PROPOSED RULES

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

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

The Texas Health and Human Services Commission (HHSC) proposes new §355.8208, concerning Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care; §355.8210, concerning Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care; §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care; and §355.8214, concerning Waiver Payments to Physician Group Practices for Uncompensated Charity Care. The new rules are proposed to be adopted in January 2019 and will apply to services provided after October 1, 2019. HHSC also proposes amendments to §355.8441, concerning Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services; §355.8600, concerning Reimbursement Methodology for Ambulance Services; §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care; and §355.8202, concerning Waiver Payments to Physician Group Practices for Uncompensated Care. The amendments are proposed to be adopted in October 2018 and will apply to services provided between October 1, 2018, and September 30, 2019. The new rules and amendments are necessary to implement revised definitions of eligible uncompensated costs and funding requirements contained in the state's approved Section 1115(a) waiver extension and to implement other policy changes.

BACKGROUND AND PURPOSE

On December 21, 2017, the Centers for Medicare & Medicaid Services (CMS) approved the state's request to extend Texas' section 1115(a) demonstration waiver project, entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project Number 11-W-00278/6).

For uncompensated-care payments attributable to services provided before October 1, 2019, the current payment and funding methodologies remain in effect, except for changes described below that are unrelated to the waiver extension. For uncompensated-care payments attributable to services provided after October 1, 2019, the terms of the extension: (1) revise the current definition of eligible uncompensated-care costs that may be reimbursed through the waiver uncompensated-care pool; and (2) require that payment amounts be unrelated to the source of the non-federal share of the payments.

The terms of the waiver extension also require that the state publish the final administrative rules describing the revised payment methodologies no later than January 30, 2019, and be effective no later than September 30, 2019. Failure to comply with this requirement will result in a reduction in funding for uncompensated-care payments.

To avoid confusion during the lengthy period between publication of the final rules in January 2019 and the date HHSC implements the revised methodologies in October of that year, HHSC is proposing new rules that will govern the revised payment and funding methodologies. The existing rules as amended will continue to govern payments made before the new methodologies go into effect.

OVERVIEW OF PROPOSED CHANGES TO EXISTING RULES

HHSC is proposing amendments to the existing rules to clarify an end date to the methodologies described in those rules. At a later time, HHSC will propose the repeal of §§355.8201 and 355.8202 and amendments to §§355.8441 and 355.8600 to remove obsolete language.

Additionally, HHSC proposes to amend §355.8201 to remove the definition of a "Rider 38 hospital" and replace it with a definition of "rural hospital." The definition of "rural hospital" differs from the current definition of a "Rider 38 hospital" in that a rural referral center (RRC) with more than 100 beds located in a metropolitan statistical area will no longer be recognized as a rural hospital for the purpose of UC waiver payments. The change is proposed to be effective for UC payments in demonstration year eight. The proposed change is in response to the growing number of large urban hospitals that have obtained Medicare designations as RRCs in the past two years. Giving preferential treatment to large urban hospitals in UC reimbursement is inconsistent with HHSC's original intent that the payment methodology provide "a certain level of protection in UC in recognition of the financial vulnerability of [rural] hospitals and the critical role they play in preserving the rural safety net." 39 TexReg 4844 (June 27, 2014).

OVERVIEW OF PROPOSED NEW RULES AND HOW THEY DIFFER FROM CURRENT METHODOLOGIES

Currently, payments from the waiver uncompensated-care pool may be used to defray the actual uncompensated cost of medical services that meet the definition of medical assistance contained in section 1905(a) of the Social Security Act that are provided to Medicaid eligible or uninsured individuals by hospitals, physician group practices, governmental ambulance providers, and publicly-owned dental providers. Starting October 1, 2019, the terms of the waiver limit payments from this pool to only defray the actual uncompensated cost of medical services that are provided to uninsured individuals as charity care. Charity-care includes full or partial discounts provided to uninsured patients.

Additionally, the terms of the waiver require that the methodology used by the state to determine uncompensated-care payments must ensure that payments are distributed based on uncompensated cost, without any relationship to source of non-federal share.

HHSC is proposing the new payment rules to implement the revised definitions of eligible uncompensated costs and funding requirements contained in the terms of the approved waiver extension.

In addition, the proposed new §355.8212 contains the following changes from the current methodology described in §355.8201:

(1) HHSC proposes eliminating non-state-owned hospital pools by hospital type (i.e., large urban, small public, and private). Instead, the funds allocated to all non-state-owned hospitals are distributed to individual hospitals based on calculated maximum payment amounts. The hospitals are then grouped into subpools by their geographic location within Medicaid service delivery areas (SDAs).

(2) HHSC proposes reimbursing rural hospitals 100 percent of their eligible charity-care costs, while non-rural hospitals will receive a lower percentage of costs. Estimates of the distribution of UC funds beginning in demonstration year nine indicate that rural hospitals will face a reduction in UC reimbursement when the definition of eligible costs is limited to charity-care. HHSC’s proposal to benefit rural hospitals continues the policy of providing a certain level of protection in UC in recognition of the financial vulnerability of rural hospitals and the critical role they play in preserving the rural safety net. The proposed definition of “rural hospital” in §355.8212 is the same as the definition of "Rider 38 hospital" proposed in §355.8201.

Estimates of UC funding for demonstration year nine also indicate that children’s hospitals will see a decline in UC funding. HHSC is interested in receiving comments from interested parties on whether children’s hospitals, or any other hospital class or type, should also receive preferential treatment in payment calculations similar to that proposed for rural hospitals.

(3) HHSC proposes revising the methodology for determining advanced payment amounts for demonstration year nine. Currently, advance payments are based on a percentage of the maximum payment amount for the prior year. However, there is a high likelihood that payment amounts in demonstration year nine will vary significantly from demonstration year eight due to the limitation to uninsured charity-care costs. For that reason, HHSC proposes basing demonstration-year-nine advance payments on estimates of eligible charity-care costs that will be incurred by each hospital or physician group practice during the demonstration year.

(4) HHSC proposes eliminating the requirement that a secondary reconciliation be performed for hospitals that submitted a request for an adjustment to the interim hospital-specific limit, as described in §355.8201(i)(2). This proposed change is in response to requests from stakeholders.

(5) HHSC proposes eliminating the penalty for failure to complete Category 4 reporting requirements for Regional Healthcare Partnerships. This change is proposed to reduce the burden on hospitals and for administrative convenience.

Section-by-Section Summary
Proposed new §355.8208, Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care, describes the eligibility requirements for publicly-owned dental providers to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities.

Subsection (e) describes payment frequency.

Subsection (f) describes limitations on total funding amounts.

Subsection (g) describes the methodology for calculating uncompensated-care maximum payment amounts.

Subsection (h) describes the payment methodology.

Subsection (i) describes the process HHSC will use to recoup any overpayments to the provider.

Proposed amended §355.8441, Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, limits application of the section describing supplemental payments to dental providers to services provided through September 30, 2019.

Subsection (a)(1) - (10): no changes are proposed.

Subsection (a)(11)(C) limits application of the subparagraph to services provided through September 30, 2019, and directs the reader to section 355.8208 of the title for a description of the methodology that will apply for services provided after that date.

Subsection (a)(12) - (b): no changes are proposed.

Proposed new §355.8210, Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care, describes the eligibility requirements for governmental ambulance providers to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities.

Subsection (e) describes payment frequency.

Subsection (f) describes limitations on total funding amounts.

Subsection (g)(1) describes the use of cost reports to document actual costs incurred by the provider and specifies deadlines for submission and other requirements related to the cost reports.

Subsection (g)(2) describes the methodology for calculating uncompensated-care maximum payment amounts.

Subsection (g)(3) describes the methodology used to ensure that total payments to providers in the pool stay within allocation amount.
Subsection (h) describes the process HHSC will use to recoup any overpayments to the provider.

Proposed amended §355.8600. Reimbursement Methodology for Ambulance Services, limits application of the section describing supplemental payments to governmental ambulance providers to services provided through September 30, 2019.

Subsection (a) - (b): no changes are proposed.

Subsection (c) proposes limiting application of the subparagraph to services provided through September 30, 2019, and directs the reader to section 355.8210 of the title for a description of the methodology that will apply for services provided after that date. No other changes to the subsection are proposed.

Subsection (d): no changes are proposed.

Proposed new §355.8212, Waiver Payments to Hospitals for Uncompensated Charity Care, describes the eligibility requirements for hospitals to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities and explains that HHSC will survey the governmental entities that provide public funds for payments to providers in the pool to determine total funding available to support payments from the pool.

Subsection (e) describes payment frequency.

Subsection (f)(1) limits payments by the maximum amount of funds allocated to the hospital uncompensated-care pool.

Subsection (f)(2) identifies the uncompensated-care pools and sub-pools, describes the providers eligible for reimbursement from each pool, and explains the method for determining the amount of funds allocated to each pool and sub-pool.

Subsection (f)(3) limits payments by the availability of funds identified in subsection (d).

Subsection (g)(1) describes the use of uncompensated-care applications to document actual costs incurred by the provider.

Subsection (g)(2) describes the components used to calculate a hospital's maximum uncompensated-care payment amount.

Subsection (g)(3) defines eligible hospital charity-care costs to be consistent with definitions in schedule S-10 of the CMS 2552-10 cost report and describes the source of the data for hospitals that submit S-10 schedules and hospitals that do not do so.

Subsection (g)(4) describes costs, other than inpatient and outpatient charity-care costs, that a hospital may claim for reimbursement from the hospital uncompensated-care pool.

Subsection (g)(5) describes adjustments the hospital may request to the cost and payment data on the hospital's cost report used to calculate interim payment amounts.

Subsection (g)(6) describes the methodology used to ensure that total payments to providers in the pool stay within allocation amounts.

Subsection (g)(7) describes the non-state-owned hospital sub-pools.

Subsection (g)(8) prohibits duplication of costs.

Subsection (g)(9) describes the methodology for calculating advance payment amounts.

Subsection (h) describes the payment methodology, including the contents of the notice HHSC will provide prior to making payments under this section, the methodology for determining payments if governmental entities transfer less than the amount necessary to fully fund hospitals in the pool, and the final payment opportunity for the demonstration year.

Subsection (i) describes the process HHSC will use to reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments made to the hospital for the same period.

Subsection (j) describes the process to recoup any overpayments to the provider.

Proposed amendments to §355.8201, Waiver Payments to Hospitals for Uncompensated Care, clarify that the rule applies only for services provided between October 1, 2018, and September 30, 2019. The proposed amendment also replaces the definition of a "Rider 38 hospital" with a definition of "rural hospital," clarifies that applications are no longer used in the reconciliation process, and removes references to transition payments, which were only available during the first demonstration year.

Subsection (a) introduces the rule and proposes to limit application of the rule to services provided between October 1, 2018, and September 30, 2019.

Subsection (b): defines terms used in the rule and proposes to replace the definition of "Rider 38 hospital" with a definition of "rural hospital" that excludes large hospital (i.e., more than 100 beds) located in metropolitan statistical areas.

Subsection (c) describes eligibility criteria for receiving a payment under this section. Paragraph (3)(A) removes obsolete language, since applications are no longer used in the reconciliation process.

Subsection (d): no changes are proposed.

Subsection (e) describes payment frequency and proposes revising the rule to post the schedule on HHSC's website.

Subsection (f) describes funding limitations based on the maximum amount of funds allocated to the hospital uncompensated-care pool and on the availability of non-federal funds. HHSC proposes eliminating references to obsolete language in paragraph (2)(C)(iii)(I) and (III).

Subsection (g)(1) describes the uncompensated-care payment application. HHSC proposes removing references to the use of the application for purposes of the reconciliation process.

Subsections (g)(2) - (4): no changes are proposed.

Subsection (g)(5) describes the reduction to stay within uncompensated-care pool aggregate limits and includes changes to replace the term "Rider 38" with "rural."

Subsections (g)(6) - (7) and (h): no changes are proposed.

Subsection (i) describes the process HHSC will use to reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments made to the hospital for the same period. HHSC proposes removing obsolete references to...
the third demonstration year and to transition payments. HHSC also proposes adding paragraph (4) to require all hospitals that received a payment during the demonstration year to cooperate in the reconciliation process, even if the hospital closed or withdrew from participation in the program.

Subsection (j): no changes are proposed.

Proposed new §355.8214, Waiver Payments to Physician Group Practices for Uncompensated Charity Care, describes the eligibility requirements for certain physician group practices to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities and explains that HHSC will survey the governmental entities that provide public funds for payments to providers in the pool to determine total funding available to support payments from the pool.

Subsection (e) describes payment frequency.

Subsection (f)(1) limits payments by the maximum amount of funds allocated to the physician group practice uncompensated-care pool, as described in §355.8212.

Subsection (f)(2) limits payments by the availability of funds identified in subsection (d).

Subsection (g)(1) describes the use of uncompensated-care applications to document actual costs incurred by the provider.

Subsection (g)(2) describes the components used to calculate provider's maximum uncompensated-care payment amount.

Subsection (g)(3) describes adjustments the provider may request to the cost and payment data used to calculate interim payment amounts.

Subsection (g)(4) describes the methodology used to ensure that total payments to providers in the pool stay within allocation amounts.

Subsection (g)(5) describes the methodology for calculating advance payment amounts.

Subsection (h) describes the payment methodology, including the contents of the notice HHSC will provide prior to making payments under this section and the methodology for determining payments if governmental entities transfer less than the amount necessary to fully fund providers in the pool.

Subsection (i) describes the process HHSC will use to reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments made to the hospital for the same period.

Subsection (j) describes the process to recoup any overpayments to the provider.

Proposed amendments to §355.8202, Waiver Payments to Physician Group Practices for Uncompensated Care, clarify that the rule applies only for services provided through September 30, 2019, and clarifies the payments schedule.

Subsection (a) introduces the rule and proposes to limit application of the rule to services provided through September 30, 2019.

Subsections (b) - (d): no changes are proposed.

Subsection (e) describes payment frequency and proposes posting the schedule on HHSC's website.

Subsections (f) - (j): no changes are proposed.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the sections will be in effect, there will be no fiscal implications to state government as a result of enacting and administering the sections as proposed.

The new methodology that will be implemented for UC will have both a positive and negative impact on the revenues that publicly owned hospitals, physician groups, and ambulance and dental providers will receive for their uncompensated cost of care each year. The impact to local governments will also be positive and negative, depending on the providers in their area and to what extent the local government is responsible for funding the non-federal share of the UC payment. This impact will vary depending on how the uncompensated cost of care for patients classified as charity care patients differ from the uncompensated cost of care for Medicaid and uninsured patients on which UC payment amounts were previously based. HHSC lacks data to provide an estimate of the change in UC payments amounts for specific local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the section(s) will be in effect:

1. the proposed rules will not create or eliminate a government program;
2. implementation of the proposed rules will not affect the number of employee positions;
3. implementation of the proposed rules will not require an increase or decrease in future legislative appropriations;
4. the proposed rules will not affect fees paid to the agency;
5. the proposed rules will create new rules;
6. the proposed rules will not expand existing rules;
7. the proposed rules will not change the number of individuals subject to the rule; and
8. HHSC has insufficient information to determine the proposed rules' effect on the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Greta Rymal, Deputy Executive Commissioner for Financial Services, has also determined that there is a possibility for adverse economic impacts to rural communities. The change in methodology from reimbursing uncompensated cost of care for Medicaid and uninsured patients to reimbursing uncompensated cost of care for charity patients for hospital and non-hospital providers will affect the reimbursement to healthcare providers in communities around the state. Some hospitals located in rural communities have informed HHSC they do not have the ability to adequately record their charity care charges and costs. It is possible that without complete records of charity
care, these rural hospitals might experience lower reimbursement with the change in reimbursement methodology. HHSC lacks data to provide an estimate of the fiscal impact in the rural communities where these hospitals are located.

There will be no adverse economic effect on small businesses or micro-businesses. There are no providers eligible for uncompensated-care payments that meet the definition of a small business or micro-business.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There is a possibility of a negative impact on local employment in some communities and a positive impact in others. The change in methodology from reimbursing uncompensated cost of care for Medicaid and uninsured patients to reimbursing uncompensated cost of care for charity patients for hospital and non-hospital providers will affect the reimbursement to healthcare providers in communities around the state. Certain providers will receive greater reimbursement while others will receive less, depending on the shift in their cost of uncompensated care when calculated using patients who qualify for the providers' charity care policy instead of Medicaid and uninsured patients.

The change in payment amounts will affect revenue received by the healthcare provider, as well as the amount of local and state dollars needed as the non-federal share of the payments. HHSC lacks sufficient data at this time both to predict those communities in which there may be an employment impact and to determine the potential impacts on local employment in those communities.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT

Selvadas Govind, Director of Rate Analysis, has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. The public benefit anticipated as a result of enforcing or administering the sections will be that local communities and private providers will continue to receive federal matching funds for some uncompensated costs of services provided to charity-care patients, which would not otherwise be available. The public will also benefit from a better understanding of the policies and methodologies governing payment calculations.

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the 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 Government Code §2007.043.

PUBLIC HEARING

A public hearing is scheduled for Thursday, September 13, 2018, beginning at 9:00 a.m. (central time) in the Public Hearing Room of the Brown Hall Building located at 4900 N. Lamar, Austin, Texas. Persons requiring further information, special assistance, or accommodations should contact Andrew Robertson at (512) 424-6892.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Mariah Ramon, Project Manager, P.O. Box 149030, Mail Code H-100, Austin, Texas 78714-9030, or street address 4900 North Lamar Blvd., Austin, Texas 78751; or e-mailed to tools@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 60 days after the date of this issue of the Texas Register. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) e-mailed by midnight on the last day of the comment period. When e-mailing comments, please indicate "Comments on Proposed Rule 18R034" in the subject line.

DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT


STATUTORY AUTHORITY

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

The amendments and new sections affect Human Resources Code Chapter 32 and Government Code Chapters 531.

§355.8201. Waiver Payments to Hospitals for Uncompensated Care.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver payments are available under this section for services provided between October 1, 2018, and September 30, 2019, by eligible hospitals described in subsection (c) of this section. Waiver payments to hospitals for uncompensated care provided beginning October 1, 2019, are described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). Waiver payments to hospitals must be in compliance with the Centers for Medicare & Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions and this section.

(b) Definitions.
(20) Rural hospital--A hospital enrolled as a Medicaid provider that is:
   (A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or
   (B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or
   (C) designated by Medicare as a Rural Referral Center (RRC) and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, or is located in an MSA but has 100 or fewer beds.

(20°) Rural hospital--A hospital located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated Rural Referral Center, a Sole Community Hospital, or a Critical Access Hospital.

(21) - (26) (No change.)

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

(1) - (2) (No change.)

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

(A) If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, withdraws from participation in an RHP, or files bankruptcy before receiving all or a portion of the uncompensated-care payments for a demonstration year, HHSC will determine the hospital's eligibility to receive payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the demonstration year and whether it can satisfy the requirement to cooperate in the reconciliation process as described in subsection (i) [submit an uncompensated-care application for the demonstration year as described in subsection (g)(1)(C)] of this section.

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

(d) Source of funding. The non-federal share of funding for payments under this section is limited to timely receipt by HHSC of public funds from a governmental entity.

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

[(1) Uncompensated-care payments will be distributed at least quarterly after the uncompensated-care application is processed.]

[(2) The payment schedule or frequency may be modified as specified by CMS or HHSC.]

(f) Funding limitations.

(1) (No change.)

(2) HHSC will establish the following seven uncompensated-care pools: a state-owned hospital pool; a large public hospital pool; a small public hospital pool; a private hospital pool; a physician group practice pool; a governmental ambulance provider pool; and a publicly owned dental provider pool as follows:

(A) (No change.)

(B) Rural hospital [Rider 38] set-aside amounts. HHSC will determine rural hospital [Rider 38] set-aside amounts as follows:

(i) Divide the amount of funds approved by CMS for uncompensated-care payments for the demonstration year by the amount of funds approved by CMS for uncompensated-care payments for the 2013 demonstration year and round the result to four decimal places.

(ii) Determine the small rural public hospital [Rider 38] set-aside amount by multiplying the value from clause (i) of this subparagraph by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all rural [Rider 38] hospitals that are eligible to receive uncompensated-care payments under this section and that meet the definition of a small public hospital from subsection (b)(21) of this section. Truncate the resulting value to zero decimal places.

(iii) Determine the private rural hospital [Rider 38] set-aside amount by multiplying the value from clause (i) of this subparagraph by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all rural [Rider 38] hospitals that are eligible to receive uncompensated-care payments under this section and that meet the definition of a private hospital from subsection (b)(16) of this section. Truncate the resulting value to zero decimal places.

(iv) Determine the total rural hospital [Rider 38] set-aside amount by summing the results of clauses (ii) and (iii) of this subparagraph.

(C) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, and the rural hospital [Rider 38] set-aside amount among the non-state-owned provider pools as described in this subsection. The remaining available uncompensated-care funds equal the amount of funds approved by CMS for uncompensated-care payments for the demonstration year less the sum of funds allocated to the state-owned hospital pool under subparagraph (A) of this paragraph and the rural hospital [Rider 38] set-aside amount from subparagraph (B) of this paragraph.

(i) HHSC will allocate the funds among non-state-owned provider pools based on the following amounts:

(1) (No change.)

(II) Small public hospitals:
   (a) The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all non-rural [non-Rider 38] small public hospitals, as defined in subsection (b)(21) of this section, eligible to receive uncompensated-care payments under this section; plus
   (b) An amount equal to the IGTs transferred to HHSC by small public hospitals to support DSH payments to themselves for Pass One and Pass Two payments for the same demonstration year.

(III) Private hospitals: The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all non-rural [non-Rider 38] private hospitals, as defined in subsection (b)(16) of this section, eligible to receive uncompensated-care payments under this section.

(IV) - (VI) (No change.)

(i) (No change.)

(iii) HHSC will calculate the aggregate limit for each non-state-owned provider pool as follows:
(I) To determine the large public hospital pool aggregate limit:

(a) multiply the remaining available uncompensated-care funds, from this subparagraph, by the amount calculated in clause (i)(I) of this subparagraph; and

(b) divide the result from item (a) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places;[ and]

[(-d-) for the third demonstration year only, add $136,309,422.]

(II) (No change.)

(III) To determine the private hospital pool aggregate limit:

(a) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(III) of this subparagraph;

(b) divide the result from item (a) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places; and

(c) add the result from item (b) of this subclause to the amount calculated in subparagraph (B)(iii) of this paragraph. [ and]

[(-d-) for the third demonstration year only, reduce the amount calculated in item (c) of this subclause by $136,309,422.]

(IV) - (VI) (No change.)

(3) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which a hospital is eligible, HHSC will reduce payments as described in subsection (b)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Application.

(A) Cost and payment data reported by the hospital in the uncompensated-care application is used to

[HH] calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection. [ and]

[III] reconcile the actual uncompensated-care costs reported by the hospital for the data year with uncompensated-care waiver payments, if any, made to the hospital for the same period. The reconciliation process is more fully described in subsection (i) of this section.

(B) (No change.)

[I] If a hospital withdraws from participation in an RHP, the hospital must submit an uncompensated-care application reporting its actual costs and payments for any period during which the hospital received uncompensated-care payments. The application will be used for the purpose described in paragraph (1)(A)(ii) of this subsection. If a hospital fails to submit the application reporting its actual costs, HHSC will reconcile the full amount of uncompensated-care payments to the hospital for the period at issue.

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

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

(A) - (E) (No change.)

(F) Notwithstanding the calculations described in subparagraphs (A) - (E) of this paragraph, if the payment period is the final payment period for the demonstration year, to the extent the payment is supported by IG, each rural [Rider 38] hospital is guaranteed a payment at least equal to its interim hospital specific limit from paragraph (2)(A) of this subsection multiplied by the value from subsection (f)(2)(B)(i) of this section for the demonstration year less any prior period payments. If this guarantee will cause payments for a pool to exceed the aggregate pool limit, the reduction required to stay within the pool limit will be distributed proportionally across all non-rural [non-Rider 38] providers in the pool based on each provider's resulting payment from subparagraphs (A) - (E) of this paragraph as compared to the payments to all non-rural [non-Rider 38] hospitals in the pool resulting from subparagraphs (A) - (E) of this paragraph.

(6) - (7) (No change.)

(h) (No change.)

(i) Reconciliation. HHSC will [Beginning in the third demonstration year, data on the uncompensated care application will be used to] reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments, if any, made to the hospital for the same period:

(1) - (2) (No change.)

[33 Transition payments are not subject to reconciliation under this subsection.]

(3) [44] If a hospital submitted a request as described in subsection (g)(4)(A)(i) of this section that impacted its interim hospital-specific limit, that hospital will be subject to an additional reconciliation as follows:

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

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

(j) - (k) (No change.)


(a) Introduction. Payments are available under this section for services provided through September 30, 2019, by an eligible physician group practice described in subsection (c) of this section. Waiver payments to physician group practices for uncompensated charity care provided beginning October 1, 2019, are described in §355.8214 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Charity Care). Waiver payments to an eligible physician group practice must be in compliance with the Centers for Medicare and Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions, and this section.

(b) - (d) (No change.)
(e) Payment frequency. HHSC will distribute waiver payments [as follows and] on a schedule to be determined by HHSC and posted on HHSC’s website. []

(1) Uncompensated-care payments will be distributed at least quarterly after the uncompensated-care physician application is processed.

(2) The payment schedule or frequency may be modified as specified by CMS or HHSC.

(f) - (j) (No change.)

§355.8208. Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, Texas Healthcare Transformation and Quality Improvement 1115 Waiver payments are available under this section for eligible publicly-owned dental providers to help defray the uncompensated cost of charity care. Waiver payments to publicly-owned dental providers for uncompensated care provided before October 1, 2019, are described in §355.8441 of this subchapter (relating to Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services).

(b) Definitions.

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

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

(3) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. Demonstration year one was October 1, 2011, through September 30, 2012.

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

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

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

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

(8) Publicly-owned dental provider--A dental provider that uses paid government employees to provide dental services directly funded by a governmental entity.

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

(10) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (2) of this subsection.

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


(c) Eligibility. To be eligible for payments under this section, a publicly-owned dental provider must submit to HHSC an acceptable uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities.

(e) Payment frequency. HHSC will distribute uncompensated-care payments on a schedule to be determined by HHSC.

(f) Funding limitations.

(1) Payments made under this section are limited by the amount of funds allocated to the provider's uncompensated-care pool for the demonstration year as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). If payments for uncompensated care for the publicly-owned dental provider pool attributable to a demonstration year are expected to exceed the amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(3) of this section.

(2) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which all publicly-owned dental providers are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Uncompensated-care application. Payments to eligible publicly-owned dental providers are based on cost and payment data reported by the provider on an application form prescribed by HHSC and on supporting documentation. Providers must certify that uncompensated-care costs reported on the application have not been claimed on any other application or cost report.

(2) (2) Calculation. A dental provider's annual maximum uncompensated-care payment amount is calculated as follows:

(A) As detailed in the cost report instructions, the provider must report their charges associated with charity-care services to uninsured patients and any payments attributable to those services.

(B) A cost-to-billed-charges ratio will be used to calculate total allowable cost.

(C) The result of subparagraph (B) of this paragraph will be reduced by any related payments to determine the provider's annual maximum uncompensated-care payment amount.

(3) Reduction to stay within the publicly-owned dental provider uncompensated-care pool allocation amount. Prior to
processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the publicly-owned dental provider pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts for each provider in the pool by the same percentage as required to remain within the pool allocation amount.

(h) Payment methodology.

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

(A) the payment amount for each publicly-owned dental provider in the pool;

(B) the maximum IGT amount necessary for providers in the pool to receive the amounts described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to providers in the pool will be determined based on the amount of funds transferred by the governmental entities as follows:

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

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

(i) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a provider's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the provider will be returned to the entity that owns or is affiliated with the provider.

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

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

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

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

§355.8210. Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, Texas Healthcare Transformation and Quality Improvement 1115 Waiver payments are available under this section for eligible governmental ambulance providers to help defray the uncompensated cost of charity care. Waiver payments to governmental ambulance providers for uncompensated care provided before October 1, 2019, are described in §355.6400 of this subchapter (relating to Reimbursement Methodology for Ambulance Services).

(b) Definitions.

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

(2) Certified public expenditure (CPE)--An expenditure certified by a governmental entity to represent its contribution of public funds in providing services that are eligible for federal matching Medicaid funds.

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

(4) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. Demonstration year one was October 1, 2011, through September 30, 2012.

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

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

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

(8) Governmental ambulance provider--An ambulance provider that uses paid government employees to provide ambulance services. The ambulance services must be directly funded by a governmental entity. A private ambulance provider under contract with a governmental entity to provide ambulance services is not considered a governmental ambulance provider for the purposes of this section.

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

(10) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (3) of this subsection.

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


(c) Eligibility.

(1) A governmental ambulance provider must submit a written request for eligibility for supplemental payment in a form prescribed by HHSC to the HHSC Rate Analysis Department by a date specified each year by HHSC. An acceptable request must include:

(A) an overview of the governmental agency;
(B) a complete organizational chart of the governmental agency;
(C) a complete organizational chart of the ambulance department within the governmental agency providing ambulance services;
(D) an identification of the specific geographic service area covered by the ambulance department, by ZIP code;
(E) copies of all job descriptions for staff types or job categories of staff who work for the ambulance department and an estimated percentage of time spent working for the ambulance department and for other departments of the governmental agency;
(F) a primary contact person for the governmental agency who can respond to questions about the ambulance department; and
(G) a signed letter documenting the governmental ambulance provider's voluntary contribution of non-federal funds.

(2) If eligible, a governmental ambulance provider may begin to claim uncompensated-care costs related to services provided on or after the first day of the month after the request for eligibility is approved.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will survey the governmental entities that provide public funds for the governmental ambulance providers in the pool to determine the amount of funding available to support payments from that pool.

(e) Payment frequency. HHSC will distribute uncompensated-care payments on a schedule to be determined by HHSC.

(f) Funding limitations.

(1) Payments made under this section are limited by the amount of funds allocated to the provider's uncompensated-care pool for the demonstration year as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). If payments for uncompensated care for the governmental ambulance provider pool attributable to a demonstration year are expected to exceed the amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(3) of this section.

(2) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which all governmental ambulance providers are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Cost reports. Governmental ambulance providers that are eligible for supplemental payments must submit an annual cost report for ground, water, and air ambulance services delivered to individuals who meet the provider's charity-care policy.

(A) The cost report form will be specified by HHSC. Providers certify through the cost report process their total actual federal and non-federal costs and expenditures for the cost reporting period.

(B) Cost reports must be completed for the full demonstration year for which payments are being calculated. HHSC may require a newly eligible provider to submit a partial-year cost report for their first year of eligibility. The beginning date for the partial-year cost report is the provider's first day of eligibility for supplemental payments as determined by HHSC. The ending date of the partial-year cost report is the last day of the demonstration year that encompasses the cost report beginning date.

(C) The cost report is due on or before March 31 of the year following the cost reporting period ending date and must be certified in a manner specified by HHSC.

(i) If March 31 falls on a federal or state holiday or weekend, the due date is the first working day after March 31.

(ii) A provider may request in writing an extension of up to 30 days after the due date to submit a cost report. HHSC will respond to all written requests for extensions, indicating whether the extension is granted. HHSC must receive a request for extension before the cost report due date. A request for extension received after the due date is considered denied.

(iii) A provider whose cost report is not received by the due date or the HHSC-approved extended due date is ineligible for supplemental payments for the federal fiscal year.

(E) The individual who completes the cost report on behalf of the provider ("the preparer") must complete the state-sponsored cost report training every other year for the odd-year cost report in order to receive credit to complete both that odd-year cost report and the following even-year cost report. If a new preparer wishes to complete an even-year cost report and has not completed the previous odd-year cost report training, to receive training credit to complete the even-year cost report, the preparer must complete an even-year cost report training. No exemptions from the cost report training requirements will be granted.

(D) A cost report documents the provider's actual allowable charity-care costs for delivering ambulance services in accordance with the applicable state and federal regulations. Because the cost report is used to determine supplemental payments, a provider must submit a complete and acceptable cost report to be eligible for a supplemental payment.

(E) The uncompensated-care payment is contingent upon the governmental ambulance provider's CPEs related to charity-care services. There are two CPE forms that must be submitted with each cost report:

(i) The cost report certification form formally acknowledges that the cost report is true, correct, and complete, and was prepared in accordance to all applicable rules and regulations.

(ii) The certification of funds form acknowledges that the claimed expenditures are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act, and in accordance with all procedures, instructions, and guidance issued by the single state agency and in effect during the cost report federal fiscal year.
(2) Calculation. An ambulance provider's annual maximum uncompensated-care payment amount is calculated as follows:

(A) As detailed in the cost report instructions, a provider must report their charges associated with charity-care services provided to uninsured patients and any payments attributable to those services.

(B) A provider's total allowable reported costs for ambulance services are allocated to uninsured charity-care patients based on the ratio of charges for uninsured charity-care patients to the charges for all patients. Only allocable expenditures related to uninsured charity care as defined in subsection (b)(3) of this section will be included in calculating the uncompensated-care payment.

(C) The result of subparagraph (B) of this paragraph will be reduced by any related payments reported on the cost report to determine the provider's annual maximum uncompensated-care payment amount.

(3) Reduction to stay within the governmental ambulance provider uncompensated-care pool allocation amount. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the governmental ambulance provider pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts for each provider in the pool by the same percentage as required to remain within the pool allocation amount.

(h) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a provider's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the federal share of the overpayment or disallowance.

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

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

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

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

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

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

(b) Definitions.

(1) Affiliation agreement--An agreement, entered into between one or more privately-operated hospitals and a governmental entity that does not conflict with federal or state law. HHSC does not prescribe the form of the agreement.

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

(3) Anchor--The governmental entity identified by HHSC as having primary administrative responsibilities on behalf of a Regional Healthcare Partnership (RHP).

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

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

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

(7) Delivery System Reform Incentive Payments (DSRIP)--Payments related to the development or implementation of a program of activity that supports a hospital's efforts to enhance access to health care, the quality of care, and the health of patients and families it serves. These payments are not considered patient-care revenue and are not offset against the hospital's costs when calculating the hospital-specific limit as described in §355.8066 of this subchapter.

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

(9) Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program that serves a disproportionate share of low-income patients and is eligible for additional reimbursement from the DSH program.

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

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

(12) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.
(13) Intergovernmental transfer (IGT)--A transfer of public funds from a governmental entity to HHSC.

(14) Large public hospital--An urban public hospital - Class one as defined in §355.8065 of this subchapter (relating to Disproportionate Share Hospital Reimbursement Methodology).

(15) Mid-Level Professional--Medical practitioners which include the following professions only:
   (A) Certified Registered Nurse Anesthetists;
   (B) Nurse Practitioners;
   (C) Physician Assistants;
   (D) Dentists;
   (E) Certified Nurse Midwives;
   (F) Clinical Social Workers;
   (G) Clinical Psychologists; and
   (H) Optometrists.

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

(17) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.

(18) RHP plan--A multi-year plan within which participants propose their portion of waiver funding and DSRIP projects.

(19) Rural hospital--A hospital enrolled as a Medicaid provider that is:
   (A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census;
   (B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or
   (C) designated by Medicare as a Rural Referral Center (RRC) and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, or is located in an MSA but has 100 or fewer beds.

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

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

(22) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (5) of this subsection.

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


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

(1) Generally. To be eligible for any payment under this section:
   (A) a hospital must be enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year; and
   (B) if it is a hospital not operated by a governmental entity, it must have filed with HHSC an affiliation agreement and the documents described in clauses (i) and (ii) of this subparagraph.
      (i) The hospital must certify on a form prescribed by HHSC:
         (I) that it is a privately-operated hospital;
         (II) that no part of any payment to the hospital under this section will be returned or reimbursed to a governmental entity with which the hospital affiliates; and
         (III) that no part of any payment to the hospital under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospital's receipt of the supplemental funds.
      (ii) The governmental entity that is party to the affiliation agreement must certify on a form prescribed by HHSC:
         (I) that the governmental entity has not received and has no agreement to receive any portion of the payments made to any hospital that is party to the agreement;
         (II) that the governmental entity has not entered into a contingent fee arrangement related to the governmental entity's participation in the waiver program;
         (III) that the governmental entity adopted the conditions described in the certification form prescribed by or otherwise approved by HHSC pursuant to a vote of the governmental entity's governing body in a public meeting preceded by public notice published in accordance with the governmental entity's usual and customary practices or the Texas Open Meetings Act, as applicable; and
         (IV) that all affiliation agreements, consulting agreements, or legal services agreements executed by the governmental entity related to its participation in this waiver payment program are available for public inspection upon request.

(iii) Submission requirements.

   (I) Initial submissions. The parties must initially submit the affiliation agreements and certifications described in this subsection to the HHSC Rate Analysis Department on the earlier of the following occurrences after the documents are executed:
      (a-) the date the hospital submits the uncompensated-care application that is further described in paragraph (2) of this subsection; or
      (b-) thirty days before the projected deadline for completing the IGT, which is posted on HHSC Rate Analysis Departments website for each payment under this section, for the first payment under the affiliation agreement.

   (II) Subsequent submissions. The parties must submit revised documentation to HHSC as follows:
(a) When the nature of the affiliation changes or parties to the agreement are added or removed, the parties must submit the revised affiliation agreement and related hospital and governmental entity certifications.

(b) When there are changes in ownership, operation, or provider identifiers, the hospital must submit a revised hospital certification.

(c) The parties must submit the revised documentation thirty days before the projected deadline for completing the IGT for the first payment under the revised affiliation agreement. The projected deadline for completing the IGT is posted on HHSC Rate Analysis Department’s website for each payment under this section.

(III) A hospital that submits new or revised documentation under subclause (I) or (II) of this clause must notify the Anchor of the RHP in which the hospital participates.

(IV) The certification forms must not be modified except for those changes approved by HHSC prior to submission.

(a) Within 10 business days of HHSC Rate Analysis Department receiving a request for approval of proposed modifications, HHSC will approve, reject, or suggest changes to the proposed certification forms.

(b) A request for HHSC approval of proposed modifications to the certification forms will not delay the submission deadlines established in this clause.

(V) A hospital that fails to submit the required documentation in compliance with this subparagraph is not eligible to receive a payment under this section.

(2) Uncompensated-care payments. For a hospital to be eligible to receive uncompensated-care payments, in addition to the requirements in paragraph (1) of this subsection, the hospital must:

(A) submit to HHSC an uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC; and

(B) submit to HHSC documentation of:

(i) its participation in an RHP; or

(ii) approval from CMS of its eligibility for uncompensated-care payments without participation in an RHP.

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

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

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

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for any uncompensated-care pool or sub-pool described in subsection (f)(2) of this section, HHSC will survey the governmental entities that provide public funds for the hospitals in that pool or sub-pool to determine the amount of funding available to support payments from that pool or sub-pool.

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

(f) Funding limitations.

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

(2) HHSC will establish the following uncompensated-care pools: a state-owned hospital pool, a non-state-owned hospital pool that is divided into sub-pools corresponding to the Medicaid managed care service delivery areas (SDAs), a physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool.

(A) The state-owned hospital pool.

(i) The state-owned hospital pool funds uncompensated-care payments to state-owned teaching hospitals, state-owned IMDs, and the Texas Center for Infectious Disease.

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

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

(i) For the physician group practice pool, the governmental ambulance provider pool, and the publicly owned dental provider pool:

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

(II) for demonstration years ten and after, an amount to equal a percentage determined by HHSC annually based on factors including the amount of reported charity-care costs for the previous demonstration year and the ratio of reported charity-care costs to hospitals’ charity-care costs.

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

(I) calculate a revised maximum payment amount for each non-state-owned hospital as described in subsection (g)(6) of this section; and
group all non-state-owned hospitals into subpools based on their geographic location within one of the state's Medicaid service delivery areas (SDAs), as described in subsection (g)(7) of this section.

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

(g) Uncompensated-care payment amount.

(1) Application.

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

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

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

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

(2) Calculation.

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

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

(I) Use self-reported information on the application to identify charges that can be claimed by the hospital in both DSH and UC and convert the charges to cost;

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

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

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

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

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

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

(iv) For each large public hospital, the amount transferred to HHSC by that hospital's affiliated governmental entity to support DSH payments for the same demonstration year.

(B) A hospital also participating in the DSH program cannot receive total uncompensated-care payments under this section (related to inpatient and outpatient hospital services provided to uninsured charity-care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's DSH hospital-specific limit (HSL) plus the unreimbursed costs of non-covered inpatient and outpatient services provided to uninsured charity-care patients.

(3) Hospital charity-care costs. The definitions of eligible hospital charity-care costs are consistent with the definitions contained in schedule S-10 of the CMS 2552-10 cost report.

(A) For each hospital required by Medicare to submit schedule S-10, HHSC will pre-populate the uncompensated-care application described in paragraph (1) of this subsection with the charity-care charges for services provided to uninsured patients reported by the hospital on schedule S-10 for the cost reporting period two years before the demonstration year.

(B) For each hospital not required by Medicare to submit schedule S-10 of the CMS 2552-10 cost report, the hospital must report its hospital charity-care charges for services provided to uninsured patients for the cost reporting period two years before the demonstration year on the uncompensated-care application described in paragraph (1) of this subsection. The definitions of eligible charity-care costs in the application instructions will be consistent with definitions in schedule S-10.

(4) Other eligible costs.

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

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

(ii) Certain pharmacy services.

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

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

(A) A hospital:

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

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

(B) Documentation supporting the request must accompany the application. HHSC will deny a request if it cannot verify that costs not reflected on the as-filed cost report will be incurred for the demonstration year.
(C) Notwithstanding the availability of adjustments impacting the cost and payment data described in this section, no adjustments to the interim hospital-specific limit will be considered for purposes of Medicaid DSH payment calculations described in §355.8065 of this subchapter.

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

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

(B) HHSC will calculate the following data points:

(i) For each provider, prior period payments to equal prior period uncompensated-care payments for the demonstration year.

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

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

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

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

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

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

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

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

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

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

(I) For rural hospitals, HHSC will:

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

(-b-) in demonstration year:

(-1-) nine, allocate to rural hospitals the amount calculated in item (-a-) of this subclause; or

(-2-) ten and after, allocate to rural hospitals the lesser of the amount calculated in item (-a-) of this subclause or the amount allocated to rural hospitals in demonstration year nine;

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

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

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

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

(-b-) allocate to non-rural hospitals an amount to equal the difference between the pool allocation amount from subsection (f)(2) of this section and the result of subclause (I)(-a-) or (-b-) of this clause;

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

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

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

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

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

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

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

(9) Advance payments.

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

(B) The amount of the advance payments will:

(i) in demonstration year nine, be based on estimates of eligible charity-care costs that will be incurred by each hospital during the demonstration year; and

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

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

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

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

(h) Payment methodology.

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

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

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

(C) the deadline for completing the IGT.

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

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

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

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

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

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

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

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

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

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

(j) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the hospital will be returned to the entity that owns or is affiliated with the hospital.

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

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

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

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


(a) Introduction. Beginning October 1, 2019, payments are available under this section to help defray the uncompensated charity-care costs incurred by eligible physician group practices described in subsection (c) of this section. Waiver payments to physician group practices for uncompensated care provided before October 1, 2019, are described in §355.8202 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Care). Waiver payments to an eligible physician group practice must be in compliance
with the Centers for Medicare & Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions, and this section.

(b) Definitions.

(1) Allocation amount--The amount of funds approved by the Centers for Medicare & Medicaid Services for uncompensated-care payments for the demonstration year that is allocated to the physician group practice uncompensated-care pool, as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

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

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

(4) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. Demonstration year one was October 1, 2011, through September 30, 2012.

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

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

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

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

(A) Certified Registered Nurse Anesthetists;
(B) Nurse Practitioners;
(C) Physician Assistants;
(D) Dentists;
(E) Certified Nurse Midwives;
(F) Clinical Social Workers;
(G) Clinical Psychologists; and
(H) Optometrists.

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

(10) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.

(11) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (3) of this subsection.

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

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


(c) Eligibility.

(1) A physician group practice is eligible to receive payments under this section if:

(A) it is enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year;

(B) for a private physician group practice only, it has met the submission requirements set forth in §355.8212(c)(1)(B)(ii) of this division, only insofar as that clause relates to certifications, and it files documents with HHSC by the date specified by HHSC, certifying that:

(i) all funds transferred to HHSC as the non-federal share of the waiver payments are public funds; and

(ii) no part of any payment received by the physician group practice under this section will be returned to the governmental entity that transferred to HHSC the non-federal share of the waiver payments;

(C) it has submitted to HHSC an acceptable uncompensated-care physician application for the demonstration year by the deadline specified by HHSC; and

(D) it either:

(i) received a supplemental payment under the Texas Medicaid State Plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011; or

(ii) is the successor in a contract to a physician group practice that received a supplemental payment under the Texas Medicaid State Plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011.

(2) A physician group practice that fails to submit the required documentation in compliance with this subsection will not receive a payment under this section.

(d) Source of funding.

(1) The non-federal share of funding for payments under this section is limited to and obtained through IGTs from the governmental entities that own or are affiliated with the providers in the physician group practice uncompensated-care pool. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will survey the governmental entities that
provide public funds for the physician group practices pool to determine the amount of funding available to support payments from that pool.

(2) An IGT that is not received by the date specified by HHSC may not be accepted.

(e) Payment frequency. HHSC will distribute waiver payments on a schedule to be determined by HHSC.

(f) Funding limitations.

(1) Payments made under this section are limited by the maximum amount of funds allocated to the physician group practice uncompensated-care pool for the demonstration year as described in §355.8212 of this division. If payments for uncompensated care for the physician group practice uncompensated-care pool attributable to a demonstration year are expected to exceed the amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(4) of this section.

(2) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which all physician group practices are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Uncompensated-care physician application. Payments to eligible physician group practices are based on cost and payment data reported by the physician group practice on an application form prescribed by HHSC.

(A) Cost and payment data reported by the physician group practice in the uncompensated-care physician application is used to:

(i) calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection; and

(ii) reconcile the actual uncompensated-care costs reported by the physician group practice for a prior period with uncompensated-care waiver payments, if any, made to the practice for the same period. The reconciliation process is more fully described in subsection (j) of this section.

(B) Unless otherwise instructed in the uncompensated-care physician application:

(i) the cost and payment data reported in the uncompensated-care physician application must be consistent with Medicare cost-reporting principles and must comply with the application instructions or other guidance issued by HHSC, and the physician group practice must maintain sufficient documentation to support the reported data or information; and

(ii) the costs associated with an episode of care where a physician group practice is paid under contract must be reduced by any revenues associated with that episode of care prior to inclusion in the uncompensated-care physician application.

(C) If a physician group practice withdraws from participation in the waiver, the practice must submit an uncompensated-care application reporting its actual costs and payments for any period during which the practice received uncompensated-care payments. The uncompensated-care physician application will be used for the purpose described in subparagraph (A)(ii) of this paragraph. If a practice fails to submit the application reporting its actual costs, HHSC will recoup the full amount of uncompensated-care payments to the practice for the period at issue.

(2) Calculation. A physician group practice’s annual maximum uncompensated-care payment amount is the sum of the following components:

(A) its unreimbursed charity-care costs, as reported on the uncompensated-care physician application; and

(B) cost and payment adjustments, if any, as described in paragraph (3) of this subsection.

(3) Adjustments. When submitting the uncompensated-care physician application, physician group practices may request that cost and payment data from the reporting period be adjusted to reflect increases or decreases in costs resulting from changes in operations or circumstances.

(A) A physician group practice may request that:

(i) costs not reflected on the financial documents supporting the application, but which would be incurred for the demonstration year, be included when calculating payment amounts; or

(ii) costs reflected on the financial documents supporting the application, but which would not be incurred for the demonstration year, be excluded when calculating payment amounts.

(B) Documentation supporting the request must accompany the application. HHSC will deny a request if it cannot verify that costs not reflected on the financial documents supporting the application will be incurred for the demonstration year.

(4) Reduction to stay within physician group practice uncompensated-care pool allocation amount. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for the physician group practice uncompensated-care pool described in §355.8212 of this division, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts providers in the pool are eligible to receive for that period as required to remain within the pool allocation amount.

(A) Calculations in this paragraph are limited to the physician group practice uncompensated-care pool.

(B) HHSC will calculate the following data points:

(i) for each provider, prior period payments to equal prior period uncompensated-care for the demonstration year;

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

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

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

(iii) the cumulative maximum payment amount to equal the sum of prior period payments from clause (i) of this subparagraph and the maximum uncompensated-care payment for the payment period from clause (ii) of this subparagraph for all members of the pool combined;
(iv) a pool-wide total maximum uncompensated-care payment for the demonstration year to equal the sum of all pool member's annual maximum uncompensated-care payment amounts for the demonstration year from paragraph (2) of this subsection; and

(v) a pool-wide ratio calculated as the pool allocation amount from §355.8212 of this division divided by the pool-wide total maximum uncompensated-care payment amount for the demonstration year from clause (iv) of this subparagraph.

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

(D) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is more than the allocation amount for the pool, HHSC will calculate a revised maximum uncompensated-care payment for the payment period for each provider in the pool. HHSC will calculate a capped payment amount equal the product of the provider's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the pool-wide ratio calculated in subparagraph (B)(v) of this paragraph. The revised maximum uncompensated-care payment for the payment period equals the lesser of:

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

(ii) the difference between the capped payment amount from this subparagraph and the prior period payments from subparagraph (B)(i) of this paragraph.

(E) Once reductions to ensure that uncompensated-care expenditures do not exceed the allocation amount for the demonstration year for the pool are calculated, HHSC will not re-calculate the resulting payments for any provider for the demonstration year, including if the estimates of available non-federal-share funding upon which the reduction calculations were based are different than actual IGT amounts.

(5) Advance payments.

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

(B) The amount of the advance payments will:

(i) in demonstration year nine, be based on estimates of eligible charity-care costs that will be incurred by each physician group practice during the demonstration year; and

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

(C) Advance payments are considered to be prior period payments as described in paragraph (4)(B)(i) of this subsection.

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

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

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

(h) Payment methodology.

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

(A) the payment amount for each physician group practice in the pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for the physician group practices to receive the amount described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) The amount of the payment to the physician group practices under paragraph (1) of this subsection will be determined based on the amount of funds transferred by the affiliated governmental entities as described as follows:

(A) If the governmental entities transfer the maximum amount of funds described in paragraph (1)(B) of this subsection, the physician group practices will receive the maximum allowable payment amounts for that period.

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

(i) Reconciliation. Data on the uncompensated-care physician application will be used to reconcile actual costs incurred by the physician group practice for a prior period with uncompensated-care payments, if any, made to the physician group practice for the same period.

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

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

(j) Recoupment.

(1) In the event of a disallowance by CMS of federal financial participation related to a physician group practice's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the physician group practice will be returned to the entity that owns or is affiliated with the physician group practice.

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

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

(A) HHSC will recoup from the physician group practice against which any disallowance was directed or to which an over-payment was made.

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

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
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For further information, please call: (512) 707-6071

DIVISION 23. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

1 TAC §355.8441

STATUTORY AUTHORITY

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

The amendments affect Human Resources Code Chapter 32 and Government Code Chapters 531.


(a) The following are reimbursement methodologies for services provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, delivered to Medicaid clients under age 21, also known as Texas Health Steps (THSteps) and the THSteps Comprehensive Care Program (CCP). Reimbursement methodologies for services provided to all Medicaid clients, including clients under age 21, are located elsewhere in this chapter.

(1) - (10) (No change.)

(11) Dental services are reimbursed in accordance with the following Medicaid reimbursement methodologies:

(A) Dental services provided by enrolled dental providers are reimbursed in accordance with §355.8085 of this subchapter.

(B) Dental services provided by federally qualified health centers (FQHCs) are reimbursed in accordance with §355.8261 of this subchapter (relating to Federally Qualified Health Center Services Reimbursement).

(C) For services provided through September 30, 2019 [Subject to approval by the Centers for Medicare and Medicaid Services, for services provided on or after March 1, 2012], publicly owned dental providers may be eligible to receive Uncompensated Care (UC) payments for dental services under the Texas Healthcare Transformation and Quality Improvement 1115 Waiver, as described in this section. For services provided beginning October 1, 2019, eligibility for publicly owned dental providers to receive waiver payments, and the methodology for calculating payment amounts, is described in section 355.8208 of this title. For purposes of this section, Uncompensated Care (UC) payments are payments intended to defray the uncompensated costs of services that meet the definition of "medical assistance" contained in §1905(a) of the Social Security Act. HHSC will calculate UC payments using the following methodology:

(i) - (vi) (No change.)

(12) (No change.)

(b) (No change.)

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

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DIVISION 31. AMBULANCE SERVICES

1 TAC §355.8600

STATUTORY AUTHORITY

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

The amendments affect Human Resources Code Chapter 32 and Government Code Chapters 531.


(a) - (b) (No change.)
(c) Reimbursement methodologies.

(1) Fee-for-service ambulance fee. Fee-for-service reimbursement is based on the lesser of a provider's billed charges or the maximum fee established by the Texas Health and Human Services Commission (HHSC). HHSC establishes fees by reviewing the Medicare fee schedule and analyzing any other available ambulance-related data. Fee-for-service rates apply to both private and governmental ambulance providers.

(2) Supplemental payment for governmental ambulance providers. For services provided through September 30, 2019, a governmental ambulance provider may be eligible to receive a supplemental payment in addition to the fee-for-service payment described in paragraph (1) of this subsection. For services provided beginning October 1, 2019, eligibility for governmental ambulance providers to receive a supplemental payment, and the methodology for calculating the payment amount, are described in §355.8210 of this chapter (relating to Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care).

(A) - (C) (No change.)

(d) (No change.)

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

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

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TITLE 7. BANKING AND SECURITIES

PART 6. CREDIT UNION DEPARTMENT

CHAPTER 91. CHARTERING, OPERATIONS, MERGERS, LIQUIDATIONS

SUBCHAPTER A. GENERAL RULES

7 TAC §91.121

The Credit Union Commission (the Commission) proposes amendments to 7 TAC, Chapter 91, §91.121, concerning complaint notification. The purpose of the proposed amendments is to implement Finance Code Section 15.409, which provides that the Commission shall maintain a system to promptly and efficiently act on complaints filed with the Credit Union Department (Department).

The proposed rule changes are intended to be explanatory in nature and generally relate to four areas: (1) how to file a complaint with the Department, (2) how a complaint is handled after receipt, (3) the authority of the Department in reviewing complaints, and (4) the privacy of information provided in a complaint.

The proposed amendments to paragraph (a) delineate the purpose of the section.

The proposed new paragraph (c) describes the Department's process for filing, receipt and handling of complaints.

The proposed new paragraph (d) explains the circumstances under which a complaint may be closed with no action by the Department beyond its review.

The proposed new paragraph (e) makes clear that any information provided with a complaint will be used in investigating a complaint and that personal, confidential, or sensitive information should not be included with the complaint.

STATE AND LOCAL GOVERNMENTS

Harold E. Feeney, Commissioner, has determined that for the first five-year period that the rule changes are in effect there will be no fiscal implications for state and local government as a result of enforcing or administering the rule changes.

STATEMENT OF PUBLIC COST AND BENEFITS

Mr. Feeney has also determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the proposed amendments because they will have access to information which will assist them in making complaints and will allow a better understanding of the process by which complaints are reviewed by the Department. There will be no anticipated cost to persons who are required to comply with the proposed amendments.

SMALL AND MICRO BUSINESSES AND RURAL COMMUNITIES

Mr. Feeney has also determined that for each year of the first five years the rule changes are in effect, there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. There is no economic cost anticipated to the credit union system or to individuals required to comply with the rule changes as proposed.

GOVERNMENT GROWTH IMPACT STATEMENT

Except as may be described below to the contrary, for each year of the first five years that the rules will be in effect, the rules will not:

- Create or eliminate a government program;
- Require the creation of new employee positions or the elimination of existing employee positions;
- Require an increase or decrease in future legislative appropriations to the agency;
- Create new regulations;
- Expand, limit, or repeal an existing regulation;
- Increase fees paid to the department;
- Increase or decrease the number of individuals subject to the rule's applicability; or
- Positively or adversely affect this state's economy.

Written comments on the proposed amendments may be submitted to Harold E. Feeney, Commissioner, Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699 or by email to CUDMail@cud.texas.gov. To allow the Commission sufficient time to fully address all the comments it receives, all comments must be received on or before 5:00 p.m. on the 31st day after the date the proposal is published in the Texas Register.
The rule changes are proposed under Texas Finance Code, Section 15.402, which authorizes the Commission to adopt reasonable rules for administering Texas Finance Code Title 2, Chapter 15 and Title 3, Subchapter D.

The statutory provision affected by the proposed amendments is Texas Finance Code, Section 15.409, regarding consumer information and complaints.

§91.121. Complaint Notices and Procedures [Notification].

(a) Purpose. This section implements Finance Code §15.409, which requires the Department to maintain a system to promptly and efficiently act on each complaint filed with the Department.

(a) Definition. For purposes of this section "required notice" means a notice in the form set forth or provided for in subsection (b)(1) of this section.

(b) Required Notice.

(1) Credit unions must provide their members with a notice that substantially conforms to the language and form of the following notice in order to let its members know how to file complaints: "If you have a problem with the services provided by this credit union, please contact us at: (Your Name) Credit Union Mailing Address Telephone Number or e-mail address. The credit union is incorporated under the laws of the State of Texas and under state law is subject to regulatory oversight by the Texas Credit Union Department. If any dispute is not resolved to your satisfaction, you may also file a complaint against the credit union by contacting the Texas Credit Union Department through one of the means indicated below: In Person or U.S. Mail: 914 East Anderson Lane, Austin, Texas 78752-1699, Telephone Number: (512) 837-9236, Facsimile Number: (512) 832-0278; email: complaints@cud.texas.gov, Website: www.cud.texas.gov."

(2) The title of this notice shall be "COMPLAINT NOTICE" and must be in all capital letters and boldface type.

(3) The credit union must provide the notice as follows:

(A) In each area where a credit union typically conducts business on a face-to-face basis, the required notice must be conspicuously posted. A notice is deemed to be conspicuously posted if a member with 20/20 vision can read it from the place where he or she would typically conduct business or if it is included in plain view on a bulletin board on which required communications to the membership (such as equal housing posters) are posted.

(B) If a credit union maintains a website, the required notice or a link to the required notice must be conspicuously posted on the homepage of the website.

(C) If a credit union distributes a newsletter, it must include the notice on approximately the same date at least once each year in any newsletter distributed to its members.

(D) If a credit union does not distribute a newsletter, the notice must be included with any privacy notice the credit union is required to provide or send its members.

(c) Filing, Receipt, and Handling of Complaints.

(1) The Department shall make available, on its public website (www.cud.texas.gov) and at its office, information on how to file a complaint.

(2) A person who alleges that a credit union has committed an act, or failed to perform at act that may constitute a violation of the Texas Credit Union Act or Department rules may file a complaint in writing with the Department. The complainant may complete and submit to the Department the complaint form the Department maintains at the Department's office and on its public website, or the complainant may submit a complaint in a letter that addresses the matters covered by the complaint form. At a minimum, all complaints should contain information necessary for the proper processing of the complaint by the Department, including, but not limited to:

(A) Complainant's name and how the complainant may be contacted;

(B) Name and address of the credit union against whom the complaint is made;

(C) A brief statement of the nature of the complaint and relevant facts, including names of persons with knowledge, times, dates, and location; and

(D) Copies of any documents or records related to the complaint. (original records should not be sent with a complaint.)

(3) Anonymous complaints may be accepted by the Department, but the lack of a witness or the inability of the Department to secure additional information from the anonymous complainant may result in the Department's inability to secure sufficient evidence to pursue action against a credit union.

(4) The Department will review all complaints to determine whether they are within the Department's jurisdiction or authority to resolve, and will send an acknowledgement letter to the complainant within five (5) business days of receipt of a complaint. At least quarterly until final disposition of the complaint, the Department shall provide status updates to the complainant and respondent credit union, orally or in writing.

(5) Upon determining that a complaint is within the Department's jurisdiction, the Department will inform the credit union respondent of the complaint and will request a written response from the credit union. Along with a request for response, the Department will transmit to the credit union a copy of the complaint and any attachments. Within fifteen (15) days from the date of the request for response, unless the period is extended by the Department, the credit union shall provide a substantive response and set forth the credit union's position with respect to the allegations in the complaint, which shall include all data, information and documentation supporting its position, or a description of corrective measures taken or intended to be taken. The Department may request and the complainant and respondent shall provide to the Department additional information or further explanation at any time during the review of the complaint.

(6) Once the Department has received the documentation from both parties, the Department will review the information and will process the complaint in accordance with the rules of the Department. The Department will advise both parties in writing of the final disposition of the complaint.

(7) The Department shall maintain a file on each complaint filed with the agency. The file shall include:

(A) the name of the complainant;

(B) the date the complaint is received by the Department;

(C) the subject matter of the complaint;

(D) a summary of the results of the review of the complaint; and

(E) an explanation of the reason the file was closed, if the Department closed the file without taking action other than to review the complaint.
(8) The Department will maintain a database of complaints in order to identify trends or issues related to violations of state laws under the Department’s jurisdiction.

(d) Complaints Closed with No Action Beyond Review. Certain complaints and disputes may be closed with no action taken other than to review the complaint. Such complaints may include those that are not within the Department authority to investigate or adjudicate, and which may be referred to as non-jurisdictional complaints. The Department, for example, will not address complaints concerning contractual matters or internal credit union practices that are not governed by the statutes or rules that the Department implements or enforces. The Department also may close without taking action other types of complaints, including undocumented factual disputes between a person and a credit union and complaints involving matters that are the subject of a pending lawsuit. The Department does not offer legal assistance and cannot represent individuals in settling claims or recovering damages. The Department does not open, operate, or control credit unions, and the Department does not establish their operating policies and procedures. Therefore, the Department may close without taking action complaints concerning the range of services a credit union offers, complaints about bad customer service, and disagreements over specific credit union policies, practices, or procedures, or about other matters that are not governed by a law or rule under the Department’s jurisdiction. The Department will inform the complainant and respondent credit union when a complaint is closed with no action taken, and will inform them of the reason for closing the case.

(e) Privacy. The information collected from complainants and respondents is solicited to provide the Department with information that is necessary and useful in reviewing complaints received from persons regarding their interactions with a credit union. A complainant is not required to give the Department any information; however, without such information, the Department’s ability to complete a review, to investigate, or to prosecute a matter may be hindered. It is intended that the information a person provides to the Department will be used within the Department and for the purpose of investigating and prosecuting a complaint. A person should not include personal or confidential information such as social security, credit card, or account numbers, or dates of birth when corresponding with the Department. If it is necessary to supply a document that contains personal or confidential information, the information should be redacted before the document is submitted to the Department.

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

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Harold E. Feeney
Commissioner
Credit Union Department

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SUBCHAPTER D. POWERS OF CREDIT UNIONS

7 TAC §91.403

The Credit Union Commission (the Commission) proposes amendments to 7 TAC, Chapter 91, Subchapter D, §91.403, concerning debt cancellation products consistent with competitive parity with federal credit unions. The amended rule is proposed to update standards governing debt cancellation products to encourage credit unions to provide such products consistent with safe and sound credit union practices and subject to appropriate consumer protections.

A debt cancellation product is a loan term or a contractual arrangement modifying loan terms linked to a credit union’s extension of credit, under which the credit union agrees to cancel or suspend all or part of a member’s obligation to repay an extension of credit from that credit union upon the occurrence of a specified event. A debt cancellation product includes a debt cancellation contract (DCC) and a debt suspension agreement (DSA).

The Department has long opined that credit unions may enter into debt cancellation contracts to the same extent as federal credit unions. Interpretive rulings issued by the National Credit Union Administration (NCUA) found that a federal credit union may sell debt cancellation products to its members as an activity that is incidental to federal credit unions’ express power of lending. NCUA codified this authority when it adopted its incidental powers regulation, which expressly noted debt cancellation and debt suspension agreements as permissible loan-related products (12 C.F.R. Section 721.3(g)). Pursuant to the authority set forth in Finance Code §123.003, relating to enlargement of powers and parity, a credit union may offer debt cancellation products. In addition, debt cancellation products are deemed to be loan products and not insurance products. The fee that may be charged with the sale of a debt cancellation is also authorized by Finance Code §124.101, relating to borrower payment of loan expenses.

The proposed amendments to subsection (a) clarify that credit unions must comply with the Truth in Lending Act (15 U.S.C. 1601 and the applicable provisions of Regulation Z (12 C.F.R. Part 226). The proposal also makes clear that a credit union’s authority to offer debt cancellation products for a fee is based upon the authority set forth in Finance Code Sections 123.003 and 124.101.

The proposed amendments to subsection (b) remove language that could be construed to prohibit the offering of a no-refund debt cancellation product because such products are permitted for federal credit unions. The amendments reflect an effort to preserve and promote parity with federal credit unions. The amendments clarify that if the debt cancellation product does provide for a refund of unearned fees, the unearned fees must be calculated using a method that produces a result at least as favorable to the member as the actuarial method.

New subsection (f) designates certain standards that credit unions should look to for guidance and apply as best practices with respect to the offer and sale of debt cancellation products. The Commission believes that guidance is necessary to facilitate members’ informed choice about whether to purchase debt cancellation products and to discourage inappropriate or abusive sales practices. In addition, the guidance promotes safety and soundness by encouraging credit unions that provide these products to maintain adequate loss reserves. The proposed rule reflects the Commission’s expectation that debt cancellation products will be offered in a safe and sound manner and consistent with appropriate consumer protections. The National Credit Union Administration (NCUA) has provided as guidance to federal credit unions, the requirements set forth in the rules of the U.S. Office of the Comptroller of the Currency (12 C.F.R. Part 37), related to DCCs and DSAs. The Commission adopts
and incorporates by reference the guidance issued by NCUA in its Letter to Federal Credit Unions No. 03-FCU-06. The Commission also directs credit unions to look to 12 C.F.R. Part 37, for guidance as to best practices related to the offer and sale of debt cancellation products.

STATE AND LOCAL GOVERNMENTS

Harold E. Feeney, Commissioner, has determined that for each year of the first five years the rule changes are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the rule changes.

STATEMENT OF PUBLIC COST AND BENEFITS

Mr. Feeney has also determined that for each year of the first five years the rule changes are in effect, the public benefits anticipated as a result of the changes will be clear guidance on best practices that credit unions may implement that are safe and sound and that afford consumer protection with regard to the offer and sale of debt cancellation products. There will be no anticipated cost to persons who are required to comply with the proposed amendments. There is no economic cost anticipated to the credit union system or to individuals required to comply with the rule changes as proposed.

SMALL AND MICRO BUSINESSES, LOCAL ECONOMY, AND RURAL COMMUNITIES

Mr. Feeney has also determined that for each year of the first five years the rule changes are in effect, there will be no adverse economic effect on small businesses, micro-businesses, local economies, or rural communities. There is no economic cost anticipated to the credit union system or to individuals required to comply with the rule changes as proposed.

GOVERNMENT GROWTH IMPACT STATEMENT

Except as may be described below to the contrary, for each year of the first five years that the rules will be in effect, the rules will not:

- Create or eliminate a government program;
- Require the creation of new employee positions or the elimination of existing employee positions;
- Require an increase or decrease in future legislative appropriations to the agency;
- Create new regulations;
- Expand, limit, or repeal an existing regulation;
- Increase fees paid to the department;
- Increase or decrease the number of individuals subject to the rule’s applicability; or
- Positively or adversely affect this state’s economy.

Written comments on the proposed amendments may be submitted in writing to Harold E. Feeney, Commissioner, Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699 or by email to CUDMail@cud.texas.gov. To be considered, a written comment must be received on or before 5:00 p.m. on the 31st day after the date the proposal is published in the Texas Register. At the conclusion of business on the 31st day after the proposal is published in the Texas Register, no further written comments will be considered or accepted by the commission.

The rule changes are proposed under Finance Code, Section 15.402, which authorizes the Commission to adopt reasonable rules for administering Finance Code Title 2, Chapter 15 and Title 3, Subchapter D of the Texas Finance Code, and under Finance Code Sections 123.003 and 124.001, which authorizes the Commission to adopt rules regarding loans to members.

§91.403. Debt Cancellation Products; Federal Parity; Adoption by Reference.

(a) Authority. Provided it complies with this section, the Truth in Lending Act (15 U.S.C. 1601), and the applicable provisions of Regulation Z (12 C.F.R. Part 226), a credit union may offer any debt cancellation product, including a debt cancellation contract (DCC) and a debt suspension agreement (DSA), a federal credit union is permitted to offer. For the purposes of this section, a debt cancellation product is a two-party agreement between the credit union and the member under which the credit union agrees to waive, suspend, defer, or cancel all or part of a member’s obligation to pay an indebtedness under a lease, loan, or other extension of credit upon the occurrence of a specified event. Debt cancellation products are considered loan products governed by this section and applicable provisions of the Finance Code, not insurance products and, consequently, are not regulated by the Texas Department of Insurance. The credit union may offer debt cancellation products for a fee pursuant to the authority set forth in Finance Code §123.003, relating to enlargement of powers and parity and the authority federal credit unions have to offer such products; the fee also is authorized by Finance Code §124.101, relating to borrower payment of loan expenses. If the debt cancellation product is offered for a fee [basis], then the member’s participation in the debt cancellation program must be optional, and the member must be informed of the fee and that participation is optional.

(b) Anti-tying and Refund Rules. For any debt cancellation product offered by a credit union:

(1) The credit union may not extend credit nor alter the terms or conditions of an extension of credit conditioned upon the member entering into a debt cancellation product with the credit union; and

(2) If the debt cancellation product provides for a refund of unearned fees, the [The debt cancellation product must provide for refunding or crediting to the member any unearned fees resulting from termination of the member’s participation in the product, whether by prepayment of the extension of credit or otherwise. Any] unearned fees must be calculated using a method that produces a result at least as favorable to the member as the actuarial method. Before the member purchases the debt cancellation product, the credit union must state in writing that the purchase of the debt cancellation product is optional, the conditions for and method of calculating any refund of the debt cancellation fee, including when fees are considered earned by the credit union, and that the member should carefully review all of the terms and conditions of the debt cancellation agreement prior to signing the agreement.

(c) Notice to Department. A credit union must notify the commissioner in writing of its intent to offer any type of debt cancellation product at least 30 days prior to the product being offered to members. The notice must contain a statement describing the type(s) of debt cancellation product(s) that the credit union will offer to its membership.

(d) Risk Management and Controls. Before offering any debt cancellation products, each credit union’s board of directors shall adopt written policies that establish and maintain effective risk management and control processes for these products. Such processes include appropriate recognition and financial reporting of income, expenses, assets and liabilities, and appropriate treatment of all expected and unexpected losses associated with the products. A credit union should also assess the adequacy of its internal control and risk mitigation activities.
in view of the nature and scope of its debt cancellation program. In
addition, the policies shall establish reasonable fees, if any, that will be
charged, the appropriate disclosures that will be given, and the claims
processing procedures that will be utilized.

(e) For purposes of this section “actuarial method” means the
method of allocating payments made on a debt between the amount
financed and the finance charge pursuant to which a payment is applied
first to the accumulated finance charge and any remainder is subtracted
from, or any deficiency is added to, the unpaid balance of the amount
financed.

(f) Best Practices. The Commission seeks to preserve and
promote parity with regard to federal credit unions, foreign credit
unions, and other depository institutions, as referenced in Finance
Code §§15.402(b-1) and 123.003. The National Credit Union Ad-
novation (NCUA) has provided as guidance for federal credit
unions the standards set forth in the rules of the U.S. Office of the
Comptroller of the Currency (OCC), related to DCCs and DSAs. The
Commission, therefore, adopts by reference the guidance issued by
NCUA in May 2003 (Letter No. 03-FCU-06). Credit unions should
also look to OCC’s rules, codified at 12 C.F.R. Part 37, for guidance as
to best practices in the industry regarding the offer and sale of DCCs
and DSAs. A copy of the NCUA letter and of the OCC rules may be
obtained on the Department website at: www.cud.texas.gov.

The agency certifies that legal counsel has reviewed the pro-
posal and found it to be within the state agency’s legal authority to
date.

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SUBCHAPTER G. LENDING POWERS

7 TAC §91.709

The Credit Union Commission (the Commission) proposes
amendments to 7 TAC, Chapter 91, Subchapter G, §91.709,
concerning member business and commercial loans. The
amended rule is proposed to amend the definition of member
business loan (MBL) with respect to 1- to 4- family dwellings to

In general, the purpose of the proposal regarding §91.709 is to
implement changes resulting from the Commission’s review of the
Chapter 91, Subchapter G under Texas Government Code,
Section 2001.039. The notice of intention to review 7 TAC Chap-
ter 91, Subchapter G, was published in the April 20, 2018, issue of
the Texas Register (43 TexReg 2455). The agency did not re-
ceive any comments on the notice of intention to review.

On May 24, 2018, the President signed the Economic Growth,
Regulatory Relief, and Consumer Protection Act, S. 2155, 115th
Cong (2018) (Economic Growth Act), which among other things,
amended the definition section of the MBL provisions of the Fed-
eral Credit Union Act. Prior to the Economic Growth Act, the
Federal Credit Union Act defined an MBL, in relevant part, as
any loan, line of credit, or letter of credit, the proceeds of which
will be used for commercial, corporate or other business invest-
ment property or venture, or agricultural purpose but does not
include and extension of credit that is fully secured by a lien on
a 1- to 4- family dwelling that is the primary residence of a mem-
ber.

The Economic Growth Act removed from that definition the
words “that is the primary residence of a member.” As a result,
the federal definition of an MBL, now excludes all extensions of
credit that are fully secured by a lien on a 1- to 4- family resi-
dential property regardless of the borrower’s occupancy status.
Because these kinds of loans are not long considered MBLs,
they do not count towards the aggregate MBL cap imposed on
each federal credit union by the Federal Credit Union Act.

The purpose of the proposal regarding §91.709 is a result of the
change to the federal definition of MBL as discussed above. The
proposed amendments will provide credit unions parity, under
Texas Finance Code Section 123.003, with federal credit unions
engaged in the business of making MBLs in Texas.

In general, the proposed amendments will clarify that mortgage
loans for non-owner occupied 1-4 family residential properties
are no longer considered commercial loans or member busi-
ness loans. The proposal will reduce regulatory burden for credit
unions concerned about going up against the MBL lending cap
and also for smaller credit unions that can now lend money for
second homes without triggering MBL obligations.

STATE AND LOCAL GOVERNMENTS

Harold E. Feehey, Commissioner, has determined that for the
first five-year period the rule changes are in effect there will be
no fiscal implications for state or local government as a result of
enforcing or administering the rule changes.

STATEMENT OF PUBLIC COST AND BENEFITS

Mr. Feehey has also determined that for each year of the first
five years the rule changes are in effect, the public benefits antici-
pated as a result of the changes will be greater clarity regarding
the rule’s requirements and significant regulatory relief for credit
unions. There is no economic cost anticipated to the credit union
system or to individuals required to comply with the rule changes
as proposed.

SMALL AND MICRO BUSINESSES AND RURAL COMMUNITIES

Mr. Feehey has also determined that for each year of the first
five years the rule changes are in effect, there will be no adverse
economic effect on small businesses, micro-businesses, or rural
communities.

GOVERNMENT GROWTH IMPACT STATEMENT

Except as may be described below to the contrary, for each year
of the first five years that the rule will be in effect, the rule will not:

- Create or eliminate a government program;
- Require the creation of new employee positions or the elimina-
tion of existing employee positions;
- Require an increase or decrease in future legislative appropri-
tions to the agency;
- Create new regulations;
- Expand or repeal an existing regulation;
- Increase fees paid to the department;

PROPOSED RULES  July 27, 2018  43 TexReg 4931
- Increase or decrease the number of individuals subject to the rule's applicability; or
- Positively or adversely affect this state's economy.

For each year of the first five years that the rule will be in effect, the rule will limit an existing regulation with respect to loans that are fully secured by a lien on a 1- to 4-family dwelling regardless of the borrower's occupancy status.

Written comments on the proposed amendments may be submitted in writing to Harold E. Feeney, Commissioner, Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699 or by email to CUDMail@cud.texas.gov. To be considered, a written comment must be received on or before 5:00 p.m. on the 31st day after the date the proposal is published in the Texas Register. At the conclusion of business on the 31st day after the proposal is published in the Texas Register, no further written comments will considered or accepted by the commission.

The rule changes are proposed under Texas Finance Code, Section 15.402, which authorizes the Commission to adopt reasonable rules for administering Title 3, Subchapter D of the Texas Finance Code, and under Texas Finance Code Section 124.001, which authorizes the Commission to adopt rules regarding loans to members.

The statutory provisions affected by the proposed amendments are contained in Texas Finance Code Chapter 124.

§91.709. Member Business and Commercial Loans.

(a) Definitions. Definitions in TEX. FIN. CODE §121.002, are incorporated herein by reference. As used in this section, the following words and terms shall have the following meanings, unless the context clearly indicates otherwise.

(1) "Borrower" means a member or any other person named as a borrower, obligor, or debtor in a loan or extension of credit; or any other person, including, but not limited to, a comaker, drawer, endorser, guarantor or surety who is considered to be a borrower under the requirements of subsection (i) of this section concerning aggregation and attribution for commercial loans.

(2) "Commercial loan" means a loan or an extension of credit to an individual, sole proprietorship, partnership, corporation, or business enterprise for commercial, industrial, agricultural, or professional purposes, including construction and development loans, any unfunded commitments, and any interest a credit union obtains in such loans made by another lender. A commercial loan does not include a loan made for personal expenditure purposes; a loan made by a corporate credit union; a loan made by a credit union to a federally insured credit union; a loan made by a credit union to a credit union service organization; a loan secured by a 1- to 4-family residential property (whether or not the residential property is the borrower's primary residence); a loan fully secured by shares in the credit union making the extension of credit or deposits in another financial institution; a loan secured by a vehicle manufactured for household use; and a loan that would otherwise meet the definition of commercial loan and which, when the aggregate outstanding balance plus unfunded commitments less any portion secured by shares in the credit union to a borrower, is equal to less than $50,000.

(3) "Control" means a person directly or indirectly, or acting through or together with one or more persons who:

(A) own, control, or have the power to vote twenty-five (25) percent or more of any class of voting securities of another person;

(B) control, in any manner, the election of a majority of the directors, trustees, or other persons exercising similar functions of another person; or

(C) have the power to exercise a controlling influence over the management or policies of another person.

(4) "Immediate family member" means a spouse or other family member living in the same household.

(5) "Loan secured by a lien on a 1- to 4-family residential property" means a loan that, at origination, is secured wholly or substantially by a lien on a 1- to 4-family residential property for which the lien is central to the extension of the credit; that is the borrower would not have been extended credit in the same amount or on terms as favorable without the lien. A loan is wholly or substantially secured by a lien on a 1- to 4-family residential property if the estimated value of the real estate collateral at origination (after deducting any senior liens held by others) is greater than fifty (50) percent of the principal amount of the loan.

(6) "Loan secured by a lien on a vehicle manufactured for household use" means a loan that, at origination, is secured wholly or substantially by a lien on a new and used passenger car or other vehicle such as a minivan, sport-utility vehicle, pickup truck, and similar light truck or heavy-duty truck generally manufactured for personal, family, or household use and not used as a fleet vehicle or to carry fare-paying passengers, for which the lien is central to the extension of credit. A lien is central to the extension of credit if the borrower would not have been extended credit in the same amount or on terms as favorable without the lien. A loan wholly or substantially secured by a lien on a vehicle manufactured for household use if the estimated value of the collateral at origination (after deducting any senior liens held by others) is greater than fifty (50) percent of the principal amount of the loan.

(7) "Loan-to-value ratio for collateral" means the aggregate amount of all sums borrowed and secured by the collateral, including outstanding balances plus any unfunded commitment or line of credit from another lender that is senior to the credit union's lien, divided by the current collateral value. The current collateral value must be established by prudent and accepted commercial loan practices and comply with all regulatory requirements.

(8) "Member business loan" has the meaning assigned by 12 C.F.R. Part 723.

(9) "Net worth" has the meaning assigned by 12 C.F.R. Part 702.2.

(10) "Readily marketable collateral" means financial instruments and bullion that are salable under ordinary market conditions with reasonable promptness at a fair market value determined by quotations based upon actual transactions on an auction or similarly available daily bid and ask price market.

(11) "Residential property" means a house, townhouse, condominium unit, cooperative unit, manufactured home, a combination of a home or dwelling unit and a business property that involves only minor or incidental business use, real property to be improved by the construction of such structures, or unimproved land zoned for 1- to 4-family residential use but does not include a boat, motor home, or timeshare property, even if used as a primary residence. This applies to such structure whether under construction or completed.

(b) Parity. A credit union may make, commit to make, purchase, or commit to purchase any member business loan if it could make it if it were operating as a federal credit union domiciled in this state, so long as for each transaction the credit union complies with all applicable regulations governing such activities by federal credit unions.
However, all such loans must be documented in accordance with the applicable requirements of this chapter.

(c) Commercial Loan Responsibilities and Operational Requirements. Prior to engaging in the business of making commercial loans, a credit union must address the responsibilities and operational requirements under this subsection:

(1) Written policies. A credit union must establish comprehensive written commercial loan policies approved by its board of directors instituting prudent loan approval, credit underwriting, loan documentation, and loan monitoring standards in accordance with this paragraph. The board must review its policies at least annually and, additionally, prior to any material change in the credit union's commercial lending program or related organizational structure, in response to any material change in the credit union's overall portfolio performance, or in response to any material change in economic conditions affecting the credit union. The board must update its policies when warranted. Policies under this paragraph must be designed to identify:

(A) type(s) of commercial loans permitted;

(B) trade area;

(C) the maximum amount of assets, in relation to net worth, allowed in secured, unsecured, and unguaranteed commercial loans and in any given category or type of commercial loan and to any one borrower;

(D) credit underwriting standards including potential safety and soundness concerns to ensure that action is taken to address those concerns before they pose a risk to the credit union's net worth; the size and complexity of the loan as appropriate to the size of the credit union; the scope of the credit union's commercial loan activities; the level and depth of financial analysis necessary to evaluate financial trends and the condition of the borrower and the ability of the borrower to meet debt service requirements; requirements for a borrower-prepared projection when historic performance does not support projected debt payments; the financial statement quality and degree of verification sufficient to support an accurate financial analysis and risk assessment; the methods to be used in evaluating collateral authorized, including loan-to-value ratio limits; the means to secure various types of collateral; and other risk assessment analyses including analysis of the impact of current market conditions on the borrower.

(E) loan approval standards including consideration, prior to credit commitment, of the borrower's overall financial condition and resources; the financial stability of any guarantor; the nature and value of underlying collateral; environmental assessment requirements; the borrower's character and willingness to repay as agreed; the use of loan covenants when warranted; and the levels of loan approval authority commensurate with the proficiency of the individuals or committee of the credit union tasked with such approval authority in evaluating and understanding commercial loan risk, when considered in terms of the level of risk the borrowing relationship poses to the credit union;

(F) loan monitoring standards including a system of independent, ongoing credit review and appropriate communication to senior management and the board of directors; the concentration of credit risk; and the risk management systems under subsection (d) of this section; and

(G) loan documentation standards including enabling the credit union to make informed lending decisions and assess risk, as necessary, on an ongoing basis; identifying the purpose of each loan and source(s) of repayment; assessing the ability of each borrower to repay the indebtedness in a timely manner; ensuring that any claim against a borrower is legally enforceable; and demonstrating appropriate administration and monitoring of each loan.

(2) Qualified Staff. A credit union must ensure that it is appropriately staffed with qualified personnel with relevant and necessary expertise and experience for the types of commercial lending in which the credit union is engaged, including appropriate experience in underwriting, processing, overseeing and evaluating the performance of a commercial loan portfolio, including rating and quantifying risk through a risk rating system and collections and loss mitigation activities for the types of commercial lending in which the credit union is engaged. At a minimum, a credit union making, purchasing, or holding any commercial loans must internally have a senior management employee that has a thorough understanding of the role of commercial lending in the credit union's overall business model and establish risk management processes and controls necessary to safely conduct commercial lending as provided by subsection (d) of this section.

(3) Use of Third-Party Experience. A third party may provide the requisite expertise and experience necessary for a credit union to safely conduct commercial lending if:

(A) the third party has no affiliation or contractual relationship with the borrower;

(B) the third party is independent from the commercial loan transaction and does not have a participation interest in a loan or an interest in any collateral securing a loan that the third party is responsible for reviewing, or an expectation of receiving compensation of any sort that is contingent on the closing of the loan, with the following exceptions:

(i) the third party may provide a service to the credit union that is related to the transaction, such as loan servicing;

(ii) the third party may provide the requisite experience to a credit union and purchase or a participation interest in a loan originated by the credit union that the third party reviewed; and

(iii) the third party is a credit union service organization and the credit union has a controlling financial interest in the credit union service organization as determined under generally accepted accounting principles.

(C) the actual decision to grant a commercial loan resides with the credit union; and

(D) qualified credit union staff exercise ongoing oversight over the third party by regularly evaluating the quality of any work the third party performs for the credit union.

(4) De Minimis Exception. The responsibilities and operational requirements described in paragraphs (1) and (2) of this subsection do not apply to a credit union if it meets all of the following conditions:

(A) the credit union's total assets are less than $250 million;

(B) the credit union's aggregate amount of outstanding commercial loan balances (including any unfunded commitments, any outstanding commercial loan balances and unfunded commitments of participations sold, and any outstanding commercial loan balances and unfunded commitments sold and serviced by the credit union) total less than fifteen (15) percent of the credit union's net worth; and

(C) in a given calendar year, the amount of originated and sold commercial loans and the amount of originated and sold commercial loans the credit union does not continue to service, total fifteen (15) percent or less of the credit union's net worth.
(D) A credit union that relies on this de minimis exception is prohibited from engaging in any acts or practices that have the effect of evading the requirements of this subsection.

(d) Commercial Loan Risk Management Systems.

(1) Risk Management Processes. A credit union’s risk management process must be commensurate with the size, scope and complexity of the credit union’s commercial lending activities and borrowing relationships. The processes must, at a minimum, address the following:

(A) use of loan covenants, if appropriate, including frequency of borrower and guarantor financial reporting;

(B) periodic loan review, consistent with loan covenants and sufficient to conduct portfolio risk management, which, based upon current market conditions and trends, loan risk, and collateral conditions, must include a periodic reevaluation of the value and marketability of any collateral, and an updated loan-to-value ratio for collateral calculation;

(C) a credit risk rating system under paragraph (2) of this subsection; and

(D) a process to identify, report, and monitor commercial loans that are approved by the credit union as exceptions to the credit union’s loan policies.

(2) Credit Risk Rating System. The credit risk rating system must be a formal process that identifies and assigns a relative credit risk rating to each commercial loan in a credit union’s portfolio, using ordinal ratings to represent the degree of risk. The credit risk score must be determined through an evaluation of quantitative factors based on the financial performance of each commercial loan and qualitative factors based on the credit union’s management, operational, market, and business environment factors. A credit risk rating must be assigned to each commercial loan at the inception of the loan. A credit risk rating must be reviewed as frequently as necessary to satisfy the credit union’s risk monitoring and reporting policies, and to ensure adequate reserves as required by generally accepted accounting principles.

(3) Independent Review. Periodic independent reviews should be conducted by a person who is both qualified to conduct such a review and independent of the function being reviewed. The review should provide an objective assessment of the overall commercial loan portfolio quality and verify the accuracy of ratings and the operational effectiveness of the credit union’s risk management processes. A credit union is not required to hire an outside third party to conduct this independent review, if it can be done in-house by a competent person that is considered unconnected to the function being reviewed.

(e) Collateral and Security for Commercial Loans.

(1) Collateral. A commercial loan must be secured by collateral commensurate with the level of risk associated with the size and type of the commercial loan. The collateral must be sufficient to ensure the credit union is protected by a prudent loan-to-value ratio for collateral along with appropriate risk sharing with the borrower and principal(s). A credit union making an unsecured commercial loan must determine and document in the loan file that mitigating factors sufficiently offset the relevant risk of making an unsecured loan.

(2) Personal Guarantees. A credit union that does not require the full and unconditional personal guarantee from all principals of the borrower who have a controlling interest, as defined by subsection (a)(3) of this section, in the borrower must determine and document in the loan file that mitigating factors sufficiently offset the relevant risk.

(f) Construction and Development Loans.

(1) Terms. In this subsection:

(A) "construction or development loan" means any financing arrangement to enable the borrower to acquire property or rights to property, including land or structures, with the intent to construct or renovate an income producing property, such as residential housing for rental or sale, or a commercial building, that may be used for commercial, agricultural, industrial, or other similar purposes. It also means a financing arrangement for the construction, major expansion or renovation of the property types referenced in this subsection. The collateral valuation for securing a construction or development loan depends on the satisfactory completion of the proposed construction or renovation where the loan proceeds are disbursed in increments as the work is completed. A loan to finance maintenance, repairs, or other improvements to an existing income-producing property that does not change the property’s use or does not materially impact the property is not a construction or development loan.

(B) "cost to complete" means the sum of all qualifying costs necessary to complete a construction project and documented in an approved construction budget. Qualifying costs generally include on- or off-site improvements; building construction; other reasonable and customary costs paid to construct or improve a project, including a general contractor's fees; other expenses normally included in a construction contract such as bonding and contractor insurance; the value of the land, determined as the sum of the cost of any improvements to the land and the lesser of appraised market value or purchase price; interest as provided by this subparagraph; project costs as provided by this subparagraph; a contingency account to fund unanticipated overruns; and other development costs such as fees and related pre-development expenses. Interest expense is a qualifying cost only to the extent it is included in the construction budget and is calculated based on the projected changes in the loan balance up to the expected "as-complete" date for owner-occupied non-income-producing commercial real property or the "as stabilized" date for income-producing real estate. Project costs for related parties, such as developer fees, leasing expenses, brokerage commissions and management fees, are included in qualifying costs only if reasonable in comparison to the cost of similar services from a third party. Qualifying costs exclude interest or preferred returns payable to equity partners or subordinated debt holders, the developer's general corporate overhead, and selling costs to be funded out of sales proceeds such as brokerage commissions and other closing costs.

(C) "prospective market value" means the market value opinion determined by an independent appraiser in compliance with the relevant standards set forth in the Uniform Standards of Professional Appraisal Practice. Prospective value opinions are intended to reflect the current expectations and perceptions of market participants, based on available data. Two (2) prospective value opinions may be required to reflect the time frame during which development, construction, or occupancy occur. The prospective market value "as-completed" reflects the real property’s market value as of the time that development is to be completed. The prospective market value "as-stabilized" reflects the real property’s market value as of the time the real property is projected to achieve stabilized occupancy. For an income producing property, stabilized occupancy is the occupancy level that a property is expected to achieve after the real property is exposed to the market for lease over a reasonable period of time and at comparable terms and conditions to other similar real properties.

(2) Policies. A credit union that elects to make a construction or development loan must ensure that its commercial loan policies under subsection (c) of this section meets the following conditions:
(A) qualified personnel representing the interest of the credit union must conduct a review and approval of any line item construction budget prior to closing the loan;

(B) a requisition and loan disbursement process approved by the credit union is established;

(C) release or disbursement of loan funds occurs only after on-site inspections which are documented in a written report by qualified personnel who represents the interest of the credit union and certifies that the work requisitioned for payment has been satisfactorily completed, and the remaining funds available to be disbursed from the construction and development loan is sufficient to complete the project; and

(D) each loan disbursement is subject to confirmation that no intervening liens have been filed.

(3) Establishing Collateral Values. The current collateral value must be established by prudent and accepted commercial loan practices and comply with all regulatory requirements. The collateral value depends on the satisfactory completion of the proposed construction or renovation where the loan proceeds are disbursed in increments as the work is completed and is the lesser of the project's cost to complete or its prospective market value.

(4) Controls and Processes for Loan Advances. A credit union that elects to make a construction and development loan must have effective commercial loan control procedures in place to ensure sound loan advances and that liens are paid and released in a timely manner. Effective controls should include segregation of duties, delegation of duties to appropriate qualified personnel, and dual approval of loan disbursements.

(g) Commercial Loan Prohibitions.

(1) Ineligible borrowers. A credit union may not grant a commercial loan to the following:

(A) any senior management employee directly or indirectly involved in the credit union's commercial loan underwriting, servicing, and collection process, and any of their immediate family members;

(B) any person meeting the requirements of subsection (i) of this section concerning aggregations and attribution for commercial loans, with respect to persons identified in subparagraph (A) of this paragraph; or

(C) any director, unless the credit union's board of directors approves granting the loan and the borrowing director was recused from the board's decision making process.

(2) Equity Agreements and Joint Ventures. A credit union may not grant a commercial loan if any additional income received by the credit union or its senior management employees is tied to the profit or sale of any business or commercial endeavor that benefits from the proceeds of the loan.

(3) Fees. No director, committee member, volunteer official, or senior management employee of a credit union, or immediate family member of such director, committee member, volunteer official, or senior management employee, may receive, directly or indirectly, any commission, fee, or other compensation in connection with any commercial loan made by the credit union. Employees, other than senior management, may be partially compensated on a commission or performance based incentive, provided the compensation is governed by a written policy and internal controls established by the board of directors. The board must review the policies and controls at least annually to ensure that such compensation is not excessive or expose the credit union to inappropriate risks that could lead to material financial loss. Loan origination employees are prohibited from receiving, in connection with any commercial loan made by the credit union, any compensation from any other source other than the credit union. For the purposes of this paragraph, compensation includes non-monetary items and anything reasonably regarded as pecuniary gain or pecuniary advantage, including a benefit to any other person in whose welfare the beneficiary has a direct and substantial interest, but compensation does not include nonmonetary items of nominal value.

(h) Aggregate Member Business Loan Limit.

(1) Limits. The aggregate limit on a credit union's net member business loan balances is the lesser of 1.75 times the actual net worth of the credit union, or 1.75 times the minimum net worth required under 12 U.S.C. Section 1790d(c)(1)(A). For purposes of this calculation, member business loan means any commercial loan, except that the following commercial loans are not member business loans and are not counted toward the aggregate limit on member business loans:

(A) any loan in which a federal or state agency (or its political subdivision) fully insure repayment, fully guarantees repayment, or provides an advance commitment to purchase the loan in full;

(B) any non-member commercial loan or non-member participation interest in a commercial loan made by another lender, provided the credit union acquired the non-member loans or participation interest in compliance with applicable laws and the credit union is not, in conjunction with one or more other credit unions, trading member business loans to circumvent the aggregate limit under this subsection;

(C) any loan that is fully secured by a lien on a 1- to 4-family dwelling.

(2) Exceptions. Any loan secured by a lien on a [1 to 4 family residential property that is not a member's primary residence, any loan secured by a lien on a vehicle manufactured for household use that will be used for commercial, corporate, or other business investment property or venture, any other loan for an agricultural purpose are not commercial loans (if the outstanding aggregate net member business loan balance is $50,000 or greater), and must be counted toward the aggregate limit on a credit union's member business loans under this subsection.

(3) Exemption. A credit union that has a federal low-income designation, or participates in the federal Community Development Financial Institution program, or was chartered for the purpose of making member business loans, or which as of the date of the Credit Union Membership Access Act of 1998 had a history of primarily making commercial loans, is exempt from compliance with the aggregate member business loan limits in paragraph (1) of this subsection.

(4) Method of Calculation for Net Member Business Loan Balance. For the purposes of NCUA form 5300 reporting (call report), a credit union's net member business loan balance is determined by calculating the sum of the outstanding loan balance plus any unfunded commitments and reducing that sum by any portion of the loan that is: secured by shares in the credit union, by shares or deposits in other financial institutions, or by a lien on a borrower's primary residence; insured or guaranteed by any agency of the federal government, a state, or any political subdivision of a state; or subject to an advance commitment to purchase by any agency of the federal government, a state, or any political subdivision of a state; or sold as a participation interest without recourse and qualifying for true sales accounting under generally accepted accounting principles.
(i) Aggregation and Attribution for Commercial Loans.

(1) General Rule. A commercial loan or extension of credit to one borrower is attributed to another person, and each person will be considered a borrower, when:

(A) the proceeds of the commercial loan or extension of credit are to be used for the direct benefit of the other person, to the extent of the proceeds so used, as provided by paragraph (2) of this subsection;

(B) a common enterprise is deemed to exist between the persons as persons as provided by paragraph (3) of this subsection; or

(C) the expected source of repayment for each commercial loan or extension of credit is the same for each person as provided by paragraph (3) of this subsection.

(2) Direct Benefit. The proceeds of a commercial loan or extension of credit to a borrower is considered used for the direct benefit of another person and attributed to the other person when the proceeds, or assets purchased with the proceeds, are transferred in any manner to or for the benefit of the other person, other than in a bona fide arm's length transaction where the proceeds are used to acquire property, goods, or services from such other person.

(3) Common Enterprise.

(A) Description. A common enterprise is considered to exist and commercial loans to separate borrowers will be aggregated when:

(i) the expected source of repayment for each loan or extension of credit is the same for each borrower and neither borrower has another source of income from which the loan (together with the borrower's other obligations) may be fully repaid. An employer will not be treated as a source of repayment under this subparagraph because of wages and salaries paid to an employee, unless the standards of clause (ii) of this subparagraph are met:

(ii) the loans or extension of credit are made:

(I) to borrowers who are related directly or indirectly through control as defined by subsection (a) of this section; and

(II) substantial financial interdependence exists between or among the borrowers. Substantial financial interdependence is deemed to exist when fifty (50) percent or more of one borrower's gross receipts or gross expenditures (on an annual basis) are derived from transactions with the other borrower. Gross receipts and expenditures include gross revenues/expenses, intercompany loans, dividends, capital contributions, and other similar receipts or payments;

(iii) separate persons borrow from a credit union to acquire a business of enterprise of which those borrowers will own more than fifty (50) percent of the voting securities of voting interest, in which case a common enterprise is deemed to exist between the borrowers for purposes of combining the acquisition loans; or

(iv) the Department determines, based upon an evaluation of the facts and circumstances of particular transactions, that a common enterprise exists.

(B) Commercial Loans to Certain Entities. A commercial loan or extension of credit:

(i) to a partnership or joint venture is considered to be a commercial loan or extension of credit to each member of the partnership or joint venture. Excepted from this subdivision is a partner or member who: is not held generally liable, by the terms of the partnership or membership agreement or by applicable law, for the debts or actions of the partnership, joint venture, or association, provided those terms are valid against third parties under applicable law; and has not otherwise agreed to guarantee or be personally liable on the loan or extension of credit.

(ii) to a member of a partnership, joint venture, or association is generally not attributed to the partnership, joint venture, or associations, or to other members of the partnership, joint venture, or association, except as otherwise provided by paragraphs (2) and (3) of this subsection, provided that a commercial loan or extension of credit made to a member of a partnership, joint venture or association for the purpose of purchasing an interest in the partnership, joint venture or association, is attributed to the partnership, joint venture or association.

(C) Guarantors and Accommodation Parties. The derivative obligation of a drawer, endorser, or guarantor of a commercial loan or extension of credit, including a contingent obligation to purchase collateral that secures a commercial loan, is aggregated with other direct commercial loans or extensions of credit to such a drawer, endorser, or guarantor.

(j) Commercial Loans to One Borrower Limit. The total aggregate dollar amount of commercial loans by a credit union to any borrower at one time may not exceed the greater of fifteen (15) percent of the credit union's net worth or $100,000, plus an additional ten (10) percent of the credit union's net worth if the amount that exceeds the credit union's fifteen (15) percent general limit is fully secured at all times with a perfected security interest in readily marketable collateral. Any insured or guaranteed portion of a commercial loan made through a program in which a federal or state agency (or its political subdivision) insures repayment, guarantees repayment, or provides an advance commitment to purchase the commercial loan in full, is excluded from this limit.

(k) Finance Code Limitation. In addition to the other limitations of this section, a credit union may not make a loan to a member or a business interest of the member if the loan would cause the aggregate amount of loans to the member and the member's business interests to exceed an amount equal to 10 percent of the credit union's total assets as provided by TEX. FIN. CODE §124.003.

(l) Commercial Loans Regarding Federal or State Guaranteed Loan Programs. A credit union may follow the loan requirements and limits of a guaranteed loan program for loans that are part of a loan program in which a federal or state agency (or its political subdivision) insures repayment, guarantees repayment, or provides an advance commitment to purchase the loan in full if that program has requirements that are less restrictive than those required by this section.

(m) Transitional Provisions.

(1) Waivers. Upon the effective date of this section, any waiver approved by the Department concerning a credit union's commercial lending activity is rendered moot, except for waivers granted for the commercial loan to one borrower limit. Borrowing relationships granted by waivers will be grandfathered however, the debt associated with those relationships may not be increased.

(2) Administrative Constraints. Limitations or other conditions imposed on a credit union in any written directive from the Department are unaffected by the adoption of this section. As of the effective date of this section, all such limitations or other conditions remain in place until such time as they are modified by the Department.

[43 TexReg 4936  July 27, 2018  Texas Register]
7 TAC §91.712

The Credit Union Commission (the Commission) proposes amendments to 7 TAC, Chapter 91, Subchapter G, §91.712, concerning plastic cards. The amended rule is proposed to update requirements to recognize the advancement of electronic communication.

In general, the purpose of the proposal regarding §91.712 is to implement changes resulting from the Commission’s review of Chapter 91, Subchapter G under Texas Government Code, Section 2001.039. The notice of intention to review 7 TAC Chapter 91, Subchapter G, was published in the April 20, 2018, issue of the Texas Register (43 TexReg 2455). The agency did not receive any comments on the notice of intention to review.

The proposed amendments to paragraph (a), subparagraph (1) would allow a plastic card to be activated by logging on to the issuer/processor's website to go through a member verification process.

STATE AND LOCAL GOVERNMENTS

Harold E. Feeney, Commissioner, has determined that for each year of the first five years the rule changes are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the rule changes.

STATEMENT OF PUBLIC COST AND BENEFITS

Mr. Feeney has also determined that for each year of the first five years the rule changes are in effect, the public benefits anticipated as a result of the changes will be that the commission’s rules will more accurately reflect the way plastic cards may be activated. There will be no anticipated cost to persons who are required to comply with the proposed amendments. There will be no adverse economic effect on small businesses, micro-businesses, or rural communities, as compared to large businesses. There is no economic cost anticipated to the credit union system or to individuals required to comply with the rule changes as proposed.

SMALL AND MICRO BUSINESSES AND RURAL COMMUNITIES

Mr. Feeney has also determined that for each year of the first five years the rule changes are in effect, there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. There is no economic cost anticipated to the credit union system or to individuals required to comply with the rule changes as proposed.

GOVERNMENT GROWTH IMPACT STATEMENT

Except as may be described below to the contrary, for each year of the first five years that the rules will be in effect, the rules will not:
- Require the creation of new employee positions or the elimination of existing employee positions;
- Require an increase or decrease in future legislative appropriations to the agency;
- Create new regulations;
- Expand, limit, or repeal an existing regulation;
- Increase fees paid to the department;
- Increase or decrease the number of individuals subject to the rule’s applicability; or
- Positively or adversely affect this state’s economy.

Written comments on the proposed amendments may be submitted in writing to Harold E. Feeney, Commissioner, Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699 or by email to CUDMail@cud.texas.gov. To be considered, a written comment must be received on or before 5:00 p.m. on the 31st day after the date the proposal is published in the Texas Register. At the conclusion of business on the 31st day after the proposal is published in the Texas Register, no further written comments will be considered or accepted by the commission.

The rule changes are proposed under Texas Finance Code, Section 15.402(b-1), which authorizes the Commission to adopt reasonable rules for administering Title 3, Subchapter D of the Texas Finance Code, and under Texas Finance Code Section 124.001, which authorizes the Commission to adopt rules regarding loans to members.

The statutory provisions affected by the proposed amendments are contained in Texas Finance Code Section 15.402 and in Finance Code Chapter 124.

§91.712. Plastic Cards.

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

(1) Card Activation - process of sending new plastic cards from the issuer to the legitimate cardholder in an "inactive" mode and making the card usable. Upon receiving the card, the legitimate cardholder must call or log on to the issuer/processor's website and go through a member verification process before the card is "activated".

(2) Card Security Code - a set of unique numbers encoded on the magnetic strip of plastic cards used to combat counterfeit fraud.

(3) Neural Network - a computer program that monitors usage patterns of an account and typical fraud patterns. The program analyzes activity to determine fraud risk scores to detect potentially fraudulent activity.

(4) Plastic Cards - includes credit cards, debit cards, automated teller machine (ATM) or specific network cards; and predetermined stored value and smart cards with micro-processor chips.

(b) Credit cards. A credit union may issue credit cards in accordance with the credit union's written policies, which shall include at a minimum:

(1) Credit policies to set individual limits for credit card accounts;

(2) A process for reviewing each member's payment and/or credit history periodically for the purpose of determining risk; and
(3) The credit underwriting standards for each type of card program offered.

(c) Program Review.

(1) A credit union shall review, on at least an annual basis, its plastic card program with particular emphasis on:

(A) The amount of losses caused by theft and fraud;

(B) The loss prevention measures (and their adequacy) currently employed by the credit union;

(C) The availability and possible implementation of other loss prevention measures such as card activation, card security codes, neural networks, and other evolving technology; and

(D) A cost benefit analysis of supplemental insurance coverage for theft and fraud related losses.

(2) The review shall be documented in writing, with any approved changes to the plastic card program being entered into the minutes of the board meeting.

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 July 13, 2018.

TRD-201803076
Harold E. Feeney
Commissioner
Credit Union Department
Earliest possible date of adoption: August 26, 2018
For further information, please call: (512) 837-9236

TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 1. AGENCY ADMINISTRATION

SUBCHAPTER O. LEARNING TECHNOLOGY ADVISORY COMMITTEE

19 TAC §1.185, §1.187

The Texas Higher Education Coordinating Board (Coordinating Board) proposes amendments to §1.185 and §1.187 concerning the authority and specific purposes of the Learning Technology Advisory Committee and committee membership and officers. The proposed amendments correct the reference of statutory authority in §1.185 and a grammatical error in §1.187.

Dr. Rex C. Peebles, Assistant Commissioner for Academic Quality and Workforce, has determined that for the first five years there will be no fiscal implications for state or local governments as a result of revising the sections.

Dr. Peebles has also determined that for the first five years the rules are in effect, the public benefits anticipated as a result of administering the sections will be the clarification of the statutory authority for the Learning Technology Advisory Committee in §1.185 and the correction of a grammatical error in §1.187. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

There will be no impact on small businesses or rural communities, as described in Texas Government Code, Chapter 2006, and therefore an Economic Impact analysis is not required.

Government Growth Impact Statement

(1) the rules will not create or eliminate a government program;

(2) implementation of the rules will not require the creation or elimination of employee positions;

(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the rules will not require an increase or decrease in fees paid to the agency;

(5) the rules will not create a new rule;

(6) the rules will not limit an existing rule; and

(7) the rules will not change the number of individuals subject to the rule.

Comments on the proposed amendments may be submitted by mail to Rex C. Peebles, Assistant Commissioner, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas, 78711 or via email at AQWComments@THECB.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

The amendments are proposed under the Texas Government Code, Chapter 2110, §2110.0012, which provides state agencies the authority to establish advisory committees.

The amendments affect the implementation of Texas Education Code, Chapter 61.

§1.185. Authority and Specific Purposes of the Learning Technology Advisory Committee.

(a) Authority. Statutory authority for this subchapter is provided in the Texas Government Code, Chapter 2110, §2110.0012.

(b) Purposes. The Learning Technology Advisory Committee is created to provide the Board with advice and recommendation(s) regarding the role that learning technology plays in Texas higher education.

§1.187. Committee Membership and Officers.

(a) - (b) (No change.)

(c) Interested persons, such as chief academic officers, and legislative and governmental relations staff shall be regularly advised of committee meetings.

(d) - (f) (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 July 13, 2018.

TRD-201803055
Bill Franz
General Counsel
Texas Higher Education Coordinating Board
Earliest possible date of adoption: August 26, 2018
For further information, please call: (512) 427-6104

43 TexReg 4938 July 27, 2018 Texas Register
CHAPTER 27. FIELDS OF STUDY
SUBCHAPTER DD. COMMUNICATION DISORDERS SCIENCES AND SERVICES FIELD OF STUDY ADVISORY COMMITTEE

19 TAC §§27.681 - 27.687

The Texas Higher Education Coordinating Board (Coordinating Board) proposes new Subchapter DD, §§27.681 - 27.687, concerning the Communication Disorders Sciences and Services Field of Study Advisory Committee. The proposed new rules authorize the Board to create an advisory committee to develop a Communication Disorders Sciences and Services field of study. The newly added rules will affect students when the Communication Disorders Sciences and Services field of study is adopted by the Board.

Dr. Rex C. Peebles, Assistant Commissioner for Academic Quality and Workforce, has determined that for the first five years there will be no fiscal implications for state or local governments as a result of adding the new sections.

Dr. Peebles has also determined that for the first five years the rules are in effect, the public benefits anticipated as a result of administering the sections will be the clarification of which lower division courses are required in a Communication Disorders Sciences and Services degree and improved transferability and applicability of courses. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

There will be no impact on small businesses or rural communities, as described in Texas Government Code, Chapter 2006, and therefore an Economic Impact analysis is not required.

Government Growth Impact Statement
(1) the rules will not create or eliminate a government program;
(2) implementation of the rules will not require the creation or elimination of employee positions;
(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;
(4) the rules will not require an increase or decrease in fees paid to the agency;
(5) the rules will create a new rule;
(6) the rules will not limit an existing rule; and
(7) the rules will not change the number of individuals subject to the rule.

Comments on the proposed amendments may be submitted by mail or email to Ada C. Peebles, Assistant Commissioner, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas, 78711 or via email at AQWComments@THECB.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

The new sections are proposed under the Texas Education Code, §61.823(a), which provides the Coordinating Board with the authority to develop fields of study curricula with the assistance of advisory committees and Texas Government Code, §2110.005, which requires a state agency that establishes an advisory committee to adopt rules that state the purpose and tasks of the committee and describe the manner in which the committee will report to the agency.

The new sections affect the implementation of Texas Education Code, Chapter 61.

§27.681. Authority and Specific Purposes of the Communication Disorders Sciences and Services Field of Study Advisory Committee.
(a) Authority. Statutory authority for this subchapter is provided in the Texas Education Code, §61.823(a).
(b) Purpose. The Communication Disorders Sciences and Services Field of Study Advisory Committee is created to provide the Commissioner and the Board with guidance regarding the Communication Disorders Sciences and Services field of study curricula.

§27.682. Definitions.
The following words and terms, when used in this subchapter, shall have the following meanings:
(1) Board--The Texas Higher Education Coordinating Board.
(2) Commissioner--The Commissioner of Higher Education, the Chief Executive Officer of the Board.
(3) Field of Study Curricula--The block of courses which may be transferred to a general academic teaching institution and must be substituted for institution's lower division requirements.
(4) Institutions of Higher Education--As defined in Texas Education Code, Chapter 61.003(8).

§27.683. Committee Membership and Officers.
(a) The advisory committee shall be equitably composed of representatives of institutions of higher education.
(b) Each university system or institution of higher education which offers a degree program for which a field of study curriculum is proposed shall be offered participation on the advisory committee.
(c) At least a majority of the members of the advisory committee named under this section shall be faculty members of an institution of higher education. An institution shall consult with the faculty of the institution before nominating or recommending a person to the board as the institution's representative on an advisory committee.
(d) Board staff will recommend for Board appointment individuals who are nominated by institutions of higher education.
(e) Members of the committee shall select co-chairs, who will be responsible for conducting meetings and conveying committee recommendations to the Board.
(f) The number of committee members shall not exceed twenty-four (24).
(g) Members shall serve staggered terms of up to three years. The terms of chairs and co-chairs (if applicable) will be two years dating from their election.

§27.684. Duration.
The Committee shall be abolished no later than October 30, 2022, in accordance with Texas Government Code, Chapter 2110. It may be reestablished by the Board.

§27.685. Meetings.
The Committee shall meet as necessary. Special meetings may be called as deemed appropriate by the presiding officer. Meetings shall be open to the public and broadcast via the web, unless prevented by technical difficulties, and minutes shall be available to the public after they have been prepared by the Board staff and reviewed by members of the Committee.

§27.686. Tasks Assigned to the Committee.

Tasks assigned to the Committee include:

(1) Advise the Board regarding the Communication Disorders Sciences and Services Field of Study Curricula;

(2) Provide Board staff with feedback about processes and procedures related to the Communication Disorders Sciences and Services Field of Study Curricula; and

(3) Any other issues related to the Communication Disorders Sciences and Services Field of Study Curricula as determined by the Board.

§27.687. Report to the Board; Evaluation of Committee Costs and Effectiveness.

The Committee shall report recommendations to the Board. The Committee shall also report Committee activities to the Board to allow the Board to properly evaluate the Committee work, usefulness, and the costs related to the Committee existence. The Board shall report its evaluation to the Legislative Budget Board in its biennial Legislative Appropriations Request.

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 July 13, 2018.

TRD-201803056

Bill Franz

General Counsel

Texas Higher Education Coordinating Board

Earliest possible date of adoption: August 26, 2018

For further information, please call: (512) 427-6104

SUBCHAPTER EE. FINE AND STUDIO ARTS FIELD OF STUDY ADVISORY COMMITTEE

19 TAC §§27.701 - 27.707

The Texas Higher Education Coordinating Board (Coordinating Board) proposes new Subchapter EE, §§27.701 - 27.707 concerning the Fine and Studio Arts Field of Study Advisory Committee. The proposed new rules authorize the Board to create an advisory committee to develop a Fine and Studio Arts field of study. The newly added rules will affect students when the Fine and Studio Arts field of study is adopted by the Board.

Dr. Rex C. Peebles, Assistant Commissioner for Academic Quality and Workforce, has determined that for the first five years there will be no fiscal implications for state or local governments as a result of adding the new sections.

Dr. Peebles has also determined that for the first five years the rules are in effect, the public benefits anticipated as a result of administering the sections will be the clarification of which lower division courses are required in a Fine and Studio Arts degree and improved transferability and applicability of courses. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

There will be no impact on small businesses or rural communities, as described in Texas Government Code, Chapter 2006, and therefore an Economic Impact analysis is not required.

Government Growth Impact Statement

(1) the rules will not create or eliminate a government program;

(2) implementation of the rules will not require the creation or elimination of employee positions;

(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the rules will not require an increase or decrease in fees paid to the agency;

(5) the rules will create a new rule;

(6) the rules will not limit an existing rule; and

(7) the rules will not change the number of individuals subject to the rule.

Comments on the proposed amendments may be submitted by mail to Rex C. Peebles, Assistant Commissioner, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas, 78711 or via email at AQWComments@THECB.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

The new sections are proposed under the Texas Education Code, §61.823(a), which provides the Coordinating Board with the authority to develop fields of study curricula with the assistance of advisory committees and Texas Government Code, §2110.005, which requires a state agency that establishes an advisory committee to adopt rules that state the purpose and tasks of the committee and describe the manner in which the committee will report to the agency.

The new sections affect the implementation of Texas Education Code, Chapter 61.

§27.701. Authority and Specific Purposes of the Fine and Studio Arts Field of Study Advisory Committee.

(a) Authority. Statutory authority for this subchapter is provided in the Texas Education Code, §61.823(a).

(b) Purpose. The Fine and Studio Arts Field of Study Advisory Committee is created to provide the Commissioner and the Board with guidance regarding the Fine and Studio Arts field of study curricula.

§27.702. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings:

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

(2) Commissioner--The Commissioner of Higher Education, the Chief Executive Officer of the Board.

(3) Field of Study Curricula--The block of courses which may be transferred to a general academic teaching institution and must be substituted for that institution’s lower division requirements for the degree program into which the student transfers, and the student shall receive full academic credit toward the degree program for the block of courses transferred.

(4) Institutions of Higher Education--As defined in Texas Education Code, Chapter 61.003(8).
§27.703. Committee Membership and Officers.

(a) The advisory committee shall be equitably composed of representatives of institutions of higher education.

(b) Each university system or institution of higher education which offers a degree program for which a field of study curriculum is proposed shall be offered participation on the advisory committee.

(c) At least a majority of the members of the advisory committee named under this section shall be faculty members of an institution of higher education. An institution shall consult with the faculty of the institution before nominating or recommending a person to the board as the institution’s representative on an advisory committee.

(d) Board staff will recommend for Board appointment individuals who are nominated by institutions of higher education.

(e) Members of the committee shall select co-chairs, who will be responsible for conducting meetings and conveying committee recommendations to the Board.

(f) The number of committee members shall not exceed twenty-four (24).

(g) Members shall serve staggered terms of up to three years. The terms of chairs and co-chairs (if applicable) will be two years dating from their election.

§27.704. Duration.
The Committee shall be abolished no later than October 30, 2022, in accordance with Texas Government Code, Chapter 2110. It may be reestablished by the Board.

§27.705. Meetings.
The Committee shall meet as necessary. Special meetings may be called as deemed appropriate by the presiding officer. Meetings shall be open to the public and broadcast via the web, unless prevented by technical difficulties, and minutes shall be available to the public after they have been prepared by the Board staff and reviewed by members of the Committee.

§27.706. Tasks Assigned to the Committee.
Tasks assigned to the Committee include:

(1) Advise the Board regarding the Fine and Studio Arts Field of Study Curricula;

(2) Provide Board staff with feedback about processes and procedures related to the Fine and Studio Arts Field of Study Curricula; and

(3) Any other issues related to the Fine and Studio Arts Field of Study Curricula as determined by the Board.

§27.707. Report to the Board; Evaluation of Committee Costs and Effectiveness.
The Committee shall report recommendations to the Board. The Committee shall also report Committee activities to the Board to allow the Board to properly evaluate the Committee work, usefulness, and the costs related to the Committee existence. The Board shall report its evaluation to the Legislative Budget Board in its biennial Legislative Appropriations Request.

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 July 13, 2018.
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Bill Franz
General Counsel
Texas Higher Education Coordinating Board
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For further information, please call: (512) 427-6104

SUBCHAPTER FF. JOURNALISM FIELD OF STUDY ADVISORY COMMITTEE

19 TAC §§27.721 - 27.727
The Texas Higher Education Coordinating Board (Coordinating Board) proposes new Subchapter FF, §§27.721 - 27.727, concerning the Journalism Field of Study Advisory Committee. The proposed new rules authorize the Board to create an advisory committee to develop a Journalism field of study. The newly added rules will affect students when the Journalism field of study is adopted by the Board.

Dr. Rex C. Peebles, Assistant Commissioner for Academic Quality and Workforce, has determined that for the first five years there will be no fiscal implications for state or local governments as a result of adding the new sections.

Dr. Peebles has also determined that for the first five years the rules are in effect, the public benefits anticipated as a result of administering the sections will be the clarification of which lower division courses are required in a Journalism degree and improved transferability and applicability of courses. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

There will be no impact on small businesses or rural communities, as described in Texas Government Code, Chapter 2006, and therefore an Economic Impact analysis is not required.

Government Growth Impact Statement
(1) the rules will not create or eliminate a government program;
(2) implementation of the rules will not require the creation or elimination of employee positions;
(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;
(4) the rules will not require an increase or decrease in fees paid to the agency;
(5) the rules will create a new rule;
(6) the rules will not limit an existing rule; and
(7) the rules will not change the number of individuals subject to the rule.

Comments on the proposed amendments may be submitted by mail to Rex C. Peebles, Assistant Commissioner, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711 or via email at AQWComments@THECB.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

The new sections are proposed under the Texas Education Code, §61.823(a), which provides the Coordinating Board with the authority to develop fields of study curricula with the assistance of advisory committees and Texas Government Code, §2110.005, which requires a state agency that establishes an
The committee to adopt rules that state the purpose and
tasks of the committee and describe the manner in which the
committee will report to the agency.

The new sections affect the implementation of Texas Education
Code, Chapter 61.

§27.721. Authority and Specific Purposes of the Journalism Field of
Study Advisory Committee.

(a) Authority. Statutory authority for this subchapter is pro-
vided in the Texas Education Code, §61.823(a).

(b) Purpose. The Journalism Field of Study Advisory Com-
mitee is created to provide the Commissioner and the Board with guid-
ance regarding the Journalism field of study curricula.

§27.722. Definitions.
The following words and terms, when used in this subchapter, shall
have the following meanings:

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

(2) Commissioner--The Commissioner of Higher Edu-
cation, the Chief Executive Officer of the Board.

(3) Field of Study Curricula--The block of courses which
may be transferred to a general academic teaching institution and must
be substituted for that institution’s lower division requirements for the
degree program into which the student transfers, and the student shall
receive full academic credit toward the degree program for the block
of courses transferred.

(4) Institutions of Higher Education--As defined in Texas
Education Code, Chapter 61.003(8).

§27.723. Committee Membership and Officers.

(a) The advisory committee shall be equitably composed
of representatives of institutions of higher education.

(b) Each university system or institution of higher education
which offers a degree program for which a field of study curriculum is
proposed shall be offered participation on the advisory committee.

(c) At least a majority of the members of the advisory com-
mitee named under this section shall be faculty members of an institution
of higher education. An institution shall consult with the faculty of the
institution before nominating or recommending a person to the board
as the institution’s representative on an advisory committee.

(d) Board staff will recommend for Board appointment indi-
viduals who are nominated by institutions of higher education.

(e) Members of the committee shall select co-chairs, who will
be responsible for conducting meetings and convening committee rec-
ommendations to the Board.

(f) The number of committee members shall not exceed
twenty-four (24).

(g) Members shall serve staggered terms of up to three years.
The terms of chairs and co-chairs (if applicable) will be two years dating
from their election.

§27.724. Duration.
The Committee shall be abolished no later than October 30, 2022, in
accordance with Texas Government Code, Chapter 2110. It may be
reestablished by the Board.

§27.725. Meetings.

The Committee shall meet as necessary. Special meetings may be
called as deemed appropriate by the presiding officer. Meetings shall
be open to the public and broadcast via the web, unless prevented by
technical difficulties, and minutes shall be available to the public after
they have been prepared by the Board staff and reviewed by members of the
Committee.

§27.726. Tasks Assigned to the Committee.

Tasks assigned to the Committee include:

(1) Advise the Board regarding the Journalism Field of
Study Curricula;

(2) Provide Board staff with feedback about processes and
procedures related to the Journalism Field of Study Curricula; and

(3) Any other issues related to the Journalism Field of
Study Curricula as determined by the Board.

§27.727. Report to the Board; Evaluation of Committee Costs and
Effectiveness.
The Committee shall report recommendations to the Board. The Com-
mitee shall also report Committee activities to the Board to allow the
Board to properly evaluate the Committee work, usefulness, and the
costs related to the Committee existence. The Board shall report its eval-
uation to the Legislative Budget Board in its biennial Legislative
Appropriations Request.

The agency certifies that legal counsel has reviewed the propo-
sal and found it to be within the state agency’s legal authority to
adopt.

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Bill Franz
General Counsel
Texas Higher Education Coordinating Board
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For further information, please call: (512) 427-6104

SUBCHAPTER GG. ANIMAL SCIENCES
FIELD OF STUDY ADVISORY COMMITTEE
19 TAC §§27.741 - 27.747

The Texas Higher Education Coordinating Board (Coordinating
Board) proposes new Subchapter GG, §§27.741 - 27.747 con-
cerning the Animal Sciences Field of Study Advisory Committee.

The proposed new rules authorize the Board to create an advisory
committee to develop an Animal Sciences field of study. The
newly added rules will affect students when the Animal Sciences
field of study is adopted by the Board.

Dr. Rex C. Peebles, Assistant Commissioner for Academic
Quality and Workforce, has determined that for the first five
years there will be no fiscal implications for state or local gov-
ernments as a result of adding the new sections.

Dr. Peebles has also determined that for the first five years the
rules are in effect, the public benefits anticipated as a result of
administering the sections will be the clarification of which lower
division courses are required in an Animal Sciences degree and
improved transferability and applicability of courses. There are
no anticipated economic costs to persons who are required to
comply with the section as proposed. There is no impact on local employment.

There will be no impact on small businesses or rural communities, as described in Texas Government Code, Chapter 2006, and therefore an Economic Impact analysis is not required.

Government Growth Impact Statement
(1) the rules will not create or eliminate a government program;
(2) implementation of the rules will not require the creation or elimination of employee positions;
(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;
(4) the rules will not require an increase or decrease in fees paid to the agency;
(5) the rules will create a new rule;
(6) the rules will not limit an existing rule; and
(7) the rules will not change the number of individuals subject to the rule.

Comments on the proposed amendments may be submitted by mail to Rex C. Peebles, Assistant Commissioner, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711 or via email at AQWComments@THECB.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

The new sections are proposed under the Texas Education Code, §61.823(a), which provides the Coordinating Board with the authority to develop fields of study curricula with the assistance of advisory committees and Texas Government Code, §2110.005, which requires a state agency that establishes an advisory committee to adopt rules that state the purpose and tasks of the committee and describe the manner in which the committee will report to the agency.

The new sections affect the implementation of Texas Education Code, Chapter 61.

§27.741. Authority and Specific Purposes of the Animal Sciences Field of Study Advisory Committee.
(a) Authority. Statutory authority for this subchapter is provided in the Texas Education Code, §61.823(a).
(b) Purpose. The Animal Sciences Field of Study Advisory Committee is created to provide the Commissioner and the Board with guidance regarding the Animal Sciences field of study curricula.

§27.742. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings:
(1) Board--The Texas Higher Education Coordinating Board.
(2) Commissioner--The Commissioner of Higher Education, the Chief Executive Officer of the Board.
(3) Field of Study Curricula--The block of courses which may be transferred to a general academic teaching institution and must be substituted for that institution's lower division requirements for the degree program into which the student transfers, and the student shall receive full academic credit toward the degree program for the block of courses transferred.
(4) Institutions of Higher Education--As defined in Texas Education Code, Chapter 61.003(8).

§27.743. Committee Membership and Officers.
(a) The advisory committee shall be equitably composed of representatives of institutions of higher education.
(b) Each university system or institution of higher education which offers a degree program for which a field of study curriculum is proposed shall be offered participation on the advisory committee.
(c) At least a majority of the members of the advisory committee named under this section shall be faculty members of an institution of higher education. An institution shall consult with the faculty of the institution before nominating or recommending a person to the board as the institution's representative on an advisory committee.
(d) Board staff will recommend for Board appointment individuals who are nominated by institutions of higher education.
(e) Members of the committee shall select co-chairs, who will be responsible for conducting meetings and conveying committee recommendations to the Board.
(f) The number of committee members shall not exceed twenty-four (24):
(g) Members shall serve staggered terms of up to three years. The terms of chairs and co-chairs (if applicable) will be two years dating from their election.

§27.744. Duration.
The Committee shall be abolished no later than October 30, 2022, in accordance with Texas Government Code, Chapter 2110. It may be reestablished by the Board.

§27.745. Meetings.
The Committee shall meet as necessary. Special meetings may be called as deemed appropriate by the presiding officer. Meetings shall be open to the public and broadcast via the web, unless prevented by technical difficulties, and minutes shall be available to the public after they have been prepared by the Board staff and reviewed by members of the Committee.

§27.746. Tasks Assigned to the Committee.
Tasks assigned to the Committee include:
(1) Advise the Board regarding the Animal Sciences Field of Study Curricula;
(2) Provide Board staff with feedback about processes and procedures related to the Animal Sciences Field of Study Curricula; and
(3) Any other issues related to the Animal Sciences Field of Study Curricula as determined by the Board.

The Committee shall report recommendations to the Board. The Committee shall also report Committee activities to the Board to allow the Board to properly evaluate the Committee work, usefulness, and the costs related to the Committee existence. The Board shall report its evaluation to the Legislative Budget Board in its biennial Legislative Appropriations Request.
The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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TRD-201803059
SUBCHAPTER HH. AGRICULTURAL BUSINESS AND MANAGEMENT FIELD OF STUDY ADVISORY COMMITTEE

19 TAC §§27.761 - 27.767

The Texas Higher Education Coordinating Board (Coordinating Board) proposes new Subchapter HH, §§27.761 - 27.767, concerning the Agricultural Business and Management Field of Study Advisory Committee. The proposed new rules authorize the Board to create an advisory committee to develop an Agricultural Business and Management field of study. The newly added rules will affect students when the Agricultural Business and Management field of study is adopted by the Board.

Dr. Rex C. Peebles, Assistant Commissioner for Academic Quality and Workforce, has determined that for the first five years there will be no fiscal implications for state or local governments as a result of adding the new sections.

Dr. Peebles has also determined that for the first five years the rules are in effect, the public benefits anticipated as a result of administering the sections will be the clarification of which lower division courses are required in an Agricultural Business and Management degree and improved transferability and applicability of courses. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

There will be no impact on small businesses or rural communities, as described in Texas Government Code, Chapter 2006, and therefore an Economic Impact analysis is not required.

Government Growth Impact Statement

(1) the rules will not create or eliminate a government program;
(2) implementation of the rules will not require the creation or elimination of employee positions;
(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;
(4) the rules will not require an increase or decrease in fees paid to the agency;
(5) the rules will create a new rule;
(6) the rules will not limit an existing rule; and
(7) the rules will not change the number of individuals subject to the rule.

Comments on the proposed amendments may be submitted by mail to Rex C. Peebles, Assistant Commissioner, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711 or via email at AQWComments@THECB.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

The new sections are proposed under the Texas Education Code, §61.823(a), which provides the Coordinating Board with the authority to develop fields of study curricula with the assistance of advisory committees and Texas Government Code, §2110.005, which requires a state agency that establishes an advisory committee to adopt rules that state the purpose and tasks of the committee and describe the manner in which the committee will report to the agency.

The new sections affect the implementation of Texas Education Code, Chapter 61.

§27.761. Authority and Specific Purposes of the Agricultural Business and Management Field of Study Advisory Committee.

(a) Authority. Statutory authority for this subchapter is provided in the Texas Education Code, §61.823(a).

(b) Purpose. The Agricultural Business and Management Field of Study Advisory Committee is created to provide the Commissioner and the Board with guidance regarding the Agricultural Business and Management field of study curricula.

§27.762. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings:

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

(2) Commissioner.--The Commissioner of Higher Education, the Chief Executive Officer of the Board.

(3) Field of Study Curricula--The block of courses which may be transferred to a general academic teaching institution and must be substituted for that institution's lower division requirements for the degree program in which the student transfers, and the student shall receive full academic credit toward the degree program for the block of courses transferred.

(4) Institutions of Higher Education--As defined in Texas Education Code, Chapter 61.003(8).

§27.763. Committee Membership and Officers.

(a) The advisory committee shall be equitably composed of representatives of institutions of higher education.

(b) Each university system or institution of higher education which offers a degree program for which a field of study curriculum is proposed shall be offered participation on the advisory committee.

(c) At least a majority of the members of the advisory committee named under this section shall be faculty members of an institution of higher education. An institution shall consult with the faculty of the institution before nominating or recommending a person to the board as the institution's representative on an advisory committee.

(d) Board staff will recommend for Board appointment individuals who are nominated by institutions of higher education.

(e) Members of the committee shall select co-chairs, who will be responsible for conducting meetings and conveying committee recommendations to the Board.

(f) The number of committee members shall not exceed twenty-four (24).

(g) Members shall serve staggered terms of up to three years. The terms of chairs and co-chairs (if applicable) will be two years dating from their election.

§27.764. Duration.
The Appropriations evaluation
Effectiveness.

§27.765. Meetings
The Committee shall meet as necessary. Special meetings may be called as deemed appropriate by the presiding officer. Meetings shall be open to the public and broadcast via the web, unless prevented by technical difficulties, and minutes shall be available to the public after they have been prepared by the Board staff and reviewed by members of the Committee.

§27.766. Tasks Assigned to the Committee.
Tasks assigned to the Committee include:

1. Advise the Board regarding the Agricultural Business and Management Field of Study Curricula;

2. Provide Board staff with feedback about processes and procedures related to the Agricultural Business and Management Field of Study Curricula; and

3. Any other issues related to the Agricultural Business and Management Field of Study Curricula as determined by the Board.

§27.767. Report to the Board: Evaluation of Committee Costs and Effectiveness.
The Committee shall report recommendations to the Board. The Committee shall also report Committee activities to the Board to allow the Board to properly evaluate the Committee work, usefulness, and the costs related to the Committee existence. The Board shall report its evaluation to the Legislative Budget Board in its biennial Legislative Appropriations Request.

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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Bill Franz
General Counsel
Texas Higher Education Coordinating Board
Earliest possible date of adoption: August 26, 2018
For further information, please call: (512) 427-6104

TITLE 34. PUBLIC FINANCE
PART 1. COMPTROLLER OF PUBLIC ACCOUNTS
CHAPTER 3. TAX ADMINISTRATION
SUBCHAPTER G. CIGARETTE TAX
34 TAC §3.102
The Comptroller of Public Accounts proposes amendments to §3.102, concerning applications, definitions, permits, and reports. The amendments to this section implement provisions in Senate Bill 1390, 85th Legislature, 2017 that changed the due date of the distributor's report from the last day of the month to the 25th day of the month.

The comptroller amends subsection (a) to delete paragraphs (4), (6), (9), and (12) because the definitions are not used in the section. Subsequent paragraphs are renumbered. The comptroller amends renumbered paragraphs (4) and (15) for readability. The comptroller amends renumbered paragraph (6) to correct a grammatical error and for readability. The comptroller amends renumbered paragraph (8) to delete "import broker" from the definition because the term is not used in the section.

The comptroller amends subsection (f) to add a new paragraph addressing cigarette manufacturer reports. New paragraph (1) states that the due date for cigarette manufacturer reports is the last day of the month. Senate Bill 1390 did not change the due date of the report for cigarette manufacturers. Subsequent paragraphs are renumbered.

The comptroller amends the existing language in renumbered paragraph (2) to remove the reference to cigarette manufacturer reports and to add wholesaler reports. Paragraph (2) now explains that all distributor and wholesaler reports, including those required under Health and Safety Code, §161.605 (Distributor's Report and Payment of Monthly Fee), are due on the 25th day of the month, in accordance with the provisions of Senate Bill 1390 and §154.212 (Reports by Wholesalers and Distributors of Cigarettes).

Throughout the section, titles are added to statutory references.

Tom Currah, Chief Revenue Estimator, has determined that during the first five years that the proposed amendments are in effect, the amendments: will not create or eliminate a government program; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to the agency; will not require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy. This proposal amends a current rule.

Mr. Currah also has determined that for each year of the first five years the rule is in effect, proposed amendments would benefit the public 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. The proposed amendment would have no anticipated significant fiscal impact on the state government, units of local government, or individuals. There would be no anticipated significant economic costs to the public.

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 amendments are proposed under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture) and §111.0022 (Application to Other Laws Administered by Comptroller), which provide the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Tax Code, Title 2, and taxes, fees, or other charges which the comptroller administers under other law.

The amendments implement legislative changes to Tax Code, §154.210(a).

§3.102. Applications, Definitions, Permits, and Reports.

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.
(1) Agency--The Comptroller of Public Accounts of the State of Texas or the comptroller's duly authorized agents and employees.

(2) Bonded agent--A person in this state who is an agent of a person outside this state and who receives cigarettes in interstate commerce and stores the cigarettes for distribution or delivery to distributors under orders from the person outside this state.

(3) Cigarette--A roll for smoking that is made of tobacco or tobacco mixed with another ingredient and wrapped or covered with a material other than tobacco. A cigarette is not a cigar.

(4) Cigarette weight--The weight of an individual cigarette shall consist of the combined weight of tobacco, nontobacco ingredients, wrapper, filter tip, mouthpiece, and any other attachments thereto that make up the total product in the form available for sale to the consumer. The weight of a cigarette does not include a carton, box, label, or other packaging materials.

(5) [§2] Commercial business location--The [for purposes of this section, a commercial business location means the] entire premises occupied by a permit applicant or a person required to hold a permit under Tax Code, Chapter 154 (Cigarette Tax). The premises where cigarettes are stored or kept cannot be a residence or a unit in a public storage facility.

(6) Common carrier--A motor carrier registered under Transportation Code, Chapter 642, or a motor carrier operating under a certificate issued by the Interstate Commerce Commission or a successor agency to the Interstate Commerce Commission.

(7) Consumer--A person who possesses cigarettes for personal consumption.

(8) Distributor--A person who is authorized to purchase cigarettes in unstamped packages from manufacturers for the purpose of making a first sale in this state [cigarettes in unstamped packages from manufacturers]; a person who is authorized to stamp cigarette packages; a person who ships, transports, or imports cigarettes into this state; a person who acquires, possesses, and makes a first sale of cigarettes in this state; or a person who manufactures or produces cigarettes.

(9) Export warehouse--A place where cigarettes from manufacturers in unstamped packages are stored for the purpose of making sales to authorized persons for resale, use, or consumption outside the United States.

(10) [§4] First sale--Except as otherwise provided, first sale means the first transfer of possession in connection with a purchase, sale, or any exchange for value of cigarettes in intrastate commerce; the first use or consumption of cigarettes in this state; or the loss of cigarettes in this state whether through negligence, theft, or other unaccountable loss. First sale [sales] also includes giving away cigarettes as promotional items.

(11) [§5] Importer or import broker--A person who ships, transports, or imports into this state cigarettes manufactured or produced outside the United States for the purpose of making a first sale in this state.

(12) Licensing--The agency process concerning the issuance, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license or permit.

(13) Manufacturer--A person who manufactures and sells cigarettes to a distributor.
cigarette permit is required for a vehicle used only to deliver invoiced cigarettes.

(5) The comptroller may issue a combination permit for cigarettes, tobacco products, or cigarettes and tobacco products to a person who is a distributor, importer, manufacturer, wholesaler, bonded agent, or retailer as defined by Tax Code, Chapter 154 and Chapter 155 (Cigars and Tobacco Products Tax). A person who receives a combination permit pays only the higher of the two permit fees.

(c) Permit period.

(1) Bonded agent, distributor, importer, manufacturer, wholesaler, and motor vehicle permits expire on the last day of February of each year.

(2) Retailer permits expire on the last day of May of each even-numbered year.

(d) Permit fees. An application for a bonded agent, distributor, importer, manufacturer, wholesaler, motor vehicle, or retailer permit must be accompanied by the appropriate fee.

(1) The permit fee for a bonded agent is $300.

(2) The permit fee for a distributor is $300.

(3) The permit fee for a manufacturer with representation in Texas is $300.

(4) The permit fee for a wholesaler is $200.

(5) The permit fee for a motor vehicle is $15.

(6) The permit fee for a retailer permit issued or renewed on or after September 1, 1999, is $180.

(7) A $50 fee is assessed in addition to the regular permit fee for failure to obtain a permit in a timely manner.

(8) No permit fee is required to obtain an importer permit or to register a manufacturer if the manufacturer is located out of state with no representation in Texas.

(9) The comptroller prorates the permit fee for new permits according to the number of months remaining in the permit period. If a permit will expire within three months of the date of issuance, the comptroller may collect the prorated permit fee for the current permit period and the total permit fee for the next permit period.

(10) An unexpired permit may be returned to the comptroller for credit on the unexpired portion only upon the purchase of a permit of a higher classification.

(e) Permit issuance, denial, suspension, or revocation.

(1) The comptroller shall issue a permit to a distributor, importer, manufacturer, wholesaler, bonded agent, or retailer if the comptroller receives an application and any applicable fee, believes that the applicant has complied with Tax Code, §154.101, and determines that issuing the permit will not jeopardize the administration and enforcement of Tax Code, Chapter 154.

(2) If the comptroller determines that an existing permit should be suspended or revoked or a permit should be denied because of the applicant's prior conviction of a crime and the relationship of the crime to the license, the comptroller will notify the applicant or permittee in writing by personal service or by mail of the reasons for the denial, suspension, revocation, or disqualification, the review procedure provided by Occupations Code, §§53.052 (Judicial Review), and the earliest date that the permit holder or applicant may appeal the denial, suspension, revocation, or disqualification.

(f) Reports.

(1) Manufacturer reports must be filed on or before the last day of each month for transactions that occurred during the preceding month.

(2) [4] With the exception of reports of sales to retailers required by the comptroller under Tax Code, §154.212, all All cigarette distributor and wholesaler [manufacturer] reports and payments must be filed on or before the 25th [last] day of each month for transactions that occurred during the preceding month [following the month in which transactions take place].

(3) [2] All wholesaler and distributor reports of sales to retailers required by the comptroller under Tax Code, §154.212 (Reports by Wholesalers and Distributors of Cigarettes), shall be filed in accordance with §3.9 of this title (relating to Electronic Filing of Returns and Reports; Electronic Transfer of Certain Payments by Certain Taxpayers).

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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Nancy Prosser

General Counsel

Comptroller of Public Accounts

Earliest possible date of adoption: August 26, 2018

For further information, please call: (512) 475-2220

SUBCHAPTER H. CIGAR AND TOBACCO TAX

34 TAC §3.121

The Comptroller of Public Accounts proposes amendments to §3.121, concerning definitions, imposition of tax, permits, and reports. The amendments to this section implement provisions of Senate Bill 1390, 85th Legislature, 2017, that changed the due date of the distributor's report from the last day of the month to the 25th day of the month.

The comptroller amends subsection (a) to delete paragraphs (6) and (11) because the definitions are not used in the section. The subsequent paragraphs are renumbered. The comptroller amends paragraph (5) to include a reference that the manufacturer's list price is synonymous with factory list price. The comptroller amends renumbered paragraph (7) to delete "import broker" from the definition because the term is not used in the section.

The comptroller amends subsection (b)(1)(A) to add a missing colon.

The comptroller amends subsections (b)(1)(B) to remove outdated language and to revise and move from subsection (b)(1)(B)(i) a reference on where to find rates for cans or packages that weigh more than two ounces.

The comptroller amends subsection (b)(4) to add a missing word.

The comptroller amends paragraphs (c)(6) for readability.

The comptroller amends paragraphs (h) to add a new paragraph addressing cigar and tobacco product manufacturer reports to comply with changes made by Senate Bill 1390. New paragraph (1) states that the due date for cigar and tobacco product manu-
factor reports is the last day of the month. Senate Bill 1390 did not change the due date of the report for cigar and tobacco product manufacturers. Subsequent paragraphs are renumbered.

The comptroller amends the existing language in renumbered paragraph (2) to remove the reference to cigar and tobacco product manufacturer reports and to add wholesaler reports. Paragraph (2) now explains that all distributor and wholesaler reports, including those required under Health and Safety Code, §161.605 (Distributor's Report and Payment of Monthly Fee), are due on the 25th day of the month, in accordance with the provisions of Senate Bill 1390 and §155.105 (Reports by Wholesalers and Distributors of Cigars and Tobacco Products).

Throughout the section, titles are added to statutory references.

Tom Currah, Chief Revenue Estimator, has determined that during the first five years that the proposed amendment is in effect, the amendment: will not create or eliminate a government program; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to the agency; will not require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy. This proposal amends a current rule.

Mr. Currah also has determined that for each year of the first five years the rule is in effect, the proposed amendment would benefit the public 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. The proposed amendment would have no significant fiscal impact on the state government, units of local government, or individuals. There would be no anticipated significant economic costs to the public.

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 amendments are proposed under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture) and §111.0022 (Application to Other Laws Administered by Comptroller), which provide the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Tax Code, Title 2, and taxes, fees, or other charges which the comptroller administers under other law.

The amendments implement legislative changes to Tax Code, §155.111(a).

§3.121. Definitions, Imposition of Tax, Permits, and Reports.

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

(1) Bonded agent--A person in Texas who is an agent for a principal located outside of Texas and who receives cigars and tobacco products in interstate commerce and stores the cigars and tobacco products for distribution or delivery to distributors under orders from the principal.

(2) Cigar--A roll of fermented tobacco that is wrapped in tobacco and that the main stream of smoke from which produces an alkaline reaction to litmus paper.

(3) Common carrier--A motor carrier registered under Transportation Code, Chapter 643 (Motor Carrier Registration), or a motor carrier operating under a certificate issued by the Interstate Commerce Commission or its successor agency.

(4) Distributor--A person who:

(A) receives tobacco products from a manufacturer for the purpose of making a first sale in Texas;

(B) brings or causes to be brought into Texas tobacco products for sale, use, or consumption.

(5) Factory list price--The published manufacturer gross cost to the distributor. The term is synonymous with manufacturer's list price.

(6) Export warehouse--A location in this state from which a person receives tobacco products from manufacturers and stores the tobacco products for the purpose of making sales to authorized persons for resale, use, or consumption outside the United States.

(7) Importer [or import broker]--A person who ships, transports, or imports into Texas tobacco products manufactured or produced outside the United States for the purpose of making a first sale in this state.

(8) Manufacturer--A person who manufactures or produces tobacco products and sells tobacco products to a distributor.

(9) Manufacturer's representative--A person who is employed by a manufacturer to sell or distribute the manufacturer's tobacco products.

(10) Manufacturer's list price--The published manufacturer gross cost to the distributor. The term is synonymous with manufacturer's list price.

(11) Manufacturer's Records and Reports.

(12) Permit holder--A bonded agent, distributor, importer, manufacturer, wholesaler, or retailer required to obtain a permit under Tax Code, §155.041 (Permits).

(13) Place of business--the term means:

(A) a commercial business location where tobacco products are sold;

(B) a commercial business location where tobacco products are kept for sale or consumption or otherwise stored and may not be a residence or a unit in a public storage facility; or

(C) a vehicle from which tobacco products are sold.
Retailer--A person who engages in the practice of selling tobacco products to consumers and includes the owner of a coin-operated vending machine.

(14) [161] Tobacco product--A tobacco product includes: a cigar; pipe tobacco, including any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco to be smoked in a pipe; chewing tobacco, including plug, scrap, and any kind of tobacco suitable for chewing and that is not intended to be smoked; snuff or other preparations of finely cut, ground, powdered, pulverized or dissolvable tobacco that is not intended to be smoked; roll-your-own smoking tobacco, including granulated, plug-cut, crimp-cut, ready rubbed, any form of tobacco, which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes or cigars, or use as wrappers thereof; or other tobacco products, including an article or product that is made of tobacco or a tobacco substitute and that is not a cigarette.

(15) [167] Trade discount, special discount, or deals--Includes promotional incentive discounts, quantity purchase incentive discounts, and timely payment or prepayment discounts.

(16) [163] Weight of a cigar--The combined weight of tobacco and nontobacco ingredients that make up the total product in the form available for sale to the consumer, excluding any carton, box, label, or other packaging materials.

(17) [169] Wholesaler--A person, including a manufacturer's representative, who sells or distributes tobacco products in this state for resale but who is not a distributor.

(b) Imposition of tax. A tax is imposed and becomes due and payable when a permit holder receives cigars or tobacco products for the purpose of making a first sale in this state.

1. Tax Rates.
   (A) the tax on cigars is calculated as:
      (i) $0.01 per 10 or fraction of 10 on cigars that weigh three pounds or less per thousand;
      (ii) $7.50 per thousand on cigars that weigh more than three pounds per thousand and that are sold at factory list price, exclusive of any trade discount, special discount, or deal, for 3.3 cents or less each;
      (iii) $11 per thousand on cigars that weigh more than three pounds per thousand and that are sold at factory list price, exclusive of any trade discount, special discount, or deal, for more than 3.3 cents each, and that contain no substantial amount of nontobacco ingredients; and
      (iv) $15 per thousand on cigars that weigh more than three pounds per thousand and that are sold at factory list price, exclusive of any trade discount, special discount, or deal, for more than 3.3 cents each, and that contain a substantial amount of nontobacco ingredients.
   (B) The [Effective September 1, 2009, House Bill 2154, enacted by the 81st Legislature, 2009, changed the] tax for tobacco products, other than cigars, is [to a tax] based on the manufacturer's listed net weight for an individual product's can or package and a rate for each ounce and proportionate rate on all fractional parts of an ounce of weight for that product. The tax imposed on a can or package of a tobacco product that weighs less than 1.2 ounces is equal to the amount of the tax imposed on a can or package that weighs 1.2 ounces. [A new rate is imposed for state fiscal years 2010, 2011, 2012, 2013, and 2014. The rate for each ounce and proportionate rate on all fractional parts of an ounce in effect for FY 2014 apply to each fiscal year thereafter. The tax rate in effect for a state fiscal year that occurs according to this subparagraph does not affect the taxes imposed before that fiscal year, and the rate in effect when those taxes were imposed continues in effect for the purposes of the liability for and collection of those taxes.] The [new] rates imposed for state fiscal years 2010, 2011, 2012, 2013, 2014, and thereafter are set forth in this subparagraph. An expanded chart showing rates for cans or packages greater than two ounces is available at comptroller.texas.gov.

   (i) The rate for the state Fiscal Year 2010 (September 1, 2009 through August 31, 2010), is $1.10 per ounce and a proportionate rate on all fractional parts of an ounce for up to two ounces according to the following. [An expanded chart showing rates for cans or packages greater than two ounces is available on the Window on State Government Web site.]
   Figure: 34 TAC §3.121(b)(1)(B)(i) (No change.)

   (ii) For the state Fiscal Year 2011 (September 1, 2010 through August 31, 2011), the tax rate and proportionate tax rate for fractional parts of an ounce for up to two ounces are as follows. Figure: 34 TAC §3.121(b)(1)(B)(ii) (No change.)

   (iii) For the state Fiscal Year 2012 (September 1, 2011 through August 31, 2012), the tax rate and proportionate tax rate for fractional parts of an ounce for up to two ounces are as follows. Figure: 34 TAC §3.121(b)(1)(B)(iii) (No change.)

   (iv) For the state Fiscal Year 2013 (September 1, 2012 through August 31, 2013), the tax rate and proportionate tax rate for fractional parts of an ounce for up to two ounces are as follows. Figure: 34 TAC §3.121(b)(1)(B)(iv) (No change.)

   (v) For state Fiscal Year 2014 (which begins September 1, 2013) and for each fiscal year thereafter, the tax rate and proportionate tax rate for fractional parts of an ounce for up to two ounces are as follows. Figure: 34 TAC §3.121(b)(1)(B)(v) (No change.)

2. (C) The tax imposed on a unit that contains multiple individual cans or packages is the sum of the taxes imposed under paragraph (1)(B) of this subsection, on each individual can or package intended for sale or distribution at retail. For example, on November 1, 2009 (Fiscal Year 2010) a distributor receives from a manufacturer for the purpose of making a first sale in Texas a unit of snuff that consists of 10 individual cans. Each can weighs 1.3 ounces. The effective tax rate for each can is $1.43. The total tax due for the unit is calculated by multiplying the effective tax rate on each individual can ($1.43) by the total number of individual cans in the unit (10 cans), for a total tax due of $14.30.

3. Free goods shall be taxed at the prevailing factory list price, except that each tobacco product other than cigars shall be taxed according to the manufacturer's listed net weight for the product and the applicable fiscal year rate for each ounce and proportionate rate for all fractional parts of an ounce according to paragraph (1)(B) of this subsection.

4. A person who receives or possesses tobacco products on which a tax of more than $50 would be due is presumed to receive or possess the tobacco products for the purpose of making a first sale in this state. This presumption does not apply to common carriers or to manufacturers.

4. A tax is imposed on manufacturers, who manufacture tobacco products in this state, at the time the tobacco products are first transferred in connection with a purchase, sale, or any exchange for value in intrastate commerce.

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(5) The delivery of tobacco products by a principal to its bonded agent in this state is not a first sale.

(6) If a manufacturer sells tobacco products to a purchaser in Texas and ships the products at the purchaser's request to a third party distributor in Texas, then the purchaser has received the tobacco products for first sale in Texas.

(7) The person in possession of cigars or tobacco products has the burden to prove payment of the tax.

(c) Permits required. To engage in business as a distributor, importer, manufacturer, wholesaler, bonded agent, or retailer a person must apply for and receive the applicable permit from the comptroller. The permits are not transferable.

(1) A person who engages in the business of a bonded agent, distributor, importer, manufacturer, wholesaler, or retailer without a valid permit is subject to a penalty of not more than $2,000 for each violation. Each day on which a violation occurs is a separate offense. A new application is required if a change in ownership occurs (sole ownership to partnership, sole ownership to corporation, partnership to limited liability company, etc.). Each legal entity must apply for its own permit(s). All permits issued to a legal entity will have the same taxpayer number.

(2) Each distributor, importer, manufacturer, wholesaler, bonded agent, or retailer shall obtain a permit for each place of business owned or operated by the distributor, importer, manufacturer, wholesaler, bonded agent, or retailer. A new permit shall be required for each physical change in the location of the place of business. Correction or change of street listing by a city, state, or U.S. Post Office shall not require a new permit so long as the physical location remains unchanged.

(3) Permits are valid for one place of business at the location shown on the permit. If the location houses more than one place of business under common ownership, an additional permit is required for each separate place of business. For example, a retailer must have a separate permit for each vending machine including several machines at one location.

(4) A vehicle from which cigars and tobacco products are sold is a place of business and requires a permit. A motor vehicle permit is issued to a bonded agent, retailer, distributor, or wholesaler holding a current permit. Vehicle permits are issued bearing a specific motor vehicle identification number and are valid only when physically carried in the vehicle having the corresponding motor vehicle identification number. Vehicle permits may not be moved from one vehicle to another. Each cigar or tobacco product manufacture's sales representative is required to purchase a wholesale dealer's permit for each manufacturer's vehicle operated. No cigar and tobacco product permit is required for a vehicle used only to deliver invoiced tobacco products.

(5) The comptroller may issue a combination permit for cigarettes, tobacco products, or cigarettes and tobacco products to a person who is a distributor, importer, manufacturer, wholesaler, bonded agent, or retailer as defined by Tax Code, Chapter 154 (Cigarette Tax) and Chapter 155 (Cigars and Tobacco Products Tax). A person who receives a combination permit pays only the higher of the two permit fees.

(6) The comptroller will not issue permits for a residence or a unit in a public storage facility because tobacco products cannot be stored at such places.

(d) Permit Period.

(1) Bonded agent, distributor, importer, manufacturer, wholesaler, and motor vehicle permits expire on the last day of February of each year.

(2) Retailer permits expire on the last day of May of each even-numbered year.

(e) Permit Fees. An application for a bonded agent, distributor, importer, manufacturer, wholesaler, motor vehicle, or retailer permit must be accompanied by the required fee.

(1) The permit fee for a bonded agent is $300.

(2) The permit fee for a distributor is $300.

(3) The permit fee for a manufacturer with representation in Texas is $300.

(4) The permit fee for a wholesaler is $200.

(5) The permit fee for a motor vehicle is $15.

(6) The permit fee for a retailer permit issued or renewed is $180. Retailers who fail to obtain or renew a retailer permit in a timely manner are liable for the fee in effect for the applicable permit period, in addition to the fee described in paragraph (7) of this subsection.

(7) A $50 fee is assessed, in addition to the regular permit fee, for failure to obtain or renew a permit in a timely manner.

(8) No permit fee is required to obtain an importer permit or to register a manufacturer when the manufacturer is located out of state with no representation in Texas.

(9) The comptroller prorates the permit fee for new permits according to the number of months remaining in the permit period. If a permit will expire within three months of the date of issuance, the comptroller may collect the prorated permit fee for the current permit period and the total permit fee for the next permit period.

(10) An unexpired permit may be returned to the comptroller for credit on the unexpired portion only upon the purchase of a permit of a higher classification.

(f) Permit issuance, denial, suspension, or revocation.

(1) The comptroller shall issue a permit to a distributor, importer, manufacturer, wholesaler, bonded agent, or retailer if the comptroller has received an application and any applicable fee, the applicant has complied with Tax Code, §155.041, and the comptroller determines that the issuance of such permit will not jeopardize the administration and enforcement of Tax Code, Chapter 155.

(2) If the comptroller determines that an existing permit should be suspended or revoked or a permit should be denied, after notice and opportunity for hearing, because the applicant has failed to disclose any information required by Tax Code, §155.041(d), (e), and (f), including the applicant's prior conviction of a crime and the relationship of the crime to the license, the comptroller will notify the applicant or permittee in writing by personal service or by mail of the reasons for the denial, suspension, revocation, or disqualification, the review procedure provided by Occupations Code, §53.052 (Judicial Review), and the earliest date that the permit holder or applicant may appeal the denial, suspension, revocation, or disqualification.

(g) Sale and delivery of tax-free cigars and tobacco products to the United States government.

(1) Distributors may use their own vehicles to deliver previously invoiced quantities of tax-free cigars and tobacco products to instrumentalities of the United States government. These tax-free products must be packaged in a manner in which they will not commingle with any other cigars or tobacco products.

(2) Each sale of tax-free cigars and tobacco products by a distributor to an instrumentality of the United States government shall be supported by a separate sales invoice and a properly completed
Texas Certificate of Tax Exempt Sale, Form 69-302. Sales invoices must be numbered and dated and must show the name of the seller, name of the purchaser, and the destination.

(h) Reports.

1. Manufacturer reports must be filed on or before the last day of each month for transactions that occurred during the preceding month.

2. [§67.44(1)] All reports required by the comptroller under Tax Code, §155.105(1), shall be filed in accordance with §§3.9 and 3.10 of this title (relating to the Filing of Returns and Reports; Electronic Transfer of Certain Payments by Certain Taxpayers).

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 July 13, 2018.

Texas Register

Nancy Prosser
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: August 26, 2018

PART 4. EMPLOYEES RETIREMENT SYSTEM OF TEXAS

CHAPTER 67. HEARINGS ON DISPUTED CLAIMS

34 TAC §67.44

The Employees Retirement System of Texas (ERS) proposes an amendment to 34 Texas Administrative Code (TAC) Chapter 67, concerning Hearings on Disputed Claims, by proposing new rule §67.44, concerning Mediation.

Following a review of ERS by the Texas Sunset Commission, the Sunset Advisory Commission issued a Staff Report which included Recommendation 5.1 to "apply standard across-the-board requirements to ERS." To implement the Commission's recommendations, the Texas Legislature added §815.1025 (SB 301) to the Texas Government Code, requiring ERS to "develop a policy to encourage the use of appropriate alternative dispute resolution procedures."

In order to comply with the requirements of §815.1025, Texas Government Code, new rule §67.44, Mediation, is proposed to be added. The proposed new rule will allow ERS to grant mediation rights to certain individuals, as appropriate, depending on the benefits claimed, the facts of the case, and the available remedies.

GOVERNMENT GROWTH IMPACT STATEMENT

ERS has determined that during the first five years the new rule will be in effect:

1. the new rule will not create or eliminate a government program;
2. implementation of the rule will not require the creation or elimination of employee positions;
3. implementation of the rule will not require an increase or decrease in future legislative appropriations to the agency;
4. the rule will not require an increase or decrease in fees paid to the agency;
5. the rule will create a new regulation;
6. the rule will not expand, limit or repeal an existing regulation;
7. the rule will not increase or decrease the number of individuals subject to the rule's applicability; and
8. the rules will not affect the state's economy.

Paula A. Jones, Deputy Executive Director and General Counsel, has determined that for the first five year period the rule is in effect, there will be no fiscal implication for state or local government or local economies as a result of enforcing or administering the rule; and small businesses, micro-businesses and rural communities will not be affected. The proposed rule does not constitute a taking. The proposed rule applies to contested case appeals setting forth factors to consider in offering mediation for appeals. To Ms. Jones' knowledge, there are no known anticipated economic costs to persons who are required to comply with the new rule as proposed unless any party seeks mediation and there are costs associated with mediation that must be paid.

The anticipated public benefit is to offer mediation rights to certain participants in the Texas Employees Group Benefits Program in accordance with the recommendations of the Texas Sunset Commission, and to comply with new statutory requirements.

Comments on the proposed new rule may be submitted to Paula A. Jones, Deputy Executive Director and General Counsel, Employees Retirement System of Texas, P.O. Box 13207, Austin, Texas 78711-3207, or by email to Ms. Jones at paula.jones@ers.texas.gov. The deadline for receiving comments is Monday, August 13, 2018, at 10:00 a.m.

The new rule is proposed under Texas Government Code §815.102(a)(4) and (5), which provides authorization for the ERS Board of Trustees to adopt rules for hearings on contested cases or disputed claims and the transaction of any other business of the Board.

No other statutes are affected by the proposed new rule.

§67.44. Mediation

Upon receipt of a timely appeal for contested cases involving eligible claims for Nonoccupational Disability Retirement benefits, Occupational Disability Retirement benefits, Long Term Disability Income Insurance benefits, Short Term Disability Income Insurance benefits, State of Texas Dental Choice PPO benefits, and when ERS determines that a participant or a participant's dependent should be removed from the Texas Employees Group Benefits Program in accordance with applicable laws, regulations, and/or plan requirements, ERS may offer mediation rights when there are material facts at issue and there are remedies available to the Appellant under applicable law. ERS will notify the Appellant or applicable Authorized Representatives if mediation is available. After receiving notification of available mediation
rights from ERS, the Appellant, applicable Authorized Representatives or ERS may request mediation through the State Office of Administra-
tive Hearings before the set hearing date.

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 July 13, 2018.
TRD-201803066
Paula A. Jones
Deputy Executive Director and General Counsel
Employees Retirement System of Texas
Earliest possible date of adoption: August 26, 2018
For further information, please call: (877) 275-4377

CHAPTER 81. INSURANCE

34 TAC §81.7
The Employees Retirement System of Texas (ERS) proposes amendments to 34 Texas Administrative Code (TAC) Chapter 81, concerning Insurance, by amending §81.7 (Enrollment and Participation).

Section 81.7, concerning Enrollment and Participation, is proposed to be amended due to changes by the Centers for Medicare & Medicaid Services (CMS). Effective April 1, 2018, CMS began issuing new Medicare cards, replacing the social security number based Health Insurance Claim Number (HICN), with a new Medicare Beneficiary Identifier (MBI). This change will require that ERS update its systems and modify processes to submit or exchange the previous HICN with the new MBI. As a result, ERS will be unable to enroll new participants in the Medicare Advantage Plan until their MBI is received.

Ms. Robin Hardaway, Director of Customer Benefits, has determined that for the first five year period the rules are in effect, there will be no fiscal implication for state or local government or local economies as a result of enforcing or administering the rules. To Ms. Hardaway's knowledge, there are no known anticipated economic effects to persons who are required to comply with the rules as proposed, and small businesses, micro-businesses or rural communities should not be affected. The proposed rule does not constitute a taking.

GOVERNMENT GROWTH IMPACT STATEMENT
ERS has determined that during the first five years the amended rules will be in effect:

(1) the proposed rules will not create or eliminate a government program;
(2) implementation of the rules will not require the creation or elimination of employee positions;
(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;
(4) the rules will not require an increase or decrease in fees paid to the agency;
(5) the rules will not create a new regulation;
(6) the rules will not expand, limit or repeal an existing regulation;
(7) the rules will not increase or decrease the number of individuals subject to the rule's applicability; and

(8) the rules will not affect the state's economy.

Ms. Hardaway also determined that for each year of the first five years the rules are in effect the public benefit anticipated as a result of enforcing the rules would be to enable ERS to enroll participants in Medicare Advantage plans, and to conform the rules with recent CMS changes to the program rules regarding automatic enrollment into the Medicare Advantage and Health-Select Medicare Rx plans.

Comments on the proposed amendments may be submitted to Paula A. Jones, Deputy Executive Director and General Counsel, Employees Retirement System of Texas, P.O. Box 13207, Austin, Texas 78711-3207, or you may email Ms. Jones at paula.jones@ers.texas.gov. The deadline for receiving comments is August 27, 2018, at 10:00 a.m.

The amendments are proposed under Texas Insurance Code, §1551.052, which provides authorization for the ERS Board of Trustees to adopt rules necessary to carry out its statutory duties and responsibilities.

No other statutes are affected by the proposed amendments.

§81.7. Enrollment and Participation.

(a) Enrollment Categories.

(1) Full-time employees and their dependents.

(A) A new employee:

(i) who is not subject to the health insurance waiting period and is eligible under the Act and as provided for in §81.5(a)(1) of this chapter (relating to Eligibility) for automatic insurance coverage, shall be enrolled in the basic plan unless the employee completes an enrollment form to elect other coverage or to waive GBP health coverage as provided in §81.8 of this chapter (relating to Waiver of Health Coverage). Coverage of an employee under the basic plan, and other coverage selected as provided in this paragraph, becomes effective on the date on which the employee begins active duty.

(ii) who is subject to the health insurance waiting period and is eligible under the Act and as provided for in §81.5(a)(1) of this chapter for automatic insurance coverage, shall be enrolled in the basic plan beginning on the first day of the calendar month following 60 days of employment unless, before this date, the employee completes an enrollment form to elect other coverage or to waive GBP health coverage as provided in §81.8 of this chapter.

(iii) who has existing, current, and continuous GBP health coverage as of the date the employee begins active duty is not subject to the health insurance waiting period and is eligible to enroll as a new employee in health insurance and additional coverage and plans which include optional coverage by completing an enrollment form before the first day of the calendar month after the date the employee begins active duty. Health and additional coverage selected before the first day of the calendar month after the date the employee begins active duty are effective the first day of the following month.

(B) Dependent enrollment and optional coverage:

(i) To enroll eligible dependents, to elect to enroll in an approved HMO, and to elect additional coverage and plans which include optional coverage, an employee not subject to the health insurance waiting period shall complete an enrollment form within 30 days after the date on which the employee begins active duty. Coverage selected within 30 days after the date on which the employee begins active duty becomes effective on the first day of the month following the date on which the enrollment form is completed. An enrollment form completed after the initial period for enrollment as provided in
this paragraph is subject to the provisions of subsection (d) of this section.

(ii) To enroll eligible dependents or to elect to enroll in an approved HMO, an employee subject to the health insurance waiting period shall complete an enrollment form before the first day of the month following 60 days of employment. Coverage selected before the first day of the month following 60 days of employment becomes effective on the first day of the month following 60 days of employment. An employee completing an enrollment form after the initial period for enrollment as provided in this paragraph is subject to the provisions of subsection (d) of this section. The provisions of subparagraph (A)(ii) of this paragraph apply to the election of additional coverage and plans, which include optional coverage, for an employee subject to the health insurance waiting period.

(C) Except as otherwise provided in this section, an employee may not change coverage.

(D) An eligible employee who enrolls in the GBP is eligible to participate in premium conversion and shall be automatically enrolled in the premium conversion plan. The employee shall be automatically enrolled in the plan for subsequent plan years as long as the employee remains on active duty.

(E) Coverage for a newly eligible dependent, other than a dependent referred to in subparagraph (F) or (H) of this paragraph, will be effective on the first day of the month following the date the person becomes a dependent if an enrollment form is completed on or within 30 days after the date the person first becomes a dependent. If the enrollment form is completed and signed after the initial period for enrollment as provided in this paragraph, the enrollment form will be governed by the rules in subsection (d) of this section.

(F) A member's newborn natural child will be covered immediately and automatically for 30 days from the date of birth in the health plan in effect for the employee/retiree. A member's newly adopted child will be covered immediately and automatically from the date of placement for adoption for 30 days in the health plan in effect for the employee/retiree. To continue coverage for more than 30 days after the date of birth or placement for adoption, an enrollment form for GBP health coverage must be submitted by the member within 30 days after the date of birth or placement for adoption.

(G) The effective date of a newborn natural child's life and AD&D coverage will be the date of birth, if the child is born alive, as certified by an attending physician or a certified nurse-midwife. The effective date of a newly adopted child's life and AD&D coverage will be the date of placement for adoption. The effective date of all other eligible dependents' life and AD&D coverage will be as stated in subparagraph (E) of this paragraph.

(H) GBP health coverage of a member's eligible child for whom a covered employee/retiree is court-ordered to provide medical support becomes effective on the date on which the member's benefits coordinator receives a valid copy of the qualified medical child support order.

(I) The effective date of GBP health coverage for an employee's/retiree's dependent, other than a newborn natural child or newly adopted child, will be as stated in subparagraph (E) of this paragraph.

(J) For purposes of this section, an enrollment form is completed when all information necessary to effect an enrollment has been transmitted to ERS in the form and manner prescribed by ERS.

(2) Part-time employees. A part-time employee or other employee who is not automatically covered must complete an applica-
ment or before the first day of the calendar month after the retiree's 65th birthday, whichever is later as appropriate. The effective date for such coverage shall be the first day of the calendar month following 60 days after the date of retirement or the first day of the calendar month following the retiree's 65th birthday, whichever is later as appropriate.

(iii) A retiree who is ineligible for health insurance on the effective date of retirement as provided in §81.5(b) of this chapter, may enroll in GBP health coverage or waive GBP health coverage as provided in §81.8 of this chapter for which the retiree is eligible, including dependent coverage, by completing an enrollment form or waiver of coverage as applicable, before the first day of the calendar month after the retiree's 65th birthday. The effective date for such coverage shall be the first day of the calendar month following 60 days after the date of retirement or the first day of the calendar month following the retiree's 65th birthday, whichever is later.

(C) A retiree who becomes eligible for minimum retiree optional life insurance coverage or dependent life insurance coverage as provided in §81.5(b)(6) of this chapter, may apply for approval of such coverage by providing evidence of insurability acceptable to ERS.

(D) Enrollments in and applications to change coverage become effective as provided in subparagraph (B) of this paragraph unless other coverage is in effect at that time. If other coverage is in effect at that time, coverage or waiver of coverage becomes effective on the first day of the month following the date of approval of retirement by ERS; or, if cancellation of the other coverage preceded the date of approval of retirement, the first day of the month following the date the other coverage was canceled.

(E) A retiree who seeks enrollment in GBP health coverage after turning age 65 will be automatically enrolled in HealthSelect of Texas until Medicare enrollment is confirmed by CMS. A retiree who is [or is retired and] enrolled in a health plan and turns age 65 will remain enrolled in that health plan until the retiree's Medicare enrollment can be confirmed by CMS. Once Medicare enrollment is confirmed, the retiree will be automatically enrolled in the Medicare Advantage Plan unless the retiree opts out of the Medicare Advantage Plan and enrolls in other coverage by completing an enrollment form as specified in subparagraph (B)(i) - (iii) of this paragraph. If the retiree is determined to be ineligible for Medicare coverage, then he/she will be returned to the coverage in place immediately before turning 65.

(F) A Medicare-eligible retiree who seeks enrollment in GBP health coverage or is retired and enrolled in a health plan and becomes eligible for Medicare, will be automatically enrolled in the HealthSelect of Texas Prescription Drug Program until Medicare enrollment is confirmed by CMS. Upon confirmation of Medicare enrollment, the retiree will be enrolled in HealthSelect Medicare Rx. A retiree who declines HealthSelect Medicare Rx loses all GBP prescription drug coverage. If the retiree is determined to be ineligible for Medicare coverage, then he/she will be returned to the coverage in place immediately before turning 65.

(4) Medicare-eligible Dependents.

(A) A dependent as defined in §81.1 of this chapter (relating to Definitions) who becomes eligible for Medicare-primary coverage as specified in §81.1 of this chapter, either through disability, age, or other requirements as set forth by CMS, will be automatically enrolled in the Medicare Advantage Plan, once Medicare enrollment is confirmed by CMS, unless the retiree and his/her dependents opt out of the Medicare Advantage Plan and enroll in other coverage by completing an enrollment form as specified in paragraph (3)(B)(i) - (iii) of this subsection. If the dependent is determined to be ineligible for Medicare coverage, then he/she will be returned to the coverage in place immediately before turning 65.

(B) A Medicare-eligible dependent eligible for GBP health coverage will be automatically enrolled in HealthSelect Medicare Rx, once Medicare enrollment is confirmed by CMS. A Medicare-eligible dependent who declines HealthSelect Medicare Rx loses all GBP prescription drug coverage. If the dependent is determined to be ineligible for Medicare coverage, then he/she will be returned to the coverage in place immediately before turning 65.

(5) Surviving dependents.

(A) Provided that the insurance required contributions are paid or deducted, the health, dental, and vision insurance coverage of a surviving dependent may be continued on the death of the deceased employee/retiree if the dependent is eligible for such coverage as provided by §81.5(e) of this chapter.

(B) A surviving spouse who is receiving an annuity shall make insurance required contribution payments by deductions from the annuity as provided in subsection (h)(7) of this section. A surviving spouse who is not receiving an annuity may make payments as provided in subsection (h)(7) of this section.

(C) A Medicare-eligible surviving dependent eligible for GBP health coverage will be automatically enrolled in the Medicare Advantage Plan, once Medicare enrollment is confirmed by CMS, unless the surviving dependent opts out of the Medicare Advantage Plan and enrolls in other coverage.

(D) A Medicare-eligible surviving dependent eligible for GBP health coverage will be automatically enrolled in HealthSelect Medicare Rx, once Medicare enrollment is confirmed by CMS. A Medicare-eligible surviving dependent who declines HealthSelect Medicare Rx loses all GBP prescription drug coverage.

(6) Former COBRA unmarried children. A former COBRA unmarried child must provide an application to continue GBP health, dental and vision insurance coverage within 30 days after the date the notice of eligibility is mailed by ERS. Coverage becomes effective on the first day of the month following the month in which continuation coverage ends. Insurance required contribution payments must be made as provided in subsection (h)(1)(A) of this section.

(b) Premium conversion plans.

(1) An eligible employee participating in the GBP is deemed to have elected to participate in the premium conversion plan and to pay insurance required contributions with pre-tax dollars as long as the employee remains on active duty. The plan is intended to be qualified under the Internal Revenue Code, §79 and §106.

(2) Maximum benefit available. Subject to the limitations set forth in these rules and in the plan, to avoid discrimination, the maximum amount of flexible benefit dollars which a participant may receive in any plan year for insurance required contributions under this section shall be the amount required to pay the participant's portion of the insurance required contributions for coverage under each type of insurance included in the plan.

(c) Special rules for additional coverage and plans which include optional coverage.

(1) Only an employee/retiree or a former officer or employee specifically authorized to join the GBP may apply for additional coverage and plans. An employee/retiree may apply for or elect additional coverage and plans for which he/she is eligible without concurrent enrollment in GBP health coverage provided by the GBP. Additional coverage and plans, as determined by the Board of Trustees, may include:

(A) dental coverage;
(B) optional term life;
(C) dependent term life;
(D) short- and long-term disability;
(E) voluntary accidental death and dismemberment;
(F) long-term care;
(G) health care and dependent care reimbursement;
(H) commuter spending account;
(I) vision;
(J) limited purpose flexible spending account; or
(K) health savings account.

(2) An eligible member in the GBP and eligible dependents may participate in an approved HMO if they reside in the approved service area of the HMO and are otherwise eligible under the terms of the contract with the HMO.

(3) An eligible member in the GBP electing additional coverage and plans and/or Consumer Directed HealthSelect, HMO or Medicare Advantage coverage in lieu of the basic plan is obligated for the full payment of insurance required contributions. If the insurance required contributions are not paid, all coverage not fully funded by the state contribution will be canceled. A person eligible for the state contribution will retain member-only GBP health coverage as a member provided the state contribution is sufficient to cover the insurance required contribution for such coverage. If the state contribution is not sufficient for member-only coverage in the health plan selected by the member employee/retiree, the member employee/retiree will be enrolled in the basic plan or the Medicare Advantage Plan, as applicable, except as provided for in subsection (g)(2)(B) of this section.

(4) An eligible member in the GBP enrolled in an HMO and the HMO’s contract is not renewed for the next fiscal year will be eligible to make one of the following elections:

(A) change to another approved HMO for which the member is eligible by completing an enrollment form during the annual enrollment period. The effective date of the change in coverage will be September 1;

(B) enroll in HealthSelect of Texas, Consumer Directed HealthSelect, or a Medicare Advantage Plan (if eligible) by completing an enrollment form during the annual enrollment period. The effective date of the change in coverage will be September 1; or

(C) if the member does not make one of the elections, as defined in subparagraphs (A) or (B) of this paragraph, the member and covered eligible dependents will automatically be enrolled in the basic plan or the Medicare Advantage Plan, as applicable.

(5) A member enrolled in an HMO whose contract with ERS is terminated during the fiscal year or that fails to maintain compliance with the terms of its contract, as determined by ERS, will be eligible to make one of the following elections:

(A) change to another approved HMO for which the member is eligible. The effective date of the change in coverage will be determined by ERS; or

(B) enroll in HealthSelect of Texas, Consumer Directed HealthSelect, or a Medicare Advantage Plan (if eligible). The effective date of the change in coverage will be determined by ERS.

(d) Changes in coverage after the initial period for enrollment.

(1) Changes for a qualifying life event.

(A) Subject to the provisions of paragraphs (3) and (4) of this subsection, a member shall be allowed to change coverage during a plan year within thirty (30) days of a qualifying life event that occurs as provided in this paragraph if the change in coverage is consistent with the qualifying life event.

(B) A qualifying life event occurs when a participant experiences one of the following changes:

(i) change in marital status;
(ii) change in dependent status;
(iii) change in employment status;
(iv) change of address that results in loss of benefits eligibility;
(v) change in Medicare or Medicaid status, or CHIP status;
(vi) significant cost of benefit or coverage change imposed by a third party provider; or
(vii) change in coverage ordered by a court.

(C) A member who loses benefits eligibility as a result of a change of address shall change coverage as provided in paragraphs (6) - (9) of this subsection.

(D) A member may apply to change coverage on, or within 30 days after, the date of the qualifying life event, provided, however, a change in election due to CHIP or Medicaid status under subparagraph (B) of this paragraph may be submitted on, or within 60 days after, the change in CHIP or Medicaid status.

(E) Except as otherwise provided in subsection (a)(1)(F) and (H) of this section, the change in coverage is effective on the first day of the month following the date on which the enrollment form is completed.

(F) Documentation may be required in support of the qualifying life event.

(G) Following a qualifying life event, a member may change applicable coverage, drop or add an eligible dependent if the change is consistent with the qualifying life event.

(2) Effects of change in cost of benefits to the premium conversion plan. There shall be an automatic adjustment in the amount of premium conversion plan dollars used to purchase optional benefits in the event of a change, for whatever reason, during an applicable period of coverage, of the cost of providing such optional benefit to the extent permitted by applicable law and regulation. The automatic adjustment shall be equal to the increase or decrease in such cost. A participant shall be deemed by virtue of participation in the plan to have consented to the automatic adjustment.

(3) An eligible member who wishes to add or increase optional coverage after the initial period for enrollment must make application for approval by providing evidence of insurability acceptable to ERS, if required. Unless not in compliance with paragraph (1) of this subsection, coverage will become effective on the first day of the month following the date approval is received by ERS, if the applicant is a retiree or an individual in a direct pay status. If the applicant is an employee whose coverage was canceled while the employee was on LWOP, the approved change in coverage will become effective on the date the employee returns to active duty if the employee returns to active duty within 30 days of the approval letter. If the date the employee returns to active duty is more than 30 days after the date on the approval letter, the approval is null and void; and a new application shall be required. An employee/retiree may withdraw the application at any time.
prior to the effective date of coverage by submitting a written notice of withdrawal.

(4) The evidence of insurability provision applies only to:
   (A) employees who wish to enroll in Elections III or IV optional term life insurance, except as otherwise provided in subsection (f) of this section;
   (B) employees who wish to enroll in or increase optional term life insurance, dependent life insurance, or disability income insurance after the initial period for enrollment;
   (C) employees enrolled in the GBP whose coverage was waived, dropped or canceled, except as otherwise provided in subsection (f) of this section; and
   (D) retirees who wish to enroll in minimum optional life insurance or dependent life insurance as provided in subsection (a)(3)(C) of this section.

(5) An employee/retiree who wishes to add eligible dependents to the employee's/retiree's HMO coverage may do so:
   (A) during the annual enrollment period; or
   (B) upon the occurrence of a qualifying life event as provided in paragraph (1) of this subsection.

(6) A member who is enrolled in an approved HMO and who permanently moves out of the HMO service area shall make one of the following elections, to become effective on the first day of the month following the date on which the member moves out of the HMO service area:
   (A) enroll in another approved HMO for which the member and all covered dependents are eligible; or
   (B) if the member and all covered dependents are not eligible to enroll in an approved HMO, either:
      (i) enroll in HealthSelect of Texas or Consumer Directed HealthSelect; or
      (ii) enroll in an approved HMO if the member is eligible, and drop any ineligible covered dependent, unless not in compliance with §81.11(c)(3) of this chapter (relating to Cancellation of Coverage and Sanctions).

(7) When a covered dependent of a member permanently moves out of the member's HMO service area, the member shall make one of the following elections, to become effective on the first day of the month following the date on which the dependent moves out of the HMO service area:
   (A) drop the ineligible dependent, unless not in compliance with §81.11(c)(3) of this chapter;
   (B) enroll in an approved HMO if the member and all covered dependents are eligible; or
   (C) enroll in HealthSelect of Texas or Consumer Directed HealthSelect, provided the eligible member and all dependents enroll in the same health plan at that time.

(8) An eligible member will be allowed an annual opportunity to make changes in coverage.
   (A) Subject to other requirements of this section, a member will be allowed to:
      (i) change or enroll themselves and any eligible dependents in an eligible health, dental or vision plan;
      (ii) enroll themselves and their eligible dependents in an eligible health, dental or vision plan from a waived or canceled status;
      (iii) add, decrease or cancel eligible coverage, unless prohibited by §81.11(c)(3) of this chapter;
      (iv) apply for coverage as provided in paragraph (3) of this subsection; and
      (v) waive any or all GBP coverage including health as provided in §81.8 of this chapter.

(B) Surviving dependents and former COBRA unmarried children are not eligible to add dependents to coverage through annual enrollment. A surviving dependent or former COBRA unmarried child may enroll an eligible dependent in dental or vision insurance coverage if the dependent is enrolled in health insurance coverage.

(C) Annual enrollment opportunities will be scheduled each year at times announced by ERS.

(9) A participant who is a retiree or a surviving dependent, or who is in a direct pay status, may decrease or cancel any coverage at any time unless such coverage is health insurance coverage ordered by a court as provided in §81.5(c) of this chapter.

(10) A member and his/her dependents who are enrolled in the Medicare Advantage Plan may collectively enroll in HealthSelect of Texas, Consumer Directed HealthSelect or an HMO.

   (A) Such opportunity will be scheduled on at least an annual basis each year, at times announced by ERS.

   (B) Additional opportunities will occur each month prior to an annual enrollment period. Coverage selected during these opportunities will be effective on the first of the month following processing by CMS.

(11) If a member drops coverage for his/her dependent because the dependent gained other coverage effective the first day of a month, then the effective date of the qualifying life event can be either the last day of the month preceding the gained coverage or on the first day of the month in which the gained coverage is effective.

(e) Special provisions relating to term life benefits

(1) An employee or annuitant who is enrolled in the group term life insurance plan may file a claim for an accelerated life benefit for himself or his covered dependent in accordance with the terms of the plan in effect at that time. An accelerated life benefit paid will be deducted from the amount that would otherwise be payable under the plan.

(2) An employee or annuitant who is enrolled in the group term life insurance plan may make, in conjunction with receipt of a viatical settlement, an irrevocable beneficiary designation in accordance with the terms of the plan in effect at that time.

(f) Re-enrollment in the GBP.

(1) The provisions of subsection (a)(1) of this section shall apply to the enrollment of an employee who terminates employment and returns to active duty within the same fiscal year, who transfers from one employer to another, or who returns to active duty after a period of LWOP during which coverage is canceled.

(2) An employee to whom paragraph (1) of this subsection applies shall be subject to the same requirements as a newly hired employee to re-enroll in the coverage in which the employee was previously enrolled. Provided that all applicable preexisting conditions exclusions were satisfied on the date of termination, transfer, or can-
cellation, no new preexisting conditions exclusions will apply. If not, any remaining period of preexisting conditions exclusions must be satisfied upon re-enrollment.

(3) If an employee is a member of the Texas National Guard or any of the reserve components of the United States armed forces, and the employee's coverage is canceled during a period of LWOP or upon termination of employment as the result of an assignment to active military duty, the period of active military duty shall be applied toward satisfaction of any period of preexisting conditions exclusions remaining upon the employee's return to active employment.

(g) Continuing coverage in special circumstances.

(1) Continuation of coverage for terminating employees. A terminating employee is eligible to continue all coverage through the last day of the month in which employment is terminated.

(2) Continuation of coverage for employees on LWOP status.

(A) An employee in LWOP status may continue the coverage in effect on the date the employee entered that status for the period of leave, but not more than 12 months. The employee must pay insurance required contributions directly as provided in subsection (h)(1)(A) of this section.

(B) An employee whose LWOP is a result of the Family and Medical Leave Act of 1993 will continue to receive the state contribution during such period of LWOP. The employee must pay insurance required contributions directly as defined in subsection (h)(1)(A) of this section. Failure to make the payment of insurance required contributions by the due date will result in the cancellation of all coverage except for member-only health and basic life coverage. The employee will continue in the health plan in which he/she was enrolled immediately prior to the cancellation of all other coverage.

(3) Continuation of coverage for a former member or employee of the Legislature. Provided that the insurance required contributions are paid, the GBP health, dental, vision and life insurance coverage of a former member or employee of the Legislature may be continued on conclusion of the term of office or employment.

(4) Continuation coverage for a former board member. Provided that the insurance required contributions are paid, the GBP health, dental, vision and life insurance coverage of a former member of a board or commission, or of the governing body of an institution of higher education, as both are described in §1551.109 of the Act, may be continued on conclusion of service if no lapse in coverage occurs after the term of office. Life insurance will be reduced to the maximum amount for which the former board member is eligible.

(5) Continuation of coverage for a former judge. A former state of Texas judge, who is eligible for judicial assignments and who does not serve on judicial assignments during a period of one calendar month or longer, may continue the coverage that was in effect during the calendar month immediately prior to the month in which the former judge did not serve on judicial assignments. This coverage may continue for no more than 12 continuous months during which the former judge does not serve on judicial assignments as long as, during the period, the former judge continues to be eligible for assignment.

(6) Continuation of coverage for a surviving spouse and/or dependent child/children of a deceased employee/retiree. The surviving spouse and/or dependent child/children of a deceased employee/retiree, who, in accordance with §81.5(j) of this chapter, elects to continue coverage may do so by submitting the required election notification and enrollment forms to ERS. The enrollment form, including all insurance required contributions due for the election/enrollment period, must be postmarked or received by ERS on or before the date indicated on the continuation of coverage enrollment form. Continuing coverage will begin on the first day of the month in which the employee/retiree dies, provided all insurance required contributions due for the month in which the employee/retiree died and for the election/enrollment period have been paid in full.

(7) Continuation of coverage for a covered employee whose employment has been terminated, voluntarily or involuntarily (other than for gross misconduct), whose work hours have been reduced such that the employee is no longer eligible for the GBP as an employee, or whose coverage has ended following the maximum period of LWOP as provided in paragraph (2)(A) of this subsection. An employee, his/her spouse and/or dependent child/children, who, in accordance with §81.5(j)(2) of this chapter, elect to continue GBP health, dental and vision coverage may do so by submitting the required election notification and enrollment forms to ERS. The enrollment form, including all insurance required contributions due for the election/enrollment period, must be postmarked or received by ERS on or before the date indicated on the continuation of coverage enrollment form. Continuing coverage will begin on the first day of the month following the month in which the employee's coverage ends, provided all insurance required contributions due for the month in which the coverage ends and for the election/enrollment period have been paid in full.

(8) Continuation of coverage for a spouse who is divorced from a member and/or the spouse's dependent child/children. The divorced spouse and/or the spouse's dependent child/children of an employee/retiree who, in accordance with §81.5(j)(4) of this chapter, elect to continue coverage may do so by submitting the required election notification and enrollment forms to ERS. The enrollment form, including all insurance required contributions due for the election/enrollment period, must be postmarked or received by ERS on or before the date indicated on the continuation of coverage enrollment form. Continuing coverage will begin on the first day of the month following the month in which the divorce decree is signed, provided all insurance required contributions due for the month in which the divorce decree is signed and for the election/enrollment period have been paid in full.

(9) Continuation of coverage for a dependent child who has attained 26 years of age. A 26-year-old dependent child (not provided for by §81.5(c) of this chapter) of a member who, in accordance with §81.5(j)(5) of this chapter, elects to continue coverage may do so by submitting the required election notification and enrollment forms to ERS. The enrollment form, including all insurance required contributions due for the election/enrollment period, must be postmarked or received by ERS on or before the date indicated on the continuation of coverage enrollment form. Continuing coverage will begin on the first day of the month following the month in which the dependent child of the member attains 26 years of age, provided all insurance required contributions due for the month in which the dependent child attained age 26 and for the election/enrollment period have been paid in full.

(10) Extension of continuation of coverage for certain dependents of former employees who are continuing coverage under the provisions of paragraph (6) of this subsection.

(A) The surviving dependent of a deceased former employee, who, in accordance with §81.5(j)(6)(A) of this chapter, elects to extend continuation coverage may do so by submitting the required election notification and enrollment forms to ERS. The enrollment form, including all insurance required contributions due for the election/enrollment period, must be postmarked or received by ERS on or before the date indicated on the continuation enrollment
form. The election/enrollment period begins on the first day of the month following the month in which the former employee died.

(B) A spouse who is divorced from a former employee and/or the divorced spouse's dependent child/children, who, in accordance with §81.5(j)(6)(B) of this chapter, elects to extend continuation coverage may do so by submitting the required election notification and enrollment forms to ERS. The enrollment form, including all insurance required contributions due for the election/enrollment period, must be postmarked or received by ERS on or before the date indicated on the continuation enrollment form. The election/enrollment period begins on the first day of the month following the month in which the divorce decree was signed.

(C) A dependent child who has attained 26 years of age, who, in accordance with §81.5(j)(6)(C) of this chapter, elects to extend continuation coverage may do so by submitting the required election notification and enrollment forms to ERS. The enrollment form, including all insurance required contributions due for the election/enrollment period, must be postmarked or received by ERS on or before the date indicated on the continuation enrollment form. The election/enrollment period begins on the first day of the month following the month in which the dependent child attained age 26.

(11) Continuation coverage defined. Continuation coverage as provided for in paragraphs (6) - (10) of this subsection means the continuation of only GBP health, dental and vision coverage which meets the following requirements.

(A) Type of benefit coverage. The coverage shall consist of only the GBP health, dental and vision coverage, which, as of the time the coverage is being provided, are identical to the GBP health, dental and vision coverage provided for a similarly situated person for whom a cessation of coverage event has not occurred.

(B) Period of coverage. The coverage shall extend for at least the period beginning on the first day of the month following the date of the cessation of coverage event and ending not earlier than the earliest of the following:

(i) in the case of loss of coverage due to termination of an employee's employment for other than gross misconduct, reduction in work hours, or end of maximum period of LWOP, the last day of the 18th calendar month of the continuation period;

(ii) in the case of loss of coverage due to termination of an employee's employment for other than gross misconduct, reduction in work hours, or end of maximum period of LWOP, if the employee, spouse, or dependent child has been certified by the Social Security Administration as being disabled as provided in §81.5(j)(3) of this chapter, up to the last day of the 29th calendar month of the continuation period;

(iii) in any case other than loss of coverage due to termination of an employee's employment for other than gross misconduct, reduction in work hours, or end of maximum period of LWOP, the last day of the 36th calendar month of the continuation period;

(iv) the date on which the employer ceases to provide any group health plan to any employee/retiree;

(v) the date on which coverage ceases under the plan due to failure to make timely payment of any insurance required contribution as provided in subsection (h) of this section;

(vi) the date on which the participant, after the date of election, becomes covered under any other group health plan under which the participant is not subject to a preexisting conditions limitation or exclusion; or

(vii) the date on which the participant, after the date of election, becomes entitled to benefits under the Social Security Act, Title XVIII.

(C) Insurance required contribution costs. The insurance required contribution for a participant during the continuation coverage period will be 102% of the employee/retiree's GBP health, dental and vision coverage rate and is payable as provided in subsection (h) of this section.

(i) The insurance required contribution for a participant eligible for 36 months of coverage will be 102% of the employee/retiree's GBP health, dental and vision coverage rate and is payable as provided in subsection (h)(1)(A) of this section.

(ii) The insurance required contribution for a participant eligible for 29 months of coverage will increase to 150% of the employee's/retiree's GBP health, dental and vision coverage rate for the 19th through 29th months of coverage and is payable as provided in subsection (h)(1)(A) of this section.

(D) No requirement of insurability. No evidence of insurability is required for a participant who elects to continue GBP health coverage under the provisions of §81.5(j)(1) - (6) of this chapter.

(E) Conversion option. An option to enroll under the conversion plan available to employees/retirees is also available to a participant who continues GBP coverage for the maximum period as provided in subparagraph (B)(i) - (iii) of this paragraph. The conversion notice will be provided to a participant during the 180-day period immediately preceding the end of the continuation period.

(h) Payment of Insurance Required Contributions.

(1) A member whose monthly cost of coverage is greater than the combined amount contributed by the state or employer for the member's coverage must pay a monthly contribution in an amount that exceeds the combined monthly contributions of the state or the employer. A member shall pay his/her monthly insurance required contributions through deductions from monthly compensation or annuity payments or by direct payment, as provided in this paragraph.

(A) A member who is not receiving a monthly compensation or an annuity payment, or is receiving a monthly compensation or annuity payment that is less than the member's monthly insurance required contribution, shall pay his/her monthly insurance required contribution under this subparagraph.

(i) An employee whose monthly compensation is less than the employee's monthly insurance required contribution shall pay his/her monthly insurance required contribution through his/her employer. A non-salaried board member of an employer shall pay his/her monthly insurance required contributions through the employer for which he/she sits as a board member.

(ii) A retiree whose monthly annuity payment is less than the retiree's monthly insurance required contribution shall pay his/her monthly insurance required contributions directly to ERS.

(B) If the member does not comply with subparagraph (A) of this subsection by the due date required, ERS will cancel all coverage not fully funded by the state contribution. If the state contribution is sufficient to cover the required insurance contribution for such coverage, the member will retain member-only health and basic life coverage. If the state contribution is not sufficient to cover the member-only coverage in the health plan selected, the member will be enrolled in the basic plan except as provided for in paragraph (2)(B) of this subsection.
(2) An institution of higher education may contribute a portion or all of the insurance required contribution for its part-time employees described by §1551.101(e)(2) of the Act, if:

(A) the institution of higher education pays the contribution with funds that are not appropriated from the general revenue fund;

(B) the institution of higher education electing to pay the contribution for its part-time employees does so for all similarly situated eligible part-time employees; and

(C) the contribution paid as provided in this paragraph is paid beginning on the first day of the month following the part-time employee's completion of any applicable waiting period.

(3) A participant who continues GBP health, dental and vision coverage under COBRA as provided in §81.5(j) of this chapter ([relating to Eligibility]) must pay his/her monthly insurance contributions on the first day of each month covered.

(A) A participant's monthly insurance required contribution is 102% of the monthly amount charged for other participants in the same coverage category and in the same plan. All insurance required contributions due for the election/enrollment period must be postmarked or received by ERS on or before the date indicated on the continuation of coverage enrollment form. Subsequent insurance required contributions are due on the first day of each month of the participant's coverage and must be postmarked or received by ERS within 30 days of the due date to avoid cancellation of coverage.

(B) A participant's monthly insurance required contribution for continuing coverage as provided in §81.5(j)(3) of this chapter is increased after the 18th month of coverage to 150% of the monthly amount charged for other participants in the same coverage category and in the same plan. The participant's monthly insurance required contribution is due on the first day of each month covered, and must be postmarked or received by ERS within 30 days of the due date.

(4) The full cost for GBP health, dental and vision coverage is required to be paid for a member's unmarried child who is over 26 years of age, whose coverage under COBRA expired, and who has reinstated coverage in the GBP pursuant to §1551.158 of the Act. No state contribution is paid for this coverage.

(5) Survivors of a paid law enforcement officer employed by the state or a custodial employee of the institutional division of the Texas Department of Criminal Justice who suffers a death in the line of duty as provided by Chapter 615, Government Code, are eligible for GBP coverage as provided in subparagraphs (A) - (C) of this paragraph.

(A) The insurance required contribution due under this paragraph for a surviving spouse's GBP coverage is the same amount as a member-only contribution. The state contribution applicable to member-only coverage is applied to the surviving spouse's contribution for the coverage.

(B) The insurance required contribution due under this paragraph for GBP coverage for a surviving spouse with dependent children is the same amount as the member-with-children contribution. The state contribution applicable to member-with-children coverage is applied to the contribution of the surviving spouse with dependent children for the coverage.

(C) The insurance required contribution due under this paragraph for a surviving dependent child's GBP coverage, when there is no surviving spouse, is the same amount as member-only contribution. The state contribution applicable to member-only coverage is applied to the surviving dependent child's contribution for the coverage.

(D) The surviving spouse or surviving dependent child must timely pay his/her insurance required contributions for the GBP coverage. The survivor's contribution must be either deducted by ERS from the survivor's annuity payment, if any, or submitted to ERS via direct payment. Any applicable state contribution will be paid directly to ERS by the employer that employed the deceased law enforcement officer or custodial employee.

(6) If a retiree whose eligibility for health insurance is based on §§1551.102(i), 1551.111(e) or 1551.112(c) of the Act, obtains interim health insurance as provided in §1551.323 of the Act, the retiree must pay the total contribution for such coverage for as long as the retiree wants the coverage or until the first day of the month following the retiree's 65th birthday. The amount of contribution shall be determined by the Board of Trustees based on an actuarial determination, as recommended by ERS' consulting actuary for insurance, of the estimated total claims costs for individuals eligible for such coverage. If a retiree who is eligible for coverage under this paragraph is also eligible for COBRA coverage, then COBRA coverage should be exhausted, if possible, before applying for the coverage under this paragraph.

(7) A member's surviving spouse or surviving dependent who is receiving an annuity shall authorize deductions for insurance required contributions from the annuity as provided in paragraph (1) of this subsection. A member's surviving spouse or surviving dependent who is not receiving an annuity may make payments as provided in paragraph (1)(A) of this subsection.

(i) The amount of state contribution for certain retirees is determined in accordance with §1551.3196 of the Act.

(1) An individual is grandfathered at the time of retirement and not subject to §1551.3196 of the Act, if on or before September 1, 2014, the individual has served in one or more positions for at least five years for which the individual was eligible to participate in the GBP as an employee.

(2) Records of ERS shall be used to determine whether or not an individual meets the grandfathering requirements specified in paragraph (1) of this subsection. ERS may, in its sole discretion, require an individual to provide additional documentation satisfactory to ERS that the individual meets the grandfathering requirements specified in paragraph (1) of this subsection.

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 July 11, 2018.
TRD-201803042
Paula A. Jones
Deputy Executive Director and General Counsel
Employees Retirement System of Texas
Earliest possible date of adoption: August 26, 2018
For further information, please call: (877) 275-4377

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS
PART 1. TEXAS DEPARTMENT OF PUBLIC SAFETY
CHAPTER 15. DRIVER LICENSE RULES

PROPOSED RULES  July 27, 2018  43 TexReg 4959
SUBCHAPTER B. APPLICATION REQUIREMENTS--ORIGINAL, RENEWAL, DUPLICATE, IDENTIFICATION CERTIFICATES

37 TAC §15.34

The Texas Department of Public Safety (the department) proposes the repeal of §15.34, concerning Renewal Period Prior to Expiration. The repeal of this rule is filed simultaneously with proposed new §15.34 and is necessary to inform the public of changes to the time period for renewal prior to expiration.

Suzy Whittenton, Chief Financial Officer, has determined that for each year of the first five-year period the repeal is in effect there will be no fiscal implications for state or local government, or local economies.

Ms. Whittenton has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities required to comply with the repeal as proposed. There is no anticipated economic cost to individuals who are required to comply with the repeal as proposed. There is no anticipated negative impact on local employment.

In addition, Ms. Whittenton has also determined that for each year of the first five-year period the repeal is in effect, the public benefit anticipated as a result of enforcing the repeal will be additional time to renew a license prior to expiration and maximize the use of the federal requirement of allowing a license to be issued for eight years.

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

The department has determined that Chapter 2007 of the Texas Government Code does not apply to this proposal. Accordingly, the department is not required to complete a takings impact assessment regarding this proposal.

The department prepared a Government Growth Impact Statement assessment for this proposed rulemaking. The proposed rulemaking does not create or eliminate a government program; will not require an increase or decrease in future legislative appropriations to the agency; require the creation of new employee positions nor eliminate current employee positions; nor will it require an increase or decrease in fees paid to the agency. The proposed rulemaking does not create, expand, or limit an existing regulation. The proposed rulemaking does not increase or decrease the number of individuals subject to its applicability. During the first five years the proposed repeal is in effect, the proposed repeal should not impact positively or negatively the state's economy.

Comments on this proposal may be submitted to Janie Sawatsky, Driver License Division, Texas Department of Public Safety, P.O. Box 4087 (MSC 0300), Austin, Texas 78773; by fax to (512) 424-5233; or by email to DLDrivercomments@dps.texas.gov. Comments must be received no later than thirty (30) days from the date of publication of this proposal.

This repeal is proposed pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work; and Texas Transportation Code, §521.005, which authorizes the department to adopt rules necessary to administer Chapter 521 of the Texas Transportation Code.

Texas Government Code, §411.004(3) and Texas Transportation Code, §521.005, are affected by this proposal.

§15.34. Renewal Period Prior to Expiration.

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 July 10, 2018.

TRD-201803021
D. Phillip Adkins
General Counsel
Texas Department of Public Safety
Earliest possible date of adoption: August 26, 2018
For further information, please call: (512) 424-5848

37 TAC §15.34

The Texas Department of Public Safety (the department) proposes new §15.34, concerning Renewal Period Prior to Expiration. This new rule is intended to provide greater customer convenience and flexibility by expanding the renewal period prior to expiration of most driver licenses (DL) or identification cards (ID) from one year to two years.

Suzy Whittenton, Chief Financial Officer, has determined that for each year of the first five-year period the rule is in effect there will be no fiscal implications for state or local government, or local economies.

Ms. Whittenton has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities required to comply with the rule as proposed. There is no anticipated economic cost to individuals who are required to comply with the rule as proposed. There is no anticipated negative impact on local employment.

In addition, Ms. Whittenton has also determined that for each year of the first five-year period the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be additional time to renew a license prior to expiration and maximize the use of the federal requirement allowing a license to be issued for eight years.

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

The department has determined that Chapter 2007 of the Texas Government Code does not apply to this proposal. Accordingly,
the department is not required to complete a takings impact assessment regarding this proposal.

The department prepared a Government Growth Impact Statement assessment for this proposed rulemaking. The proposed rulemaking does not create or eliminate a government program; will not require an increase or decrease in future legislative appropriations to the agency; require the creation of new employee positions nor eliminate current employee positions; nor will it require an increase or decrease in fees paid to the agency. The proposed rulemaking does not create, expand, or limit an existing regulation. The proposed rulemaking does not increase or decrease the number of individuals subject to its applicability. During the first five years the proposed rule is in effect, the proposed rule should not impact positively or negatively the state’s economy.

Comments on this proposal may be submitted to Janie Sawatsky, Driver License Division, Texas Department of Public Safety, P.O. Box 4087 (MSC 0300), Austin, Texas 78773; by fax to (512) 424-5233; or by email to DLDrulecomments@dps.texas.gov. Comments must be received no later than thirty (30) days from the date of publication of this proposal.

This rule is proposed pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department’s work; and Texas Transportation Code, §521.005, which authorizes the department to adopt rules necessary to administer Chapter 521 of the Texas Transportation Code.

Texas Government Code, §411.004(3) and Texas Transportation Code, §521.005, are affected by this proposal.

§15.34. Renewal Period Prior to Expiration. (a) Any class of driver license or identification card, except those noted in paragraphs (1) - (3) of this subsection, may be renewed 24 months before the expiration date.

(1) Provisional licenses may be renewed 30 days before expiration.

(2) Driver licenses or identification cards issued to applicants required to register under Code of Criminal Procedure, Chapter 62, Sex Offender Registration Program, may be renewed 60 days before expiration.

(3) Driver licenses with an expiration date determined by Transportation Code, §521.2711 (person at least 85 years of age) may be renewed 180 days before expiration.

(b) Any applicant for a renewal driver license or identification card must present at least one identity document listed in §15.24 of this title (relating to Identification of Applicants) if the driver license or identification card is not presented.

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 July 10, 2018.

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D. Phillip Adkins
General Counsel
Texas Department of Public Safety
Earliest possible date of adoption: August 26, 2018
For further information, please call: (512) 424-5848

SUBCHAPTER C. EXAMINATION REQUIREMENTS

37 TAC §15.59

The Texas Department of Public Safety (the department) proposes amendments to §15.59, concerning Alternative Methods for Driver License Transactions. The amendments are intended to provide greater customer convenience by allowing commercial driver license (CDL) holders to obtain duplicates and change of address by alternative methods.

Suzy Whittenton, Chief Financial Officer, has determined that for each year of the first five-year period the rule is in effect there will be no fiscal implications for state or local government, or local economies.

Ms. Whittenton has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities required to comply with the rule as proposed. There is no anticipated economic cost to individuals who are required to comply with the rule as proposed. There is no anticipated negative impact on local employment.

In addition, Ms. Whittenton has also determined that for each year of the first five-year period the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be greater convenience for eligible CDL holders to obtain duplicate cards without visiting a driver license office.

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

The department has determined that Chapter 2007 of the Texas Government Code does not apply to this proposal. Accordingly, the department is not required to complete a takings impact assessment regarding this proposal.

The department prepared a Government Growth Impact Statement assessment for this proposed rulemaking. The proposed rulemaking does not create or eliminate a government program; will not require an increase or decrease in future legislative appropriations to the agency; require the creation of new employee positions nor eliminate current employee positions; nor will it require an increase or decrease in fees paid to the agency. The proposed rulemaking does not create, expand, or limit an existing regulation. The proposed rulemaking does not increase or decrease the number of individuals subject to its applicability. During the first five years the proposed rule is in effect, the proposed rule should not impact positively or negatively the state’s economy.

Comments on this proposal may be submitted to Janie Sawatsky, Driver License Division, Texas Department of Public Safety, P.O. Box 4087 (MSC 0300), Austin, Texas 78773; by fax to (512) 424-5233; or by email to DLDrulecomments@dps.texas.gov. Comments must be received no later than thirty (30) days from the date of publication of this proposal.
This rule is proposed pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work; Texas Transportation Code, §§521.005 and §522.005, which authorizes the department to adopt rules necessary to administer Chapter 521 and Chapter 522 of the Texas Transportation Code; and Texas Transportation Code, §§521.054, 521.146, and 522.032.

Texas Government Code, §411.004(3) and Texas Transportation Code, §§521.005, 521.146, 522.005, and 522.032, are affected by this proposal.


(a) If eligible, driver license or identification certificate holders may utilize alternative methods to renew or obtain a duplicate of their Texas driver license or identification certificate.

(b) Applicants must apply in the manner provided by the department and pay the applicable fee.

(c) Alternative renewal cannot be used for any two consecutive renewal periods for the purpose of updating the digital images.

(d) Commercial driver license applicants are not eligible to renew their driver license by alternative methods, but commercial driver license applicants are eligible to apply for a duplicate license and change of address by alternative methods.

(e) The applicants, listed in paragraphs (1) - (8) of this subsection, are not eligible to renew or apply for a duplicate of their driver license or identification certificate by alternative methods:

(1) any holder of a learner, provisional, or occupational[ commercial driver] license;

(2) any driver license holder who has an administrative or card status that requires review by the department, including but not limited to, a medical or physical condition that may affect the driver license holder's ability to safely operate a motor vehicle;

(3) any driver license holder applying for renewal that will be 79 years of age or older on the expiration of their current license;

(4) any driver license or identification certificate holder subject to the registration requirements of Code of Criminal Procedure, Chapter 62, Sex Offender Registration Program;

(5) any driver license or identification certificate holder who is suspended, canceled, revoked, or denied renewal;

(6) any driver license or identification certificate holder who does not have a verified social security number on file with the department;

(7) any driver license or identification certificate holder who does not have a digital image (e.g. photograph or signature) on file with the department; or

(8) any applicant whose lawful presence needs to be verified.

(f) The department may reject an application for an alternative transaction and require the personal appearance of the applicant at a driver license office if it has information concerning the eligibility of the applicant, including but not limited to, medical and vision conditions.

(g) Applicants who are eligible for alternative renewal may elect to renew at any local driver license office. A vision test will be conducted on all applicants renewing a driver license at a local driver license office, in addition to any other tests required by the department.

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

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D. Phillip Adkins

General Counsel

Texas Department of Public Safety

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For further information, please call: (512) 424-5848


CHAPTER 16. COMMERCIAL DRIVER LICENSE

SUBCHAPTER A. LICENSING REQUIREMENTS, QUALIFICATIONS, RESTRICTIONS, AND ENDORSEMENTS

37 TAC §16.1

The Texas Department of Public Safety (the department) proposes amendments to §16.1, concerning General Requirements. These amendments are intended to conform to changes to Federal Motor Carrier Safety Regulations, Title 49, Code of Federal Regulations (CFR) part 383, as amended through May 1, 2018.

The proposed rule clarifies that Texas will follow the federal definition of a commercial motor vehicle if there is conflict between state and federal law. The amendment reduces the number of people required to operate with a CDL and allows those drivers to have a class A or B non-CDL instead.

Suzy Whittenton, Chief Financial Officer, has determined that for each year of the first five-year period the rule is in effect there will be no fiscal implications for state or local government, or local economies.

Ms. Whittenton has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities required to comply with the rule as proposed. There is no anticipated economic cost to individuals who are required to comply with the rule as proposed. There is no anticipated negative impact on local employment.

In addition, Ms. Whittenton has also determined that for each year of the first five-year period the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to align the rule with federal statute.

The department has determined this proposal is not a "major environmental rule" as defined by Texas Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule that 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.

The department has determined that Chapter 2007 of the Texas Government Code does not apply to this proposal. Accordingly,
the department is not required to complete a takings impact assessment regarding this proposal.

The department prepared a Government Growth Impact Statement assessment for this proposed rulemaking. The proposed rulemaking does not create or eliminate a government program; will not require an increase or decrease in future legislative appropriations to the agency; require the creation of new employee positions nor eliminate current employee positions; nor will it require an increase or decrease in fees paid to the agency. The proposed rulemaking does not create, expand, or limit an existing regulation. The proposed rulemaking does not increase or decrease the number of individuals subject to its applicability. During the first five years the proposed rule is in effect, the proposed rule should not impact positively or negatively the state’s economy.

Comments on this proposal may be submitted to Janie Sawatsky, Driver License Division, Texas Department of Public Safety, P.O. Box 4087, Austin, Texas 78773; by fax to (512) 424-5233; or by email to DDLrulescomments@dps.texas.gov. Comments must be received no later than thirty (30) days from the date of publication of this proposal.

This rule is proposed pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department’s work; and Texas Transportation Code, §522.005, which authorizes the department to adopt rules necessary to administer Chapter 522 of the Texas Transportation Code.

Texas Government Code, §411.004(3) and Texas Transportation Code, §522.005, are affected by this proposal.


(a) The Federal Motor Carrier Safety Administration (FMCSA) is the lead federal agency responsible for regulating states' commercial driver license (CDL) programs and providing safety oversight of commercial driver licensing and commercial motor vehicles (CMV). In accordance with the Federal Commercial Motor Vehicle Safety Act, Texas is mandated to follow all federal regulations governing commercial driver licensing. Failure to adhere to or deviating from these regulations can result in the decertification of Texas' CDL program, thereby prohibiting Texas from issuing commercial driver licenses to Texas residents and the withdrawal of federal highway funding in accordance to 49 CFR §§384.401, 384.403 and 384.405.

(b) All rules and regulations adopted in this chapter apply to every person, including employers of such persons, who holds a Texas CDL [commercial driver license (CDL)] or operates a commercial motor vehicle (CMV) in this state, regardless if they are operating in interstate, foreign, or intrastate commerce.

(1) The department incorporates by reference and adopts:

(A) The Federal Motor Carrier Safety Regulations, Title 49, Code of Federal Regulations (CFR) Part 383 including all interpretations thereto, as amended through May 1, 2018 [March 1, 2016]. Where there is conflict between 49 CFR Part 383 and Texas Transportation Code, Chapter 522, Texas Transportation Code, Chapter 522 controls with the exception of the definition of CMV.

(B) 49 CFR §390.5--Definitions.

(2) The CFR permits states discretion to exempt or not exempt certain individuals from CDL standards, requirements, and penalties. The department, utilizing the discretion permitted by the CFR, does not adopt the CFR exemptions detailed in subparagraph (A) - (C) of this paragraph. [The CFRs detailed in this paragraph are excepted from adoption]:

(A) 49 CFR §383.3(d)--related to drivers employed by a local government for the purpose of removing snow and ice from roadways.

(B) 49 CFR §383.3(c)--related to certain restricted CDL issued in the State of Alaska.

(C) 49 CFR §383.3(g)--related to restricted CDL for certain drivers in the pyrotechnic industry.

(3) The Federal Commercial Motor Vehicle Safety Act and the CFR allows states to enact laws and regulations that are stricter than the federal requirements. The department does not adopt the CFR provisions detailed in subparagraph (A) and subparagraph (B) of this paragraph because Texas has enacted stricter requirements.

(A) 49 CFR §383.31(a)--related to the requirement that a person must notify the department upon conviction for a motor traffic control violation within 30 days after the date the person has been convicted. Texas Transportation Code, Chapter 522 requires the license holder to report the conviction within 7 days.

(B) 49 CFR §383.31(b)--related to the requirement that a person must notify his/her employer upon conviction for a motor traffic control violation within 30 days after the date the person has been convicted. Texas Transportation Code, Chapter 522 requires the license holder to report the conviction within 7 days.

(4) 49 CFR §383.51(c)(9)

(5) 49 CFR §383.153(10)

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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D. Phillip Adkins
General Counsel

Texas Department of Public Safety

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For further information, please call: (512) 424-5848

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CHAPTER 37. SEX OFFENDER REGISTRATION

37 TAC §37.2

The Texas Department of Public Safety (the department) proposes amendments to §37.2, concerning Commercial Social Networking Sites. The proposed amendments clarify the process for creating a user account and update the department’s email address.

Suzy Whittenberg, Chief Financial Officer, has determined that for each year of the first five-year period the rule is in effect there will be no fiscal implications for state or local government, or local economies.

Ms. Whittenberg has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities required to comply with the rule as proposed.
There is no anticipated economic cost to individuals who are required to comply with the rule as proposed. There is no anticipated negative impact on local employment.

In addition, Ms. Whitten has also determined that for each year of the first five-year period the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be publication of the updated method by which social networking sites may request online identifiers from the department relating to persons required to register as sex offenders under Code of Criminal Procedure, Chapter 62, to prescreen or preclude those persons from using the site.

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

The department has determined that Chapter 2007 of the Texas Government Code does not apply to this proposal. Accordingly, the department is not required to complete a takings impact assessment regarding this proposal.

The department prepared a Government Growth Impact Statement assessment for this proposed rulemaking. The proposed rulemaking does not create or eliminate a government program; will not require an increase or decrease in future legislative appropriations to the agency; require the creation of new employee positions nor eliminate current employee positions; nor will it require an increase or decrease in fees paid to the agency. The proposed rulemaking does not create, expand, or limit an existing regulation. The proposed rulemaking does not increase or decrease the number of individuals subject to its applicability. During the first five years the proposed rule is in effect, the proposed rule should not impact positively or negatively the state's economy.

Comments on this proposal may be submitted to Michelle Farris, Crime Records, Texas Department of Public Safety, P.O. Box 4087, Austin, Texas 78752-4143. Comments must be received no later than thirty (30) days from the date of publication of this proposal.

This rule is proposed pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work; and Code of Criminal Procedure, Article 62.0061(b) which authorizes the department to establish a procedure through which a commercial social networking site may request online identifiers, and Code of Criminal Procedure, Article 62.010, which authorizes the department to adopt any rule necessary to implement Code of Criminal Procedure, Chapter 62.

Texas Government Code, §411.004(3) and Code of Criminal Procedure, Article 62.0061(b) and Article 62.010, are affected by this proposal.

§37.2. Commercial Social Networking Sites.

(a) A commercial social networking site may request access to online identifiers maintained by the department under Code of Criminal Procedure, Article 62.051(c)(7).

(b) Requests may be submitted to: Crime Records Service, Attn: Sex Offender Registration Unit, Texas Department of Public Safety, P.O. Box 4143, Austin, Texas 78765-4143; or via e-mail at: txsor@dps.texas.gov [txsor@dps.texas.gov].

(c) Requests for access submitted to the department must contain [the following]:

(1) the name of the commercial social networking site;
(2) the website address of the commercial social networking site;
(3) the name, mailing address, e-mail address of a point of contact for the commercial social networking site;
(4) the state or country where the commercial social networking site's articles of incorporation are filed; and
(5) a statement indicating whether or not a combination of advertising revenue and subscription fees generated by the commercial social networking site is in excess of $10,000 per annum.

(d) The department will determine if a requester of online identifiers meets the definition of provider.

(e) Approved providers will be instructed to create [assigned] a user account and furnished instructions to access public information as defined by Code of Criminal Procedure, Article 62.005(b), and online identifiers maintained by the department under Code of Criminal Procedure, Article 62.051(c)(7).

(f) Information disseminated to the provider by the department is subject to the restrictions outlined by Code of Criminal Procedure, Article 62.0061.

(g) User accounts will be deactivated after six (6) months of inactivity. This does not preclude a provider from requesting reactivation of a user account.

(h) The department reserves the right to terminate a user account for a violation of any statute, administrative rule, or department policy.

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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