for the small business indicator and the expedited underwriting indicator will be small because insurers that do not collect that information can report the correct "not available" code. The proposal does not require any insurer, regardless of size, to collect information that it is not already collecting. Further, multiple sets of reporting requirements would diminish the utility of experience comparisons. This option has been rejected.

Exempting small or micro businesses from the revised reporting requirements. As previously noted, multiple sets of reporting requirements would be burdensome and would diminish the utility of experience comparisons. The negative effects of exempting small or micro businesses from the revised reporting requirements would outweigh the relatively small anticipated costs for small and micro businesses to comply. This option has been rejected.

After considering the relative benefits and costs of the alternatives and the purpose of the proposed revisions to the Plan, the department does not believe it is feasible to waive or modify the requirements of the proposal for small and micro businesses.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. If you wish to comment on this proposal or request a hearing, you must do so in writing no later than 5 p.m., Central time, on April 25, 2016.

Send your written comments or hearing request by email to chiefclerk@tdi.texas.gov, or by mail to Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. You must simultaneously submit an additional copy of the written comments or hearing request by email to jne.byckovski@tdi.texas.gov or by mail to J'ne Byckovski, Director and Chief Actuary, Property and Casualty Actuarial Office, Mail Code 105-5F, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A request for a hearing must be submitted separately from written comments on the proposal. If a hearing is held, the department will consider written comments and public testimony presented at the hearing.

STATUTORY AUTHORITY. The department proposes the amendments under Insurance Code §§38.202, 38.204(a), 38.205, 38.207, and 36.001.

Section 38.202 allows the commissioner to, for a line or subline of insurance, designate or contract with a qualified organization to serve as the statistical agent for the commissioner to gather data relevant for regulatory purposes.

Section 38.204(a) provides that a designated statistical agent must collect data from reporting insurers under a statistical plan adopted by the commissioner.

Section 38.205 requires insurers to provide all premium and loss cost data to the commissioner or the designated statistical agent as the commissioner or agent requires.

Section 38.207 authorizes the commissioner to adopt rules necessary to accomplish the purposes of Chapter 38, Subchapter E, relating to statistical data collection.

Section 36.001 provides the commissioner's general rulemaking authority to adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of the state.

CROSS REFERENCE TO STATUTE. Section 5.9501 implements Insurance Code Chapter 38, Subchapter E, codified by SB 1467, 76th Legislature, Regular Session (1999).

§5.9501. *Texas Commercial Lines Statistical Plan.*

(a) Purpose and Applicability.

(1) The purpose of this section is to establish requirements for the reporting of premium and loss data by direct commercial lines insurers under ~~[pursuant to the]~~ Insurance Code Chapter 38, Subchapter E.

(2) Under ~~[Pursuant to the]~~ Insurance Code §38.202, the commissioner has designated a statistical agent for commercial lines of insurance.

(3) As provided by ~~[Pursuant to the]~~ Insurance Code §38.205, all insurers writing direct commercial lines business in ~~[the State of]~~ Texas are required to provide a report of their premium and loss cost experience to the commissioner or the statistical agent designated under ~~[the]~~ Insurance Code §38.202. The report must comply with the reporting requirements and instructions specified in the Texas Commercial Lines Statistical Plan adopted by reference in ~~[pursuant to]~~ subsection (b) of this section.

(4) This section applies to all reports required to be filed with the department under this section ~~[filed with the department]~~ for reporting periods beginning on or after April 1, 2017 ~~[January 1, 2010]~~.

(b) Adoption by Reference. The commissioner adopts by reference the Texas Commercial Lines Statistical Plan, effective

April 1, 2017 [January 1, 2010]. This document is published by the department [Texas Department of Insurance] and is available on [from the Data Services Division, Mail Code 105-5D, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or] the department's [department] website at www.tdi.texas.gov.

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

Filed with the Office of the Secretary of State on March 10, 2016.

TRD-201601204

Norma Garcia

General Counsel

Texas Department of Insurance

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 676-6584



TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 1. GENERAL LAND OFFICE

CHAPTER 13. LAND RESOURCES

SUBCHAPTER B. RIGHTS-OF-WAY OVER PUBLIC LANDS

31 TAC §13.17

The General Land Office (GLO) proposes an amendment to 31 TAC §13.17 relating to fees for pipeline right-of-way easements and power line right-of-way easements, respectively. The proposed amendment will update the attached graphics in §13.17(a) and §13.17(e) to accurately depict current GLO fees. An additional note will also be added that provides the Commissioner of the General Land Office (Commissioner) the ability to negotiate the terms of right-of-way easements for pipelines transporting oil and gas related products outside the State of Texas.

BACKGROUND AND ANALYSIS OF PROPOSED AMENDMENT

In accordance with Texas Natural Resources Code §51.291, the Commissioner of the General Land Office may execute grants of easements for rights-of-way across, through, and under unsold public school land, the portion of the Gulf of Mexico within the jurisdiction of the state, the state-owned riverbeds and beds of navigable streams in the public domain, and all islands, saltwater lakes, bays, inlets, marshes, and reefs owned by the state within tidewater limits. Texas Natural Resources Code §51.295 provides that right-of-way easements shall be executed on terms to be determined by the Commissioner. Figure: 31 TAC §13.17(a) and Figure: 31 TAC §13.17(e) list the fees, surface damages and terms for pipeline right-of-way easements and power line right-of-way easements across public lands as established by the Commissioner. The graphics were last updated in 2008. However, the notes included in the graphics provide for a base rate adjustment on September 1 of each year according to the change in the Consumer Price Index for Urban Consumers (CPI-U), so long as the annual increase does not exceed 3% of the previous year rate. The duration since the last update coupled with the yearly adjustments have left a discrepancy in what is currently charged from what is listed. This discrepancy could create

confusion. Furthermore, the increase in pipelines transporting oil and gas related products outside the State of Texas necessitate an additional note which allows for the Commissioner to negotiate the terms of these right-of-way easements on a case-by-case basis.

FISCAL AND EMPLOYMENT IMPACTS

Brian Carter, Senior Deputy Director of Asset Enhancement, has determined that during the first five-year period the proposed amended rule is in effect, there will be no negative fiscal implications for state or local government or small businesses. Since the fees are not actually increasing, but rather the graphics are being updated to reflect the cumulative annual increases since the last update in 2008, the amendment will only serve to clarify the rates and prevent any confusion.

The additional note regarding easements for pipelines transporting oil and gas related products outside the State of Texas will allow the Commissioner the flexibility to negotiate based on the merits of each of these specific easements.

PUBLIC BENEFIT

Mr. Carter has determined that the public will benefit from the proposed amendments by preventing any future confusion with regard to GLO fees.

ENVIRONMENTAL REGULATORY ANALYSIS

The GLO has evaluated the proposed rulemaking action in light of the regulatory analysis requirements of Texas Government Code §2001.0225, and determined that the action is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in the statute.

TAKINGS IMPACT ASSESSMENT

The GLO has evaluated the proposed rulemaking in accordance with Texas Government Code §2007.043(b) and §2.18 of the Attorney General's Private Real Property Rights Preservation Act Guidelines to determine whether a detailed takings impact assessment is required. GLO has determined that the proposed rulemaking does not affect private real property in a manner that requires real property owners to be compensated as provided by the Fifth and Fourteenth Amendments to the United States Constitution or Article I, §17 and §19 of the Texas Constitution. Furthermore, GLO has determined that the proposed rulemaking would not affect any private real property in a manner that restricts or limits the owner's right to the property that would otherwise exist in the absence of the rule amendment.

PUBLIC COMMENT REQUEST

Comments may be submitted to Walter Talley, Office of General Counsel, Texas General Land Office, 1700 N. Congress Avenue, Austin, Texas 78701 or by facsimile to (512) 463-6311 by no later than 30 days after publication.

STATUTORY AUTHORITY

The amendments to §13.17(a) and §13.17(e) are proposed under the Texas Natural Resources Code §§51.291 - 51.307 relating to the Commissioner's ability to grant easements or other interests in property for rights-of-way or access across, through, and under state public land; and Texas Natural Resources Code §51.014 providing that the Commissioner may adopt rules necessary to carry out the provisions of Chapter 51, Texas Natural Resources Code and may alter or amend the rules to protect the public interest.

The proposed amendment affects no other code, article, or statute.

§13.17. Fees for Right-of-Way Easement.

(a) The following table lists the fees, surface damages and terms for pipeline right-of-way easements across public lands as established by the commissioner of the General Land Office.
Figure: 31 TAC §13.17(a)

(b) - (d) (No change.)

(e) The following table lists the fees, rates, and terms for power line rights-of-way easements over and across public lands as established by the commissioner.
Figure: 31 TAC §13.17(e)

(f) - (g) (No change.)

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

Filed with the Office of the Secretary of State on March 14, 2016.

TRD-201601220

Anne L. Idsal

Chief Clerk, Deputy Land Commissioner

General Land Office

Earliest possible date of adoption: April 24, 2016

For further information, please call: (512) 475-1859



TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION

SUBCHAPTER O. STATE AND LOCAL SALES AND USE TAXES

34 TAC §3.364

The Comptroller of Public Accounts proposes amendments to §3.364, concerning staff leasing services. The proposed amendments implement Senate Bill 1286, 83rd Legislature, 2013 (SB 1286). The title of this section is amended to "Professional Employer Services" to reflect the changes to the Labor Code made by SB 1286. Definitions are amended and new terminology is introduced to reflect the conforming changes to Tax Code, §151.057 made by SB 1286.

Subsection (a) is amended to incorporate new terminology and definitions. Existing paragraphs (1) and (2) are deleted and new paragraphs (1) - (4) are added.

New paragraph (1) defines the term "client" to mean any person who enters into a professional employer services agreement with a professional employer organization. This definition is based upon Labor Code, §91.001(3).

New paragraph (2) defines the term "coemployer" to mean a professional employer organization or a client that is a party to a co-employment relationship. This definition restates Labor Code, §91.001(3-a).

New paragraph (3) defines the term "coemployment relationship" to mean a contractual relationship between a client and a profes-

sional employer organization that involves the sharing of employment responsibilities with or allocation of employment responsibilities to covered employees in accordance with a professional employer services agreement. This definition is based upon Labor Code, §91.001(3-b).

New paragraph (4) defines "covered employee." This definition implements Labor Code, §91.001(7-a) and §91.0012 and incorporates guidance previously provided in the definition of the term "assigned employee," which is proposed to be deleted. Subsequent paragraphs are renumbered accordingly.

Renumbered paragraph (5) (formerly paragraph (3)) defines the term "independent contractor." This paragraph is amended to replace the phrase in subparagraph (A) from "is paid by the job even when consideration is based on a time-measure basis" to "is paid by the job, not by the hour or some other time measured basis." This amendment is made to reflect the definition set out in Labor Code, §91.0001(10)(A).

Paragraphs (4) and (5), defining shared employment relationship and staff leasing company, respectively, are deleted.

Paragraph (6) is amended to define the term "professional employer organization." The term "staff leasing services" and its definition are deleted. A professional employer organization is defined by Tax Code, §151.057 as a business that offers professional employer services and is licensed under Labor Code, Chapter 91, or is exempt from the licensing requirements of Labor Code, Chapter 91. Currently, the Labor Code does not exempt any professional employer organizations from the licensing requirements of Chapter 91. Consequently, this portion of the definition is not included in the rule.

New paragraph (7) defines the term "professional employer services" to mean services provided through coemployment relationships in which all or a majority of the employees providing services to a client or to a division or work unit of a client are covered employees. The term does not include temporary help; an independent contractor; the provision of services that otherwise meet the definition of "professional employer services" by one person solely to other persons who are related to the service provider by common ownership; or a temporary common worker employer as defined by Labor Code, Chapter 92. This definition is based upon Labor Code, §91.001(14).

New paragraph (8) defines the term "temporary help" to mean an arrangement by which an organization hires its own employees and assigns them to a company to support or supplement the company's work force in a special work situation, including: an employee absence; a temporary skill shortage; a seasonal workload; or a special assignment or project. The definition is based on the definition given in Labor Code, §91.001(16).

Subsection (b), which sets out the responsibilities of persons providing staff leasing services, is amended to implement the terminology of Labor Code, Chapter 91 and Tax Code, §151.057. No substantive change is intended as a result of these revisions.

Subsection (c), which relates to independent contractors, is amended to replace the terms "staff leasing services" and "staff leasing company" with the terms "professional employer services" and "professional employer organization." All other changes in subsection (c) reflect the changes in terminology made to Tax Code, §151.057 by SB 1286 and are not substantive in nature.

Tom Currah, Chief Revenue Estimator, has determined that for the first five-year period the rule will be in effect, there will be no

significant revenue impact on the state or units of local government.

Mr. Currah also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be by conforming the rule to current statutes. This rule is proposed under Tax Code, Title 2, and does not require a statement of fiscal implications for small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Teresa G. Bostick, Director, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711-3528. Comments must be received no later than 30 days from the date of publication of the proposal in the *Texas Register*.

The amendment is proposed under Tax Code, §111.002, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of Tax Code, Title 2.

The amendment implements Tax Code, §151.057 (Services by Employees).

§3.364. Professional Employer [Staff Leasing] Services.

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

(1) Client--Any person who enters into a professional employer services agreement with a professional employer organization.

(2) Coemployer--A professional employer organization or a client that is a party to a coemployment relationship.

(3) Coemployment relationship--A contractual relationship between a client and a professional employer organization that involves the sharing of employment responsibilities with or allocation of employment responsibilities to covered employees in accordance with a professional employer services agreement and the provisions of Labor Code, Chapter 91.

(4) Covered employee--An individual having a coemployment relationship with a professional employer organization and a client. The term does not include an independent contractor, a temporary common worker as defined by Labor Code, Chapter 92, or an employee providing temporary help.

~~{(1) Assigned employee--An employee who is assigned to a client company by a staff leasing company, whose work is performed in this state, and as to whom the staff leasing company and the client company share employment responsibilities. The term does not include an employee or independent contractor retained or hired by a client company for a limited period of time to support or supplement a client company's workforce in a special work situation, including:}~~

~~{(A) an employee absence;}~~

~~{(B) a temporary skill shortage;}~~

~~{(C) a seasonal workload; or}~~

~~{(D) a special assignment or project.}~~

~~{(2) Client company--A person that contracts with a staff leasing company and is assigned employees by the staff leasing company under the contract.}~~

~~{(3) Independent contractor--A person who contracts to perform work or provide a service for the benefit of another and who:~~

~~(A) is paid by the job even, not by the hour or some other time measured basis [when consideration is based on a time measured basis];~~

~~(B) is free to hire as many helpers as the person desires and to determine what each helper will be paid;~~

~~(C) is free to work for other customers, or to send helpers to work for other customers, while under contract to the hiring customer; and~~

~~(D) is in control of the details of the work and the right to terminate the employment of its employees.~~

~~{(4) Shared employment relationship--An employment relationship among an assigned employee, client company, and staff leasing company in which by written contract and in fact the staff leasing company and client company share employment responsibilities.}~~

~~{(5) Staff leasing company--A business that offers staff leasing services and is licensed under the Labor Code, Chapter 91, or a business that offers staff leasing services but is exempt from the licensing requirements of the Labor Code.}~~

~~(6) Professional employer organization--A business entity that offers professional employer services and is licensed under Labor Code, Chapter 91. [Staff leasing services--Services performed by assigned employees, together with personnel management services, such as employee benefit and payroll services, performed by the staff leasing company and related to shared employees, for the client company under a written contract between the staff leasing company and the client company that provides for a shared employment relationship as to the assigned employees.}~~

~~(7) Professional employer services--Services provided to a client by a professional employer organization through a coemployment relationship when a majority of the employees providing services to the client, or to a division or work unit of the client, are covered employees. The term does not include:~~

~~(A) temporary help;~~

~~(B) the provision of services by an independent contractor;~~

~~(C) the provision of services that otherwise meet the definition of "professional employer services" by one person solely to other persons who are related to the service provider by common ownership; or~~

~~(D) services provided by a temporary common worker employer as defined by Labor Code, Chapter 92.~~

~~(8) Temporary help--An arrangement by which an organization hires its own employees and assigns them to a company to support or supplement the company's work force in a special work situation, including:~~

~~(A) an employee absence;~~

~~(B) a temporary skill shortage;~~

~~(C) a seasonal workload; or~~

~~(D) a special assignment or project.~~

~~(b) Tax responsibilities of professional employer organizations [persons who perform staff leasing services].~~

~~(1) Sales tax is not due on professional employer [staff leasing] services if all of the following conditions are met:~~

(A) at least 75% of the covered [assigned] employees providing services under the professional employer services agreement [staff leasing contract] were previously employees of the client [company] for a period of at least three months immediately prior to commencement of the professional employer services agreement [staff leasing contract];

(B) none of the covered [assigned] employees were employed previously:

(i) by the company providing professional employer [staff leasing] services under the agreement [contract] unless the previous employment was through a coemployment [shared employment] relationship; or

(ii) by a person [an entity] that previously provided or currently provides taxable services to the client [company]; and

(C) a coemployment [shared employment] relationship exists between the client [company] and the professional employer organization [staff leasing company] as to the covered [assigned] employees.

(2) The following are exceptions to paragraph (1) of this subsection.

(A) A professional employer services agreement [staff leasing contract] must comply only with paragraph (1)(B) and (C) of this subsection when the client [company] has been in operation for less than a year; provided that a client [company] that has been in existence less than a year solely due to a change in legal entity, merger, or corporate reorganization must meet all three conditions. In the latter situation, the combined experience of all entities involved in such legal change, merger, or corporate reorganization will be considered when applying the tests set forth in paragraph (1) of this subsection.

(B) When a professional employer organization [staff leasing company] enters into an agreement [a contract] with a client [company] that previously was in a coemployment [shared employment] relationship with another professional employer organization [staff leasing company] immediately prior to the effective date of such new agreement [contract], the [shared] employees that were subject to the coemployment relationship will be considered employees of the client [company] in meeting the requirement in paragraph (1)(A) of this subsection.

(C) A professional employer services agreement [staff leasing contract] that has met the qualifications in paragraph (1) of this subsection will not have to re-qualify if a covered [an] employee [assigned under the contract] is fired or resigns and is replaced. However, an agreement [a contract] must re-qualify under paragraph (1) if, within six months after it is entered into, all of the covered [assigned] employees or an identifiable segment of the covered [assigned] employees are replaced by:

(i) employees previously employed by the professional employer organization [staff leasing company] unless the previous employment was through a coemployment [shared employment] relationship with another client [company]; or

(ii) employees of an entity that previously provided or currently provides taxable services to the client [company].

(D) If the scope of an existing professional employer services agreement [staff leasing contract] is expanded to increase the volume of services of the type already provided by the professional employer organization [staff leasing company] by adding employees to perform the same work functions of employees already under the agreement (for example [contract (e.g.)], another shift is added), the

amended agreement [contract] must meet the qualifications in paragraph (1)(B)(i) and (C) of this subsection.

(E) If the scope of an existing professional employer services agreement [staff leasing contract] is expanded to include services not previously provided by the professional employer organization [staff leasing company] by adding employees to perform functions that are not currently performed by employees under the agreement (for example [contract (e.g.)], employees are added to perform debt collection services for a client who previously had not performed those services in house), the amended agreement [contract] must meet the qualifications in paragraph (1)(B) and (C) of this subsection.

(3) The client [company] and the professional employer organization [staff leasing company] must sign a written certification that the professional employer services agreement [staff leasing contract] or amendments to the agreement [contract] meet the requirements and conditions set out in this section, and both parties must retain a copy of the certification in their files.

(4) If an agreement [a contract] does not meet the conditions for exemption set out in subsection (b) of this section, taxable services as defined in [the] Tax Code, §151.0101, performed under the agreement [contract] are subject to sales tax, unless purchased for resale as provided in §3.285 of this title (relating to Sales for Resale; Resale Certificates).

(5) When both nontaxable professional employer [staff leasing] services and taxable services are being performed under the same agreement [contract], the parties to the agreement [contract] should separately identify the taxable from nontaxable services in the agreement [a contract] and the charges applicable to each. Failure to separate the charges will result in the entire agreement [contract] being presumed to be for taxable services. Documentation that clearly defines the work being performed should be retained by both parties to show that had the nontaxable professional employer [staff leasing] services and taxable services been performed independently of each other, the cost of each would be reasonably near the allocation of charges. Examples of acceptable documentation include written agreements, [contracts] which detail the scope of work, bid sheets, tally sheets, payroll records, and job descriptions. If there is not a written agreement [contract] signed by both parties clearly showing agreement as to the taxable and nontaxable work being performed, the customer and the service provider may prepare a written certification verifying the allocation of nontaxable professional employer services [staff leasing] and taxable services. All services performed will be presumed to be taxable if the parties fail to provide the written certification. The comptroller may recalculate the charges if the allocation appears unreasonable and either party may be held responsible for the additional tax due.

(c) Independent contractor. Professional employer [Staff leasing] services do not include services performed by an independent contractor regardless of the status of the contractor as a licensed professional employer organization [staff leasing company].

(d) Temporary help service. For information on the taxability of services performed by a temporary help service, see §3.356 of this title (relating to Real Property Service).

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

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Don Neal
Chief Deputy General Counsel
Comptroller of Public Accounts
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For further information, please call: (512) 475-0387

