

ADOPTED RULES

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES SUBCHAPTER A. COST DETERMINATION PROCESS

1 TAC §355.112

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §355.112, concerning Attendant Compensation Rate Enhancement. Section 355.112 is adopted with changes to the proposed text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3565). This rule will be republished.

BACKGROUND AND PURPOSE

Title 42, Code of Federal Regulations (CFR) §441.301(c)(4)(i) - (v) requires home and community-based settings in programs authorized by §1915(c) of the Social Security Act to have certain qualities, including being integrated into and supporting full access of individuals to the greater community. HHSC adopted rules to implement individualized skills and socialization in the December 23, 2022, issue of the *Texas Register*.

The 2022-2023 General Appropriations Act (GAA), Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 23) authorized funding for the provision of individualized skills and socialization in the Home and Community-based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities (DBMD) programs. HHSC adopted rates for individualized skills and socialization based on the available appropriations, effective January 1, 2023. The amendment replaces day habilitation with individualized skills and socialization services for the Attendant Compensation Rate Enhancement Program.

The amendment clarifies that providers contracted with a managed care organization to provide attendant care services may participate in the Attendant Compensation Rate Enhancement Program through their managed care organizations. The amendment removes references to Community Based Alternatives (CBA)--Assisted Living/Residential Care (AL/RC) and CBA--Home and Community Support Services (HCSS). These programs were carved into managed care in 2015, and HHSC neither enrolls these providers in the Attendant Compensation Rate Enhancement Program nor determines spending requirements associated with the program.

The amendment modifies several aspects of the Attendant Compensation Rate Enhancement Program. The amendment

changes the requirements for participating providers to submit an attendant compensation report for determining spending requirements in the Attendant Compensation Rate Enhancement Program. The amendment clarifies that if providers are required to submit a cost report for a rate year, HHSC will use the cost report as an attendant compensation report. For rate years in which participating providers are not required to submit a cost report, HHSC will require a subset of participating providers to submit an accountability report to serve as an attendant compensation report. These providers will be selected at random from the total number of participating contracts that are not required to submit a cost report for a rate year. The number selected will represent a statistically valid sample of participating providers. The amendment modifies report submission requirements for contracts participating in the Attendant Compensation Rate Enhancement Program undergoing a change of ownership or a contract termination by relaxing the requirement that these providers must submit a report to HHSC. The amendment removes provisions allowing limited providers to submit the request for revision report or request for recalculation while modifying parameters regarding limitations.

The amendment implements some recommendations in HHSC's legislative report, *Rates: Intermediate Care Facilities and Certain Waiver Providers*, required by the 2022-2023 GAA, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 30). The amendment repeals the requirement that an attendant must perform attendant functions at least 80 percent of his or her total time worked to be considered an attendant for determining spending requirements in the Attendant Compensation Rate Enhancement Program or for calculating the attendant compensation rate component. The amendment provides that any staff who performs attendant functions to prevent a break in service will be considered an attendant.

The amendment modifies the methodology HHSC uses to calculate the attendant compensation rate component for each attendant service. HHSC will calculate the attendant compensation rate component by calculating a median of attendant compensation cost center data weighted by each attendant service units of service from the most recent Medicaid cost report database. The attendant compensation cost component will be inflated using HHSC's inflation methodology from the cost reporting period to the prospective rate period and limited to available levels of state and federal appropriations.

COMMENTS

The 21-day comment period ended July 28, 2023.

During this period, HHSC received comments regarding the proposed rule from four commenters, including the following organizations: the Providers Alliance for Community Services of Texas (PACSTX), Private Providers Association of Texas

(PPAT), Texas Association for Home Care & Hospice (TAHC&H), and the Texas Council of Community Centers (Texas Council).

A summary of comments relating to §355.112 and HHSC's responses follow:

Comment: Several commenters expressed support for the definition of attendant in §355.112(c).

Response: HHSC appreciates the supportive comment regarding this proposed change and will adopt this section without changes. No changes were made in response to this comment.

Comment: Several commenters expressed opposition to the amendment to §355.112(m) to limit the attendant compensation rate component to available levels of appropriated state and federal funds as specified in §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid). Commenters are concerned that the amendment changes the rate methodology allowing HHSC to bypass the true costs in the most recent provider cost report to what is adopted by the Legislature. Commenters contend the amendment would give HHSC the ability to abdicate its responsibility as the state's Medicaid agency to inform the Legislature when appropriations fall short in supporting rates that ensure access to care.

Response: HHSC will revise §355.112(m)(4) as it was not the agency's intention to limit the methodological rate component to appropriated levels but rather to emphasize that adopted rates are limited to available appropriations as already specified in §355.201.

Comment: One commenter expressed concerns that the service support portion of the attendant rate has not been upwardly adjusted since 2007, over 16 years. The rate methodology as proposed will prevent adjustment beyond the appropriation allowing the continuation of insufficient funding of service supports and impacting every aspect of operations for community care.

Response: HHSC disagrees, as the methodology related to the service support or administration and operations rate components are outside the scope of the amendment to §355.112. No changes were made in response to this comment.

Comment: Several commenters expressed opposition to removing recoupment recalculations from §355.112(n).

Response: HHSC disagrees and declines to modify the rule because recalculations were a process affiliated with a retired cost report collection system and are no longer used under HHSC's current practices. A provider will still be able to request that HHSC reevaluate recoupment determinations if the provider believes there was an error in the original calculations. Furthermore, a provider can still seek an informal review and provide additional supporting information if the provider believes any revisions made during HHSC's financial examination process were made in error.

Comment: Several commenters expressed opposition to eliminating a limited provider's opportunity to submit a request for revision during the annual open enrollment period for the attendant compensation rate enhancement program.

Response: HHSC disagrees and declines to make any change in response to this comment. The request for revision process allows a provider to overturn the provider's limitation by using unverified data, which could include unallowable costs. The rate enhancement program relies on a limited funding pool. Therefore, the request for revision process may enable a provider who

regularly misses the provider's spending requirements to remain in the program at a higher level and prevents a provider who meets program requirements from the opportunity to obtain a higher enhancement level.

Comment: Several commenters expressed support for new subsection (i)(2), which specifies HHSC will require a subset of participating contracted providers at random to submit an annual attendant compensation report on years a provider does not submit a cost report. It would be helpful for provider associations to know how HHSC plans to implement this provision, including the estimated number of providers HHSC plans to use to establish a statistically valid sample and how HHSC will define a statistically valid sample.

Response: HHSC appreciates the supportive comments. HHSC will engage with stakeholders, including provider associations, regarding how §355.112(i)(2) will be implemented. No changes were made in response to this comment.

Comment: Several commenters expressed support for new subsection (m)(3)(B), which clarifies which services in HCS are subject to the 1.07 inflator. Providers had expressed concerns about the application of a lower inflator for individualized skills and socialization while still maintaining a facility. The proposed subsection appears to remedy those concerns.

Response: HHSC appreciates the supportive comments. HHSC's intention with the amendment to §355.112(m)(3)(B) was to revise the rate methodology for individualized skills and socialization so that the 1.07 factor is applied to both on-site and off-site service rates. No changes were made in response to this comment.

Editorial revisions were made to correct spelling and grammar.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

§355.112. Attendant Compensation Rate Enhancement.

(a) Eligible programs. Providers contracted in the following programs are eligible to participate in the attendant compensation rate enhancement:

- (1) Community Living Assistance and Support Services (CLASS)--Direct Service Agency (DSA);
- (2) Day Activity and Health Services (DAHS);
- (3) Deaf-Blind with Multiple Disabilities Waiver (DBMD);
- (4) Home and Community-based Services (HCS);
- (5) Intermediate Care Facilities for Individuals with Intellectual Disability or Related Conditions (ICF/IID) ("Related Condi-

tions" has the same meaning as in 26 TAC §261.203 (relating to Definitions));

- (6) Primary Home Care (PHC);
- (7) Residential Care (RC); and
- (8) Texas Home Living (TxHmL).

(b) **Managed Care Providers.** A provider contracted with a managed care organization (MCO) to provide attendant care services may participate in any Attendant Compensation Rate Enhancement Program through the MCO with whom it is contracted, as provided by the MCO's managed care contract with HHSC. Each MCO is responsible for managing any Attendant Compensation Rate Enhancement Program for its contracted providers, including provider enrollment and compliance with the program's spending requirements or any spending requirements imposed under state or federal law.

(c) **Definition of attendant.** For the purposes of the Attendant Compensation Rate Enhancement Program under this section, an attendant is an unlicensed caregiver providing direct assistance to individuals with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).

(1) Attendants do not include the director, administrator, assistant director, assistant administrator, clerical and secretarial staff, professional staff, other administrative staff, licensed staff, attendant supervisors, cooks and kitchen staff, maintenance and groundskeeping staff, activity director, DBMD Interveners I, II or III, Qualified Intellectual Disability Professionals (QIDPs) or assistant QIDPs, direct care worker supervisors, direct care trainer supervisors, job coach supervisors, foster care providers, and laundry and housekeeping staff. Staff other than attendants may deliver attendant services and be considered an attendant if they must perform attendant services that cannot be delivered by another attendant to prevent a break in service.

(2) An attendant also includes the following:

(A) a driver who is transporting individuals in the DAHS, ICF/IID, and RC programs and the HCS SL/RSS and HCS and TxHmL individualized skills and socialization settings;

(B) a medication aide in the HCS SL/RSS setting, ICF/IID, and RC programs; and

(C) direct care workers, direct care trainers, job coaches, employment assistance direct care workers, and supported employment direct care workers.

(d) **Attendant compensation cost center.** This cost center will include employee compensation, contract labor costs, and personal vehicle mileage reimbursement for attendants as defined in subsection (c) of this section.

(1) Attendant compensation is the allowable compensation for attendants defined in §355.103(b)(1) of this title (relating to Specifications for Allowable and Unallowable Costs) and required to be reported as either salaries and/or wages, including payroll taxes and workers' compensation, or employee benefits. Benefits required by §355.103(b)(1)(A)(iii) of this title to be reported as costs applicable to specific cost report line items, except as noted in paragraph (3) of this subsection, are not to be included in this cost center. For ICF/IID, attendant compensation is also subject to the requirements detailed in §355.457 of this title (relating to Cost Finding Methodology). For HCS and TxHmL, attendant compensation is also subject to the requirements detailed in §355.722 of this title (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).

(2) Contract labor refers to personnel for whom the contracted provider is not responsible for the payment of payroll taxes, such as FICA, Medicare, and federal and state unemployment insurance, and who perform tasks routinely performed by employees where allowed by program rules.

(3) Mileage reimbursement paid to the attendant for the use of his or her personal vehicle and which is not subject to payroll taxes is considered compensation for this cost center.

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

(f) **Open enrollment.** Open enrollment begins on the first day of July and ends on the last day of that same July preceding the rate year for which payments are being determined. The Texas Health and Human Services Commission (HHSC) notifies providers of open enrollment via email sent to an authorized representative per the signature authority designation form applicable to the provider's contract or ownership type. Requests to modify a provider's enrollment status during an open enrollment period must be received by HHSC by the last day of the open enrollment period through HHSC's enrollment portal or another method designated by HHSC. If the last day of open enrollment is on a weekend day, state holiday, or national holiday, the next business day will be considered the last day requests will be accepted. If open enrollment has been postponed or canceled, HHSC will notify providers by email before the first day of July. Should conditions warrant, HHSC may conduct additional enrollment periods during a rate year.

(g) **Enrollment contract amendment.**

(1) For CLASS--DSA, DBMD, DAHS, RC and PHC, an initial enrollment contract amendment is required from each provider choosing to participate in the attendant compensation rate enhancement. On the initial enrollment contract amendment, the provider must specify for each contract a desire to participate or not to participate and a preferred participation level.

(2) For ICF/IID, HCS and TxHmL, an initial enrollment contract amendment is required from each provider choosing to participate in the attendant compensation rate enhancement. On the initial enrollment contract amendment, the provider must specify for each component code a desire to participate or not to participate and a preferred participation level. All contracts of a component code within a specific program must either participate at the same level or not participate.

(A) For the ICF/IID program, the participating provider must also specify the services the provider wishes to participate in the attendant compensation rate enhancement. Eligible services are residential services and day habilitation services. The participating provider must specify whether the provider wishes to participate for residential services only, day habilitation services only or both residential services and day habilitation services.

(B) For the HCS and TxHmL programs, eligible services are divided into three categories. The three categories of services eligible for rate enhancement are the following:

(i) non-individualized skills and socialization services:

(I) SHL/CFC PAS HAB/CSS;

(II) in-home respite (IHR) and out-of-home respite (OHR);

(III) supported employment (SE); and

(IV) employment assistance (EA);

and (ii) individualized skills and socialization services;

(iii) residential services:

(I) SL; and

(II) RSS.

(C) The participating provider must specify which combination of the three categories of services the attendant compensation rate enhancement will apply to. For providers delivering services in both the HCS and TxHmL programs, the selected categories must be the same for their HCS and TxHmL programs, except for residential services which are only available in the HCS program.

(3) After initial enrollment, participating and nonparticipating providers may request to modify their enrollment status during any open enrollment period as follows:

(A) a nonparticipant can request to become a participant;

(B) a participant can request to become a nonparticipant; or

(C) a participant can request to change its participation level.

(4) Providers whose prior year enrollment was limited by subsection (v) of this section who request to increase their enrollment levels will be limited to increases of three or fewer enhancement levels during the first open enrollment period after the limitation. Providers that were subject to an enrollment limitation may request to participate at any level during open enrollment beginning two years after limitation.

(5) Requests to modify a provider's enrollment status during an open enrollment period must be received by HHSC by the last day of the open enrollment period as per subsection (f) of this section. If the last day of open enrollment is on a weekend day, state holiday, or national holiday, the next business day will be considered the last day requests will be accepted.

(6) For PHC, DAHS, RC, and CLASS--DSA providers from which HHSC has not received an acceptable request to modify their enrollment by the last day of the open enrollment period will continue at the level of participation in effect during the open enrollment period within available funds until the provider notifies HHSC in accordance with subsection (y) of this section that it no longer wishes to participate or until the provider's enrollment is limited in accordance with subsection (v) of this section.

(7) To be acceptable, an enrollment contract amendment must be completed according to instructions, signed by an authorized representative as per HHSC's signature authority designation form applicable to the provider's contract or ownership type, and legible.

(h) Enrollment of new contracts. For the purposes of this section, for each rate year a new contract is defined as a contract or component code whose effective date is on or after the first day of the open enrollment period, as defined in subsection (f) of this section, for that rate year. Contracts that underwent a contract assignment or change of ownership and new contracts that are part of an existing component code are not considered new contracts. For purposes of this subsection, an acceptable contract amendment is defined as a legible enrollment contract amendment that has been completed according to instructions, signed by an authorized representative as per HHSC's signature authority designation form applicable to the provider's contract or ownership type, and received by HHSC within 30 days of notification to the provider that such an enrollment contract amendment must be submitted. If the

30th day is on a weekend day, state holiday, or national holiday, the next business day will be considered the last day requests will be accepted. New contracts will receive the nonparticipant attendant compensation rate as specified in subsection (m) of this section with no enhancements. For new contracts specifying their desire to participate in the attendant compensation rate enhancement on an acceptable enrollment contract amendment, the attendant compensation rate is adjusted as specified in subsection (s) of this section, effective on the first day of the month following receipt by HHSC of an acceptable enrollment contract amendment. If the granting of newly requested enhancements was limited by subsection (q)(2)(B) of this section during the most recent enrollment, enrollment for new contracts will be subject to that same limitation. If the most recent enrollment was canceled by subsection (f) of this section, new contracts will not be permitted to be enrolled.

(i) Attendant Compensation Report.

(1) Definition of Attendant Compensation Report. An attendant compensation report is a report reflecting the provider's activities while delivering contracted services from the first day of the rate year through the last day of the rate year or provider's cost report year while participating in the attendant compensation rate enhancement program. This report is used as the basis for determining compliance with the spending requirements as described in subsection (t) of this section. Cost and accountability reports requested by HHSC are considered attendant compensation reports, and preparers must complete mandatory training requirements per §355.102(d) of this subchapter (relating to General Principles of Allowable and Unallowable Costs).

(2) Providers must file Attendant Compensation Reports as follows. HHSC will require a subset of participating contracted providers to submit an annual Attendant Compensation Report to HHSC in a method specified by HHSC.

(A) Cost reports serving as Attendant Compensation Reports. If HHSC requires a participating provider to file a cost report for a rate year, HHSC will use that provider's cost report as an Attendant Compensation Report as the basis for determining compliance with the spending requirements as described in subsection (t) of this section.

(B) Accountability reports serving as Attendant Compensation Reports. HHSC will require a select number of participating providers who are not required to submit a cost report for a rate year to submit an accountability report, which will serve as an Attendant Compensation Report as the basis for determining compliance with the spending requirements as described in subsection (t) of this section. These providers will be selected at random from the total number of participating contracts that are not required to submit a cost report for a rate year. The number selected must represent a statistically valid sample of participating providers.

(C) The Attendant Compensation Report must be submitted for each participating contract if the provider requested participation individually for each contract; or, if the provider requested participation as a group, the report must be submitted as a single aggregate report covering all contracts participating at the end of the rate year within one program of the provider. A participating contract that has been terminated in accordance with subsection (w) of this section or that has undergone a contract assignment in accordance with subsection (x) of this section will be considered to have participated on an individual basis for compliance with reporting requirements for the owner prior to the termination or contract assignment.

(D) If required to submit a report by HHSC, contracted providers failing to submit an acceptable annual Attendant Compensation Report within 60 days of the end of the rate year will be placed

on vendor hold until such time as an acceptable report is received and processed by HHSC.

(E) When a participating provider changes ownership through a contract assignment, the prior owner may be required to submit an Attendant Compensation Report covering the period from the beginning of the rate year to the effective date of the contract assignment as determined by HHSC, or its designee. If required, this report will be used as the basis for determining any recoupment amounts as described in subsection (t) of this section. The new owner may be required to submit an Attendant Compensation Report covering the period from the day after the date recognized by HHSC, or its designee, as the contract-assignment effective date to the end of the rate year.

(F) Participating providers whose contracts are terminated voluntarily or involuntarily may be required to submit an Attendant Compensation Report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the contract termination date. If required, this report will be used as the basis for determining recoupment as described in subsection (t) of this section.

(G) Participating providers who voluntarily withdraw from participation, as described in subsection (y) of this section, may be required to submit an Attendant Compensation Report within 60 days from the date of withdrawal as determined by HHSC. If required, this report must cover the period from the beginning of the rate year through the date of withdrawal as determined by HHSC and will be used as the basis for determining any recoupment amounts as described in subsection (t) of this section.

(H) Participating providers whose cost report year, as defined in §355.105(b)(5) of this subchapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures), coincides with the state of Texas fiscal year, are exempt from the requirement to submit a separate Attendant Compensation Report. For these contracts, their cost report will be considered their Attendant Compensation Report.

(3) Cost Reports. Cost reports as described in §355.105(b) - (c) of this subchapter will serve as the Attendant Compensation Report with the following exceptions.

(A) When a participating provider changes ownership through a contract assignment or change of ownership, the previous owner may be required to submit an Attendant Compensation Report covering the period from the beginning of the provider's cost reporting period to the date recognized by HHSC, or its designee, as the contract-assignment or ownership-change effective date. If required, this report will be used as the basis for determining any recoupment amounts as described in subsection (t) of this section. The new owner may be required to submit a cost report covering the period from the day after the date recognized by HHSC or its designee as the contract-assignment or ownership-change effective date to the end of the provider's fiscal year.

(B) When one or more contracts or, for the ICF/IID, HCS, and TxHmL programs, component codes of a participating provider are terminated, either voluntarily or involuntarily, the provider may be required to submit an Attendant Compensation Report for the terminated contract(s) or component code(s) covering the period from the beginning of the provider's cost reporting period to the date recognized by HHSC, or its designee, as the contract or component code termination date. This report will be used as the basis for determining any recoupment amounts as described in subsection (t) of this section.

(C) When one or more contracts or, for the ICF/IID, HCS and TxHmL programs, component codes of a participating provider are voluntarily withdrawn from participation as per subsection (y) of this section, the provider may be required to submit an Attendant Compensation Report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the provider's cost reporting period to the date of withdrawal as determined by HHSC. If required, this report will be used as the basis for determining any recoupment amounts as described in subsection (t) of this section. These providers may still be required to submit a cost report covering the entire cost reporting period. The cost report will be used for determining any recoupment amounts.

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

(E) Existing providers who become participants in the enhancement as a result of the open enrollment process described in subsection (f) of this section on any day other than the first day of their fiscal year may be required to submit an Attendant Compensation Report with a reporting period that begins on their first day of participation in the enhancement and ends on the last day of the provider's fiscal year. If required, this report will be used as the basis for determining any recoupment amounts as described in subsection (t) of this section. These providers may still be required to submit a cost report covering the entire cost reporting period. The cost report will be used for determining any recoupment amounts.

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

(4) Other reports. HHSC may require other reports from all contracts as needed.

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

(A) Participating contracts or, for the ICF/IID, HCS and TxHmL programs, component codes may be required to submit an Attendant and Compensation Report. Participating facilities required to submit an Attendant and Compensation Report that do not submit an acceptable report completed in accordance with all applicable rules and instructions within 60 days of the due dates described in this subsection or, for cost reports, the due dates described in §355.105(b) of this subchapter will become nonparticipants retroactive to the first day of the reporting period in question and will be subject to an immediate recoupment of funds related to participation paid to the contractor for services provided during the reporting period in question. These contracts or component codes will remain nonparticipants and recouped funds will not be restored until they submit an acceptable report and repay to HHSC, or its designee, funds identified for recoupment from subsection (t) of this section. If an acceptable report is not received within 365 days of the due date, the recoupment will become permanent and, if all funds associated with participation during the reporting period in question have been recouped by HHSC, or its designee, the vendor hold associated with the report will be released.

(B) Participating contracts or, for the ICF/IID, HCS, and TxHmL programs, component codes that have terminated or undergone a contract assignment or ownership-change from one legal entity

to a different legal entity may be required to submit an Attendant and Compensation Report. Participating facilities required to submit an Attendant and Compensation Report that do not submit an acceptable report completed in accordance with all applicable rules and instructions within 60 days of the contract assignment, ownership-change, or termination effective date will become nonparticipants retroactive to the first day of the reporting period in question. These contracts or component codes will remain nonparticipants, and recouped funds will not be restored until they submit an acceptable report and repay to HHSC, or its designee, funds identified for recoupment under subsection (t) of this section. If an acceptable report is not received within 365 days of the contract assignment, ownership-change, or termination effective date, the recoupment will become permanent and, if all funds associated with participation during the reporting period in question have been recouped by HHSC, or its designee, the vendor hold associated with the report will be released.

(6) Provider-initiated amended Attendant Compensation Reports and cost reports functioning as Attendant Compensation Reports. Reports must be received before the date the provider is notified of compliance with spending requirements for the report in question in accordance with subsection (t) of this section.

(j) Report contents. Each Attendant Compensation Report and cost report functioning as an Attendant Compensation Report will include any information required by HHSC to implement this attendant compensation rate enhancement.

(k) Completion of compensation reports. All Attendant Compensation Reports and cost reports functioning as Attendant Compensation Reports must be completed in accordance with the provisions of §§355.102 - 355.105 of this subchapter (relating to General Principles of Allowable and Unallowable Costs; Specifications for Allowable and Unallowable Costs; Revenues; and General Reporting and Documentation Requirements, Methods, and Procedures) and may be reviewed or audited in accordance with §355.106 of this subchapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). All Attendant Compensation Reports and cost reports functioning as Attendant Compensation Reports must be completed by preparers who have attended the required cost report training for the applicable program under §355.102(d) of this subchapter. For the ICF/IID program, cost reports functioning as Attendant Compensation Reports must also be completed in accordance with the provisions of §355.456 of this chapter (relating to Reimbursement Methodology). For the HCS and TxHmL programs, cost reports functioning as Attendant Compensation Reports must also be completed in accordance with the provisions of §355.722 of this chapter (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).

(l) Enrollment. Providers choosing to participate in the attendant compensation rate enhancement must submit to HHSC a signed enrollment contract amendment as described in subsection (g) of this section. Participation is determined separately for each program specified in subsection (a) of this section, except that for providers delivering both HCS and TxHmL services, participation includes both the HCS and TxHmL programs. For PHC, participation is also determined separately for priority and nonpriority services. For ICF/IID, participation is also determined separately for residential services and day habilitation services. For HCS and TxHmL, participation is also determined separately for the non-individualized skills and socialization services, individualized skills and socialization services, and residential services categories as defined in subsection (g)(2)(B) of this section. Participation will remain in effect, subject to availability of funds, until the provider notifies HHSC, in accordance with subsection (y) of this section, that it no longer wishes to participate or until HHSC excludes the

contract from participation for reasons outlined in subsection (v) of this section. Contracts or component codes voluntarily withdrawing from participation will have their participation end effective with the date of withdrawal as determined by HHSC. Contracts or components codes excluded from participation will have their participation end effective on the date determined by HHSC.

(m) Determination of attendant compensation rate component for nonparticipating contracts.

(1) For CLASS--DSA; DAHS; DBMD; PHC; RC; STAR+PLUS AL; STAR+PLUS HCBS and Non-HCBS programs, HHSC will calculate an attendant compensation rate component for nonparticipating contracts by calculating a median of attendant compensation cost center data as defined in subsection (d) of this section for each applicable attendant service, weighted by the applicable attendant service's units of service from the most recently examined cost report database for each program, and adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 (related to Determination of Inflation Indices).

(A) The weighted median cost component is multiplied by 1.044 for CLASS--DSA, DBMD, PHC, STAR+PLUS HCBS, and Non-HCBS; and by 1.07 for DAHS, RC and STAR+PLUS AL. The result is the attendant compensation rate component for nonparticipating contracts.

(B) If HHSC has insufficient cost data, the attendant compensation rate component will be established through a pro forma costing approach as defined in §355.105(h) of this subchapter.

(2) For ICF/IID DH, ICF/IID residential services, HHSC will calculate an attendant compensation rate component for nonparticipating contracts for each service by calculating a median of attendant compensation cost center data as defined in subsection (d) of this section for each DH and Residential services, weighted by ICF/IID units of service from the most recently examined ICF/IID cost report database, and adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 (related to Determination of Inflation Indices).

(A) The weighted median attendant cost component is adjusted by modeled direct care hours to unit ratios to determine attendant compensation rate components for each level of need (LON).

(B) The weighted median cost component is multiplied by 1.07 for both ICF/IID DH and residential services.

(C) If HHSC has insufficient cost data, the attendant compensation rate component will be established through a pro forma costing analysis as defined in §355.105(h) of this subchapter.

(3) For HCS and TxHmL programs, HHSC will calculate an attendant compensation rate component for nonparticipating contracts for each service by calculating a median of attendant compensation cost center data as defined in subsection (d) of this section for each applicable attendant service, weighted by the applicable attendant service's units of service from the most recently examined HCS/TxHmL cost report database, and adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 (related to Determination of Inflation Indices).

(A) The weighted median cost component is multiplied by 1.044 for the following services:

- (i) EA;
- (ii) IHR;
- (iii) OHR in a camp;

- (iv) OHR in a respite facility;
- (v) OHR in a setting where host home / companion care (HH/CC) is provided;
- (vi) OHR in a setting that is not listed; and
- (vii) SE;

(B) The weighted median cost component is multiplied by 1.07 for the following services:

- (i) individualized skills and socialization services;
- (ii) OHR in an individualized skills and socialization facility;
- (iii) OHR in a setting with SL or RSS is provided;
- (vi) RSS; and
- (v) SL.

(C) For services with rates that are variable by LON as specified in §355.723(b) of this chapter (relating to Reimbursement Methodology for Home and Community-based Services and Texas Home Living Programs), the weighted median attendant cost component is adjusted by modeled direct care hours to unit or direct care staff to individual ratios to determine attendant compensation rate components for each LON.

(D) If HHSC has insufficient cost data, the attendant compensation rate component will be established through a pro forma costing analysis as defined in §355.105(h) of this subchapter.

(4) The adopted attendant compensation rate component for nonparticipating contracts will be limited to available levels of appropriated state and federal funds as specified in §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid).

(n) Determination of attendant compensation base rate for participating contracts. For each of the programs identified in subsection (a) of this section, the attendant compensation base rate is equal to the attendant compensation rate component for nonparticipating contracts from subsection (m) of this section.

(o) Determination of attendant compensation rate enhancements. HHSC will determine a per diem add-on payment for each enhanced attendant compensation level using data from sources such as cost reports, surveys, and/or other relevant sources and taking into consideration quality of care, labor market conditions, economic factors, and budget constraints. The attendant compensation rate enhancement add-ons will be determined on a per-unit-of-service basis applicable to each program or service. Add-on payments may vary by enhancement level.

(p) Enhanced attendant compensation. Contracts or component codes desiring to participate in the enhanced attendant compensation rate may request attendant compensation levels from an array of enhanced attendant compensation options and associated add-on payments determined in subsection (o) of this section during open enrollment.

(1) ICF/IID providers must select a single attendant compensation level for all contracts within a component code for the day habilitation and/or residential services they have selected for participation.

(2) HCS and TxHmL must select a single attendant compensation level for all contracts within a component code for the non-individualized skills and socialization services and/or individualized

skills and socialization services and/or residential services they have selected for participation.

(q) Granting attendant compensation rate enhancements. Eligible programs are divided into two populations for purposes of granting attendant compensation rate enhancements. The first population includes the PHC; DAHS; RC; CLASS--DSA; and DBMD programs, and the second population includes the ICF/IID; HCS; and TxHmL programs. Enhancements for the two populations are funded separately; funds intended for enhancements for the first population of programs will never be used for enhancements for the second population, and funds intended for enhancements for the second population of programs will never be used for enhancements for the first population. For each population of programs, HHSC divides all requested enhancements, after applying any enrollment limitations from subsection (v) of this section, into two groups: pre-existing enhancements, which providers request to carry over from the prior year, and newly-requested enhancements. Newly-requested enhancements may be enhancements requested by providers who were nonparticipants in the prior year or by providers who were participants in the prior year who seek additional enhancements. Using the process described herein separately for each population of programs, HHSC first determines the distribution of carry-over enhancements. If funds are available after the distribution of carry-over enhancements, HHSC determines the distribution of newly-requested enhancements. HHSC may not distribute newly-requested enhancements to providers owing funds identified for recoupment under subsection (t) of this section.

(1) For all programs and levels, HHSC determines projected units of service for contracts and/or component codes requesting each enhancement level and multiplies this number by the enhancement rate add-on amount associated with that enhancement level as determined in subsection (o) of this section.

(2) HHSC compares the sum of the products from paragraph (1) of this subsection to available funds.

(A) If the sum of the products is less than or equal to available funds, all requested enhancements are granted.

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

(r) Notification of granting of enhancements. Participating contracts and component codes are notified, in a manner determined by HHSC, as to the disposition of their request for attendant compensation rate enhancements.

(s) Total attendant compensation rate for participating providers. Each participating provider's total attendant compensation rate will be equal to the attendant compensation base rate from subsection (n) of this section plus any add-on payments associated with enhanced attendant compensation levels selected by and awarded to the provider during open enrollment.

(t) Spending requirements for participating contracts and component codes. HHSC will determine from the Attendant Compensation Report or cost report functioning as an Attendant Compensation Report, as specified in subsection (i) of this section and other appropriate data sources, the amount of attendant compensation spending per unit of service delivered. The provider's compliance with the spending requirement is determined based on the total attendant compensation spending as reported on the Attendant Compensation Report or cost

report functioning as an Attendant Compensation Report for each participating contract or component code. Compliance with the spending requirement is determined separately for each program specified in subsection (a) of this section, except for providers delivering services in both the HCS and TxHmL programs whose compliance is determined by combining both programs. HHSC will calculate recoupment, if any, as follows.

(1) The accrued attendant compensation revenue per unit of service is multiplied by 0.90 to determine the spending requirement per unit of service. The accrued attendant compensation spending per unit of service will be subtracted from the spending requirement per unit of service to determine the amount to be recouped. If the accrued attendant compensation spending per unit of service is greater than or equal to the spending requirement per unit of service, there is no recoupment.

(2) The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracts or component codes in subsection (k) of this section.

(3) In cases where more than one enhancement level is in effect during the reporting period, the spending requirement will be based on the weighted average enhancement level in effect during the reporting period calculated as follows.

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

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

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

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

(u) Notification of recoupment. The estimated amount to be recouped is indicated in the State of Texas Automated Information Reporting System (STAIRS), the online application for submitting cost reports and Attendant Compensation reports. STAIRS will generate an email to the entity contact, indicating that the provider's estimated recoupment is available for review. The entity contact is the provider's authorized representative per the signature authority designation form applicable to the provider's contract or ownership type. If a subsequent review by HHSC or audit results in adjustments to the Attendant Compensation Report or cost reporting, as described in subsection (i) of this section, that change the amount to be repaid, the provider will be notified by email to the entity contact that the adjustments and the adjusted amount to be repaid are available in STAIRS for review. HHSC, or its designee, will recoup any amount owed from a provider's vendor payment(s) following the date of the initial or subsequent notification. For the HCS and TxHmL programs, if HHSC, or its designee, is unable to recoup owed funds in an automated fashion, the requirements detailed under subsection (dd) of this section apply.

(v) Enrollment limitations. A provider will not be enrolled in the attendant compensation rate enhancement at a level higher than the level it achieved on its most recently available audited Attendant Compensation Report or cost report functioning as an Attendant Compensation Report. HHSC will notify a provider of its enrollment limitations

after HHSC has completed a financial examination of the report in accordance with §355.106 of this title (concerning Basic Objectives and Criteria for Audit and Desk Review of Cost Reports).

(1) Notification of enrollment limitations. The enrollment limitation level is indicated in STAIRS. STAIRS will generate an e-mail to the entity contact, indicating that the provider's enrollment limitation level is available for review.

(2) Informal reviews and formal appeals. The filing of a request for an informal review or formal appeal relating to a provider's most recently available audited Attendant Compensation Report or cost report functioning as an Attendant Compensation Report under §355.110 of this title (relating to Informal Reviews and Formal Appeals) does not stay or delay implementation of an enrollment limitation applied in accordance with the requirements of this subsection. If an informal review or formal appeal relating to a provider's most recently available audited Attendant Compensation Report or cost report functioning as an Attendant Compensation Report is pending at the time the enrollment limitation is applied, the result of the informal review or formal appeal shall be applied to the provider's enrollment retroactively to the beginning of the rate year to which the enrollment limitation was originally applied.

(3) New owners after a contract assignment or change of ownership that is an ownership change from one legal entity to a different legal entity. Enhancement levels for a new owner after a contract assignment or change of ownership that is an ownership change from one legal entity to a different legal entity will be determined in accordance with subsection (i) of this section. A new owner after a contract assignment or change of ownership that is an ownership-change from one legal entity to a different legal entity will not be subject to enrollment limitations based upon the prior owner's performance.

(4) New providers. A new provider's enrollment will be determined in accordance with subsection (h) of this section.

(w) Contract terminations. For contracted providers or component codes required to submit an Attendant Compensation Report due to a termination as described in subsection (i) of this section, HHSC, or its designee, will place a vendor hold on the payments of the contracted provider until HHSC receives an acceptable Attendant Compensation Report, as specified in subsection (i) of this section, and funds identified for recoupment from subsection (t) of this section are repaid to HHSC or its designee. Informal reviews and formal appeals relating to these reports are governed by §355.110 of this title. HHSC, or its designee, will recoup any amount owed from the provider's vendor payments that are being held. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (dd) of this section will be jointly and severally liable for any additional payment due to HHSC or its designee. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in the recoupment of the owed funds from other HHSC contracts controlled by the responsible entity, placement of a vendor hold on all HHSC contracts controlled by the responsible entity, and will bar the responsible entity from enacting new contracts with HHSC until repayment is made in full. The responsible entity for these contracts will be notified as described in subsection (u) of this section prior to the recoupment of owed funds, placement of vendor hold on additional contracts, and barring of new contracts.

(x) Contract assignments. The following applies to contract assignments.

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

(A) Assignee--A legal entity that assumes a Community Care contract through a legal assignment of the contract from the contracting entity as provided in 40 TAC §49.210 (relating to Contractor Change of Ownership or Legal Entity).

(B) Assignor--A legal entity that assigns its Community Care contract to another legal entity as provided in 40 TAC §49.210.

(C) Contract assignment--The transfer of a contract by one legal entity to another legal entity as provided in 40 TAC §49.210.

(i) Type One Contract Assignment--A contract assignment by which the assignee is an existing Community Care contract.

(ii) Type Two Contract Assignment--A contract assignment by which the assignee is a new Community Care contract.

(2) Participation after a contract assignment. Participation after a contract assignment is determined as follows:

(A) Type One Contract Assignments. For Type One contract assignments, the assignee's level of participation remains the same while the assignor's level of participation changes to the assignee's.

(B) Type Two Contract Assignments. For Type Two contract assignments, the level of participation of the assignor contract(s) will continue unchanged under the assignee contract(s).

(3) Reporting requirements. The assignee is responsible for the reporting requirements in subsection (i) of this section for any reporting period days occurring after the contract assignment effective date. If the contract assignment occurs during an open enrollment period as defined in subsection (f) of this section, the owner recognized by HHSC, or its designee, on the last day of the enrollment period may request to modify the enrollment status of the contract in accordance with subsection (g) of this section.

(4) Vendor holds. For contracted providers required to submit an Attendant Compensation Report due to contract assignment, as described in subsection (i) of this section, HHSC, or its designee, will place a vendor hold on the payments of the existing contracted provider until HHSC receives an acceptable Attendant Compensation Report, as specified in subsection (i) of this section, and until funds identified for recoupment from subsection (t) of this section are repaid to HHSC or its designee. HHSC, or its designee, will recoup any amount owed from the provider's vendor payments that are being held. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (dd) of this section will be jointly and severally liable for any additional payment due to HHSC or its designee. Failure to repay the amount due within 60 days of notification will result in the recoupment of the owed funds from other HHSC contracts controlled by the responsible entity, placement of a vendor hold on all HHSC contracts controlled by the responsible entity, and will bar the responsible entity from enacting new contracts with HHSC until repayment is made in full. The responsible entity for these contracts will be notified, as described in subsection (u) of this section, prior to the recoupment of owed funds, placement of vendor hold on additional contracts, and barring of new contract.

(y) Voluntary withdrawal. Participating contracts or component codes wishing to withdraw from the attendant compensation rate enhancement must notify HHSC in writing by certified mail and the request must be signed by an authorized representative as designated per the HHSC signature authority designation form applicable to the provider's contract or ownership type. The requests will be effective the first of the month following the receipt of the request. Contracts or component codes voluntarily withdrawing must remain nonpartici-

pants for the remainder of the rate year. Providers whose contracts are participating as part of a component code must request withdrawal of all the contracts in the component code.

(z) Adjusting attendant compensation requirements. Providers that determine that they will not be able to meet their attendant compensation requirements may request to reduce their attendant compensation requirements and associated enhancement payment to a lower participation level by submitting a written request to HHSC by certified mail, and the request must be signed by an authorized representative as designated per the HHSC signature authority designation form applicable to the provider's contract or ownership type. These requests will be effective the first of the month following the receipt of the request. Providers whose contracts are participating as part of a component code must request the same reduction for all of the contracts in the component code.

(aa) All other rate components. All other rate components will continue to be calculated as specified in the program-specific reimbursement methodology and will be uniform for all providers.

(bb) Failure to document spending. Undocumented attendant compensation expenses will be disallowed and will not be used in the determination of the attendant compensation spending per unit of service in subsection (t) of this section.

(cc) Appeals. Subject matter of informal reviews and formal appeals is limited as per §355.110 of this title.

(dd) Responsible entities. The contracted provider, owner, or legal entity which received the attendant compensation rate enhancement is responsible for the repayment of the recoupment amount.

(1) HCS and TxHmL providers required to repay enhancement funds will be jointly and severally liable for any repayment.

(2) Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in placement of a vendor hold on all HHSC contracts controlled by the responsible entity.

(ee) Manual Repayment. For the HCS and TxHmL programs, if HHSC, or its designee, is unable to recoup owed funds using an automated system, providers will be required to repay some or all of the enhancement funds to be recouped through a check, money order, or other non-automated method. Providers will be required to submit the required repayment amount within 60 days of notification.

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

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

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

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

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

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

(2) Aggregation. For an entity, for two or more commonly owned corporations, or for a combined entity that controls more than

one participating contract or component code in a program (with HCS and TxHmL considered a single program), compliance with the spending requirements detailed in subsection (t) of this section can be determined in the aggregate for all participating contracts or component codes in the program controlled by the entity, commonly owned corporations, or combined entity at the end of the rate year, the effective date of the change of ownership of its last participating contract or component code in the program, or the effective date of the termination of its last participating contract or component code in the program rather than requiring each contract or component code to meet its spending requirement individually. Corporations that do not meet the definitions under paragraph (1)(A) - (C) of this subsection are not eligible for aggregation to meet spending requirements.

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

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

(C) **Ownership changes or terminations.** For the ICF/IID, HCS, TxHmL, DAHS, RC, and DBMD programs, contracts or component codes that change ownership or terminate effective after the end of the applicable reporting period, but prior to the determination of compliance with spending requirements as per subsection (t) of this section, are excluded from all aggregate spending calculations. These contracts' or component codes' compliance with spending requirements will be determined on an individual basis, and the costs and revenues will not be included in the aggregate spending calculation.

(gg) **Conditions of participation for ICF/IID day habilitation and HCS/TxHmL individualized skills and socialization services.** The following conditions of participation apply to each ICF/IID, HCS, and TxHmL provider specifying its wish to have day habilitation services or individualized skills and socialization services participate in the attendant compensation rate enhancement.

(1) A provider who provides day habilitation or individualized skills and socialization services in-house or who contracts with a related party to provide day habilitation or individualized skills and socialization services will report job trainer and job coach compensation and hours on the required cost report items (e.g., hours, salaries and wages, payroll taxes, employee benefits/insurance/workers' compensation, contract labor costs, and personal vehicle mileage reimbursement). Day habilitation costs cannot be combined and reported in one cost report item.

(2) A provider who contracts with a non-related party to provide day habilitation or individualized skills and socialization services will report its payments to the contractor in a single cost report item as directed in the instructions for the cost report or Attendant Compensation Report as described in subsection (i)(3) and (4) of this section. HHSC will allocate 50 percent of reported payments to the attendant compensation cost area for inclusion with other allowable day habilitation or individualized skills and socialization services attendant costs in order to determine the total attendant compensation spending for day habilitation or individualized skills and socialization services as described in subsection (t) of this section.

(3) The provider must ensure access to any and all records necessary to verify information submitted to HHSC on Attendant Compensation Reports and cost reports functioning as an Attendant Compensation Report.

(4) HHSC will require each ICF/IID, HCS, and TxHmL provider specifying their wish to have day habilitation or individualized skills and socialization services participate in the attendant compensation rate enhancement to certify during the enrollment process that it will comply with the requirements of paragraphs (1) - (3) of this subsection.

(hh) **New contracts within existing component codes.** For ICF/IID, HCS, and TxHmL, new contracts within existing component codes will be assigned a level of participation equal to the existing component code's level of participation effective on the start date of the contract as recognized by HHSC or its designee.

(ii) **Disclaimer.** Nothing in these rules should be construed as preventing providers from compensating attendants at a level above that funded by the enhanced attendant compensation rate.

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

Filed with the Office of the Secretary of State on August 9, 2023.

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For further information, please call: (512) 867-7817



SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §355.304, §355.308

The Texas Health and Human Services Commission (HHSC) adopts new rule §355.304, concerning Direct Care Staff Spending Requirement on or after September 1, 2023, and an amendment to §355.308, concerning Direct Care Staff Rate Component. Section 355.304 and §355.308 are adopted with changes to the proposed text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3577). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the adoption is to implement the 2024-25 General Appropriations Act (GAA), House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 24). Rider 24 provides appropriations for rate increases for nursing facilities. Nursing facilities must report to HHSC on their biennial cost report information regarding the use of these funds, including information related to efforts to improve or maintain client care and quality of services, and to demonstrate that at least 90 percent of the funds were expended for the purpose of direct care staff wages or benefits. This new rule operationalizes the rider requirements to enable nursing facilities to receive increased reimbursement rates. The adoption also amends §355.308, related to the Direct Care Staff Rate Component.

HHSC is modifying the adopted amendments to lower the benchmark for the base rate calculation as described in detail in the comments and response summary section below. HHSC is modifying the adopted rule to reflect a 70 percent threshold for the direct care base rate spending floor instead of the 90 percent in the original proposal. Furthermore, HHSC is lowering the spending requirement in the direct care staff enhancement program by changing the direct care spending floor to 70 percent of direct care revenues from the current 85 percent requirement. HHSC is making this change upon adoption to align spending requirements related to the direct care rate increases in new §355.304 and the direct care staff enhancement program in §355.308.

The amendment to §355.308 maintains the deleted provisions related to request for revision report, the request for recalculation, and references to reinvestment.

COMMENTS

The 21-day comment period ended July 28, 2023.

During this period, HHSC received comments regarding the proposed rules from approximately 400 commenters from the following organizations: Amarillo Center for Skilled Care; Amistad Nursing & Rehabilitation Center; Arbor Hills Rehabilitation and Healthcare Center; Beaumont Nursing and Rehab; Beaumont Nursing and Rehabilitation; Belterra Health & Rehabilitation Center; Bertram Nursing Home & Rehabilitation Center; Big Spring Center For Skilled Care; Bluebonnet Nursing and Rehabilitation; Brazos Healthcare Center; Bremond Nursing & Rehab Center; Brenham Nursing & Rehabilitation Center; Brentwood Terrace Nursing and Rehabilitation Center; Briarcliff Skilled Nursing Facility; Bridgecrest Rehabilitation Suites; Broadmoor Medical Lodge; Brodie Ranch Nursing & Rehabilitation Center; Brownfield Rehabilitation and Care Center; Brownwood Nursing & Rehabilitation; Buena Vida Nursing and Rehabilitation Center; Canton Oaks; Caprock Healthcare; Care Inn of La Grange; Castle Pines Health and Rehabilitation; Cedar Creek Nursing and Rehabilitation Center; Cherokee Rose Nursing and Rehabilitation; Christian Care Center; Cityview Nursing & Rehabilitation Center; Coalition of Independent Nursing Home Providers; Concho Health & Rehabilitation Center; Country View Nursing and Rehabilitation; Crestview Healthcare Residence; Crimson Heights Health and Wellness; Cross Timbers Rehabilitation & Healthcare Center; Crossroads Nursing and Rehabilitation; De Leon Nursing and Rehabilitation Center; Decatur Medical Lodge; Devine Health and Rehabilitation; Diamond Care Health Services; Duncanville Healthcare and Rehabilitation Center; Eagle Pass Nursing & Rehabilitation; Emerald Hills Rehabilitation and Healthcare Center; Ensign Services, Inc.; Five Points Nursing and Rehabilitation; Five Points-DeSoto; Flatonia Healthcare Center; Fortress Nursing and Rehabilitation; Franklin Nursing Home; Georgia Manor Nursing and Rehabilitation; Graham Oaks Care Center; Granbury Care Center; Grapevine Medical Lodge; Greenbrier Healthcare Center; Greenbrier Nursing & Rehabilitation Center; Greenhill Villas; Groveton Nursing Home; Hays Nursing and Rehabilitation Center; Health Services Management; Heritage at Longview; Heritage at Turner Park Nursing & Rehab; Heritage House Nursing and Rehabilitation; Heritage Place; Hillside Heights Rehabilitation; HMG Healthcare, LLC; Holiday Nursing & Rehab; Homestead of Sherman Nursing & Rehab; Huebner Creek Health and Rehabilitation Center; Human Resource Coordinator; Human Resource of River City Care Center; Keeneland Nursing & Rehabilitation; Kemp Care Center; Kerens Care Center; Kingsland Hills Care Center; Leading Age of Texas, La

Hacienda de Paz Rehab & Care Center; La Vida Serena Nursing & Rehabilitation; Labahia Nursing and Rehabilitation Center; Lake Hills Healthcare; Lake Lodge Nursing & Rehabilitation; Lakeview Rehab & Healthcare Center; Lampstand Nursing and Rehabilitation; Las Ventanas de Socorro; Leading Age of Texas; Longmeadow Healthcare Center; Lubbock Health Care Center; M Chest Pharmacies; Madisonville Care Center; Mansfield Medical Lodge; Marbridge Villa; Marine Creek Nursing & Rehabilitation; Matagorda Nursing and Rehabilitation Center; McLean Care Center; Memphis Convalescent Center; Mesa Vista Health; Mission Ridge Rehabilitation & Nursing Center; Mission Valley Nursing and Transitional Care; Mountain View Health and Rehabilitation; Navasota Nursing and Rehabilitation; Nexion Health; Normandy Terrace Healthcare & Rehabilitation; North Las Vegas Care Center; North Park Health and Rehabilitation Center; Northeast Rehabilitation and Healthcare Center; Northgate Health and Rehabilitation Center; NorthStar Ranch; Oakmont Healthcare & Rehabilitation; Oasis Nursing & Rehabilitation Center; Paradigm at Kountze; Paradigm at the Prairies; Paradigm Health Care Services; Park Highlands Nursing & Rehabilitation; Peach Tree Place; Pecan Creek Healthcare; Pecan Manor Nursing & Rehabilitation; Pine Tree Lodge; Pleasant Springs Healthcare; Port Lavaca Nursing & Rehabilitation Center; Priority Management Group; Providence Park Rehabilitation and Skilled Nursing; Regency Integrated Health Services; Regency Integrated Healthcare; Renaissance Rehabilitation and Healthcare Center; Reunion Plaza Skilled Nursing; Ridgmar Medical Lodge; River City Care Center; Robstown Nursing & Rehabilitation; Rock Creek Health and Rehabilitation; San Pedro Manor; San Saba Rehabilitation and Nursing; Sandy Lake Rehabilitation & Care Center; Seven Oaks; Shady Oak Nursing and Rehabilitation Center; Shiner Nursing and Rehabilitation Center; Sienna Nursing and Rehabilitation; Skilled Care of Mexia; Slaton Care Center; Solidago Health & Rehabilitation; South Place Rehabilitation & Skilled Nursing; Spanish Hills Wellness Suites; Sterling Oaks Rehabilitation; Stonegate Senior Living; Summit LTC Management; Summit Nursing & Rehab of San Augustine; Sunflower Park Healthcare; Sunrise Nursing & Rehab Center; Terra Bella Health and Wellness; Texas Healthcare Association; Texoma Healthcare Center; The Arbors Healthcare and Rehabilitation; The Atrium of Bellmead; The Brazos of Waco; The Courtyards at Pasadena; The Hills Nursing and Rehabilitation; The Meadows Health & Rehabilitation Center; The Park in Plano; The Pavilion at Creekwood; The Rehabilitation & Wellness Centre of Dallas, LLC; The Rio at Mission Trails; Touchstone Communities; Treemont Healthcare; Trinity Healthcare, LLC; Twilight Home Nursing & Rehabilitation; Twin Oaks Nursing & Rehabilitation Center; Twin Pines North Nursing and Rehabilitation; Vidor Health and Rehabilitation; Villa Haven Health and Rehabilitation; Villa Residential Care of Wolfforth; Village Creek Rehabilitation & Nursing Center; Walnut Springs Health & Rehabilitation; Weatherford Healthcare Center; Wellington Care Center; Westward Trails Nursing and Rehabilitation; Whispering Pines Lodge; Willow Springs Health & Rehabilitation; Windsor Arbor View; Windsor Calallen; Windsor Nursing and Rehabilitation Center.

A summary of comments relating to §355.304 and HHSC's responses follows:

Comment: Several commenters expressed opposition to the direct care staff base rate spending floor as proposed in the rule. Commenters expressed concerns about setting a spending threshold on the direct care component of the rate, as none exists today nor is required, but recognized the need for a

benchmark to compare the rate increase to ensure that 90 percent is spent on wages. Commenters said this benchmark should be noted as only a measurement tool, and no higher than 70 percent. One commenter suggested a benchmark of 65 percent.

Response: HHSC agrees to modify the spending requirement such that the direct care staff base rate spending floor in §355.304(e)(1) will be calculated as 70 percent of the Medicaid fee-for-service and managed care revenues proportional to the direct care base rates in effect on August 31, 2023. HHSC made a clarifying modification to §355.304(e)(3) so that it clarifies a provider will be held to 90 percent of revenues proportional to the direct care rate increases effective on September 1, 2023.

Comment: Several commenters asked to modify the definition of responsible entity in §355.304(b)(4) to not include "new owner following a change of ownership."

Response: HHSC agrees and made the change. HHSC's current processes ensures the responsible entity (the contracted provider, owner, or legal entity that received the revenue) is required to submit a report to "demonstrate that at least 90 percent of the funds were expended for the purpose of direct care staff wages or benefits" and the funds will be recouped from the responsible entity who does not utilize the funds in accordance with Rider 24.

Comment: Multiple commenters expressed that the spending requirement in the proposed rule is beyond the scope of Rider 24 and has no legislative basis.

Response: HHSC disagrees and declines to make the change. Holding providers to a base rate spending floor is necessary to meet the Rider's intention that HHSC "shall only expend funds...to provider reimbursement rate increases in a manner that will increase the wages and benefits of direct care staff" and that "at least 90 percent of the funds are expended for the benefit of direct care staff wages." A base rate spending floor establishes a baseline comparison of direct care expenditures and revenue that allows HHSC to understand the proportion of expenditures spent on direct care using the revenue associated with the direct care rate component in effect on August 31, 2023. Calculation of the direct care spending floor allows HHSC to evaluate whether providers increased their direct spending using the revenue associated with the direct care rate increases implemented on September 1, 2023, relative to the expenditures already being spent on direct care using the revenue from the direct care rate component prior to the increase.

Comment: Multiple commenters stated the rule contemplates a recoupment process, but Rider 24 simply has a biennial reporting requirement for facilities. Commenters say the recoupment process described in §355.304(e) was not contemplated by the Legislature.

Response: Rider 24 directs HHSC to "implement the rate increases in a manner that will enable HHSC to ensure that at least 90 percent of the funds are expended for the benefit of direct care staff wages and benefits and shall return to the Comptroller of Public Accounts any amount recouped from a provider who does not utilize the funds in accordance with that purpose." The Rider also provides that the providers will submit biennial cost reports "to demonstrate that at least 90 percent of the funds were expended for the purpose of direct care staff wages or benefits." From these two sentences in the Rider, HHSC understands the legislature's intent to be that HHSC shall recoup funds from any

provider who fails to meet spending to support direct care staff. No changes were made in response to this comment.

Comment: One commenter encourages HHSC to clarify requirements in §355.304(h) regarding the responsibilities of the prior and new owners when a facility undergoes a change of ownership.

Response: HHSC agrees and modified §355.304(h) to clarify the prior owner must submit a report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the ownership-change effective date to meet reporting requirements under subsection (f) of this section, and the new owner is responsible for the reporting requirements for any reporting period days after the change of ownership effective date to the end of the rate year.

Comment: One commenter appreciates the inclusion of an aggregation component under §355.304(j) but is concerned that the spending requirement does not take into account regional cost variation and will require providers to shift spending to direct care from non-direct care costs. The commenter encourages HHSC to provide facility-specific individual detail spending performance to providers to allow them to make adjustments at the facility level if requirements are not met.

Response: Each combined entity or corporation owning multiple facilities may choose to aggregate their spending across multiple facilities within an entity for the purpose of meeting spending requirements in §355.304. HHSC will provide worksheets that allow a provider to calculate anticipated expenditures and revenue so the provider can ensure compliance with the spending requirements in the rule. HHSC acknowledges that some providers may need to adjust their spending to meet the rule requirements but believes these requirements are necessary to ensure Rider 24 appropriations are spent for the benefit of direct care staff compensation. No changes were made in response to this comment.

Comment: One commenter reiterated concerns provided during the public rate hearing on July 11, 2023, regarding the allocation of the appropriations provided under Rider 24 to the direct care rate component for each RUG group will result in a loss of total base rate reimbursement for certain facilities compared to the total base rate for each RUG group in effect on August 31, 2023, plus the \$19.63 add-on.

Response: HHSC appreciates the comment related to the proposed rate increase. However, the rate adoption process for nursing facility rates proposed to be effective on September 1, 2023, is outside the scope of this rule proposal. No changes were made in response to this comment.

Comment: One commenter encourages HHSC to amend the rule to clarify that there is no requirement to meet the direct care base rate spending floor in subsection §355.304(e)(2), and that there is no penalty for not meeting the direct care base rate spending floor. Rather, the comments contends the direct care base rate spending floor is only established to calculate the direct care spending floor as described in §355.304(e)(3).

Response: HHSC disagrees and declines to make the change. The language in §355.304(e)(2) specifies there will be no recoupment associated with failure to meet the direct care base rate spending floor. Moreover, §355.304(e)(5) reiterates that at no time will HHSC recoup more than the rate increases established under this section.

Comment: One commenter encouraged HHSC to mitigate administrative burden when developing new reporting requirements and expressed appreciation for using existing reports to evaluate compliance.

Response: HHSC will seek to mitigate the administrative burden on providers as much as feasible in the implementation of this rule. No changes were made in response to this comment.

Comment: One commenter indicated references in §355.304(g)(1) incorrectly reference subsection (d) and subsection (e) instead of subsection (e) and subsection (f).

Response: HHSC agrees and will make the change.

A summary of comments relating to §355.308 and HHSC's responses follows:

Comment: Several commenters expressed opposition to increasing the direct care staff spending requirements in §355.308(o) to 90 percent as proposed but are supportive of a threshold of no higher than 70 percent. One commenter encourages HHSC to maintain the requirement at 85 percent.

Response: HHSC agrees to reduce the spending requirement in the Direct Care Staff Enhancement Program as specified in 355.308(o) from 85 percent to 70 percent to align the spending requirements in both §355.304 and §355.308 and reduce provider confusion and enhance compliance.

Comment: Several commenters oppose calculating the direct care base rate for staff enhancement using the most recent cost reports. Commenters say calculating the direct care base rate for staff enhancement using the most recent cost reports, and inflating by 1.07, will create a misalignment with the direct care rate used for staff enhancement versus the direct care rate component to be paid. If this is used for each new cost report without increased appropriations, commenters say the spending required to qualify for staff enhancement will become more and more difficult to meet.

Response: HHSC disagrees and declines to make a change. Section 355.308(k) provides the methodology for the methodological base rate and does not impact current rates being paid or appropriation levels to support the program. The current methodology references an initial database from the 2000 cost report. The proposed language replaces the reference from the 2000 cost report to the most recently audited database to better reflect providers' current costs when rebasing the methodological rate.

Comment: Several commenters expressed opposition to eliminating a limited provider's opportunity to submit a request for revision during the annual open enrollment period for the direct care staff enhancement program.

Response: HHSC disagrees and declines to make the change. The request for revision process allows a provider to overturn the provider's limitations by using unverified data, which could include unallowable costs. Because the rate enhancement program relies on a limited funding pool, the request for revision process enables a provider who regularly misses the provider's spending requirements to remain in the program and prevents a provider who meets program requirements from the opportunity to obtain a higher enhancement level.

STATUTORY AUTHORITY

The amendment and new section are adopted under Texas Government Code §531.033, which authorizes the Executive Com-

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

§355.304. Direct Care Staff Spending Requirement on or after September 1, 2023.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to establish rate increases to the direct care staff component base rate for nursing facility services while limiting the use of funds received by the provider through these increases. This section describes the spending requirements associated with receiving the rate increases and circumstances in which recoupments will be necessary for a provider's failure to meet those requirements.

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

(1) Direct care staff base rate--The direct care staff base rate is calculated in accordance with §355.308(k) of this chapter (relating to Direct Care Staff Rate Component).

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

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

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

(c) Eligibility. To receive and retain rate increases under this section, the provider must be contracted with HHSC or a managed care organization (MCO) to provide nursing facility services through the Medicaid program.

(d) Direct Care Staff Base Rate Increase. Effective September 1, 2023, HHSC will increase the direct care staff base rate for nursing facility services for each Resource Utilization Group (RUG), Version III (RUG-III) case-mix group by an amount that is proportional to the level of the direct care staff base rate for each RUG-III case-mix group in effect on August 31, 2023. The direct care staff base rate increases will be limited to available state and federal appropriated amounts provided for the direct care base rate increase. The direct care rate increase will be applied proportionally to the level of each nursing component payer group under the Texas-specific patient driven payment methodology once that methodology is implemented.

(e) Spending Requirements for providers. Providers are subject to a direct care staff cost center spending requirement with recoupment calculated as follows.

(1) At the end of the rate year, HHSC will calculate a direct care staff base rate spending floor by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues proportional to the direct care base rates effective on August 31, 2023 by 0.70, for each provider.

(2) Accrued allowable Medicaid direct care staff expenses for the rate year will be compared to the base rate spending floor from paragraph (1) of this subsection. If the base rate spending floor is less than the accrued allowable Medicaid direct care staff expenses, HHSC or its designee will notify the provider as specified in subsection (g) of this section. There will be no recoupment associated with a provider's failure to meet the direct care base rate spending floor specified in this paragraph.

(3) At the end of the rate year, HHSC will calculate the direct care spending floor by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues proportional to the direct care staff rate increases specified under subsection (d) of this section by 0.90 and the direct care staff base rate spending floor as specified in paragraph (1) of this subsection.

(4) Accrued allowable Medicaid direct care staff expenses for the rate year will be compared to the total direct care staff spending floor from paragraph (3) of this subsection. If the direct care spending floor is less than the accrued allowable Medicaid direct care staff expenses, HHSC or its designee will recoup the difference between the direct care spending floor and the accrued allowable Medicaid direct care staff expenses from providers whose Medicaid direct care staff spending is less than their direct care spending floor.

(5) At no time will a provider's direct care rates after recoupment be less than the direct care base rates in effect prior to the direct care staff base rate increase established under this section.

(6) For participants in the direct care staff enhancement program, HHSC will calculate spending requirement as specified under §355.308 of this subchapter.

(f) Reporting Requirements. Providers receiving the direct care rate increases established under this section must report their direct care revenues and spending to HHSC or its designee in a manner and frequency prescribed by HHSC. HHSC will use cost reports or staffing and compensation reports (accountability reports) requested to comply with the direct care staff enhancement program as specified in §355.308 of this subchapter to meet the requirements of this section if applicable. Providers must also report information related to the use of funds, including information related to efforts to improve or maintain client care and quality of services on their biennial cost reports, as specified by HHSC. All reports must be completed in accordance with the provisions of §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs), §355.103 of this chapter (relating to Specifications for Allowable and Unallowable Costs), §355.104 of this chapter (relating to Revenues), and §355.105 of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures) and may be reviewed or audited in accordance with §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). All reports must be completed by preparers who have attended the required nursing facility cost report training, as per §355.102(d) of this chapter.

(g) Notification of recoupment, appeals, and repayment requirements.

(1) The estimated amount to be recouped for a provider's failure to meet spending requirements as specified under subsection (e) of this section will be indicated in the State of Texas Automated Information and Reporting System (STAIRS) or successor system. STAIRS will generate an email to the entity contact, indicating that the facility's estimated recoupment is available for review. If a subsequent review by HHSC results in additional adjustments to the report, as described in subsection (f) of this section, that results in a revised recoupment amount, HHSC will notify the provider's entity contact via email of

both the report adjustments and revised recoupment amount are available in STAIRS for review.

(2) Informal reviews and formal appeals relating to these reporting requirements in subsection (f) of this section are governed by §355.110 of this chapter (relating to Informal Reviews and Formal Appeals).

(3) HHSC or its designee will recoup any amount owed from the facility's vendor payments that are being held following the initial or subsequent notification date. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (b) of this section will be jointly and severally liable for any additional payment due to HHSC or its designee. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in the recoupment of the owed funds from other Medicaid contracts controlled by the responsible entity, placement of a vendor hold on all Medicaid contracts controlled by the responsible entity, and barring of new contracts. The vendor hold will bar the responsible entity from receiving any new contracts with HHSC or its designees until repayment is made in full. The responsible entity for these contracts will be notified as described in paragraph (1) of this subsection prior to the recoupment of owed funds, placement of vendor hold, and barring of new contracts.

(h) Change of ownership. When there is a change of ownership before the end of a rate year, the prior owner must submit a report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the ownership-change effective date to meet reporting requirements under subsection (f) of this section. The new owner may be responsible for the reporting requirements in subsection (f) of this section for any reporting period days after the change of ownership effective date to the end of the rate year as specified by HHSC or its designee.

(i) Vendor hold. HHSC or its designee will place on hold the vendor payments for any participating facility that does not submit a timely report as described in subsection (f) of this section in accordance with §355.403 of this subchapter (relating to Vendor Hold).

(j) Aggregation. For an entity, commonly owned corporation, or combined entity that controls more than one participating nursing facility contract, compliance with the spending requirements detailed in subsection (e) of this section can be determined in the aggregate for all nursing facility contracts controlled by the entity, commonly owned corporations, or combined entity in accordance with aggregation requirements specified in §355.308(aa) of this subchapter.

§355.308. Direct Care Staff Rate Component.

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

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

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

(3) Nurse aides must meet the qualifications enumerated under 26 TAC §556.3 (relating to Nurse Aide Training and Competency Evaluation Program (NATCEP) Requirements) to be included in this cost center. Nurse aides include certified nurse aides and nurse aides in training.

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

(5) For facilities receiving supplemental reimbursement for children with tracheostomies requiring daily care as described in §355.307(b)(3)(F) of this title (relating to Reimbursement Setting Methodology), staff required by 26 TAC §554.901(15)(C)(iii) (relating to Quality of Care) performing nursing-related duties for Medicaid contracted beds are included in the direct care staff cost center.

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

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

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

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

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

(c) Open enrollment. Open enrollment for the enhanced direct care staff rates will begin on the first day of July and end on the last day of that same July preceding the rate year for which payments are being determined. HHSC notifies providers of open enrollment by electronic mail (e-mail) to an authorized representative per the signature authority designation form applicable to the provider's contract or ownership type. If open enrollment has been postponed or cancelled, the Texas Health and Human Services Commission (HHSC) will notify providers by e-mail prior to the first day of July. Should conditions warrant, HHSC may conduct additional enrollment periods during a rate year.

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

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

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

(f) Staffing and Compensation Report submittal requirements.

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

(A) When a participating facility changes ownership, the prior owner must submit a Staffing and Compensation Report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the ownership-change effective date.

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

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

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

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

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

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

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

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

(D) Participating facilities who voluntarily withdraw from participation as per subsection (r) of this section must submit a Staffing and Compensation Report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the facility's cost reporting period to the date of withdrawal

as determined by HHSC. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section. These facilities must still submit a cost report covering the entire cost reporting period. The cost report will not be used for determining any recoupment amounts.

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

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

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

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

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

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

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

contract termination date, the recoupment will become permanent and if all funds associated with participation during the reporting period in question have been recouped by HHSC or its designee, the vendor hold associated with the report will be released.

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

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

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

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

(1) Notification of enrollment limitations. The enrollment limitation level is indicated in the State of Texas Automated Information Reporting System (STAIRS), the online application for submitting cost reports and accountability reports. STAIRS will generate an e-mail to the entity contact, indicating that the facility's enrollment limitation level is available for review. The entity contact is the provider's authorized representative per the signature authority designation form applicable to the provider's contract or ownership type.

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

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

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

(j) Determination of staffing requirements for participants. Facilities choosing to participate in the enhanced direct care staff rate agree to maintain certain direct care staffing levels above the minimum staffing levels described in paragraph (1) of this subsection. In order to permit facilities the flexibility to substitute RN, LVN and aide (Medication Aide and nurse aide) staff resources and, at the same time, comply

with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN equivalent minutes. Conversion factors to convert RN and aide minutes into LVN equivalent minutes are based upon most recently available, reliable relative compensation levels for the different staff types.

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

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

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

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

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

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

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

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

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

(G) In cases where the minimum required LVN-equivalent minutes per resident day of service associated with a RUG-III case mix group or supplemental reimbursement group change during the reporting period, the minimum required LVN-equivalent minutes for the RUG-III case mix group or supplemental reimbursement group for the

reporting period will be equal to the weighted average LVN-equivalent minutes in effect during the reporting period for that group calculated as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) Determination of direct care staff base rate.

(1) Determine the sum of recipient care costs from the direct care staff cost center in subsection (a) of this section in all nursing facilities included in the most recently available Texas Nursing Facility Cost Report database (hereinafter referred to as the initial database).

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

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

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

(5) The direct care staff per diem base rates will be limited to available levels of appropriated state and federal funds as specified in §355.201 of this chapter. HHSC may also recommend adjustments to the rates in accordance with §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

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

(m) Staffing requirements for participating facilities. Each participating facility will be required to maintain adjusted LVN-equiv-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Effective September 1, 2023, HHSC will complete calculations associated with the direct care rate increases and spending requirements in accordance with §355.304 of this subchapter (relating to Direct Care Staff Spending Requirement on or after September 1, 2023).

(2) At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues by 0.70.

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

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

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

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

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

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

graph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year.

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

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

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

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

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

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

(s) Notification of recoupment based on Annual Staffing and Compensation Report or cost report. The estimated amount to be recouped is indicated in STAIRS. STAIRS will generate an e-mail to the entity contact, indicating that the facility's estimated recoupment is available for review. If a subsequent review by HHSC or audit results in adjustments to the Annual Staffing and Compensation Report or cost report as described in subsection (f) of this section that changes the amount to be repaid to HHSC or its designee, the facility will be notified by e-mail to the entity contact that the adjustments and the adjusted amount to be repaid are available in STAIRS for review. HHSC or its designee will recoup any amount owed from a facility's vendor payment(s) following the date of the initial or subsequent notification.

(t) Change of ownership and contract terminations. Facilities required to submit a Staffing and Compensation Report due to a change of ownership or contract termination as described in subsection (f) of this section will have funds held as per 26 TAC §554.210 (relating to Change of Ownership and Notice of Changes) until an acceptable

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

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

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

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

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

(y) Change of ownership. Participation in the enhanced direct care staff rate confers to the new owner as defined in 26 TAC §554.210 (relating to Change of Ownership and Notice of Changes) when there is a change of ownership. The new owner is responsible for the reporting requirements in subsection (f) of this section for any reporting period days occurring after the change. If the change of ownership occurs during an open enrollment period as defined in subsection (c) of this section, then the owner recognized by HHSC or its designee on the last day of the enrollment period may request to modify the enrollment status of the facility in accordance with subsection (d) of this section.

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

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

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

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

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

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

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

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

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

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

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

(bb) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes NF nursing care to a Medicaid recipient under 26 TAC §554.2326 (relating to Medicaid Swing Bed Program for Rural Hospitals), HHSC or its designee makes payment to the hospital using the same procedures, the same case-mix methodology, and the same RUG-III rates that HHSC authorizes for reimbursing NFs receiving the direct care staff base rate with no enhancement levels. These hospitals are not subject to the staffing and spending requirements detailed in this section.

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

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

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

Filed with the Office of the Secretary of State on August 11, 2023.

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Texas Health and Human Services Commission

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Proposal publication date: July 7, 2023

For further information, please call: (512) 867-7817



SUBCHAPTER E. COMMUNITY CARE FOR AGED AND DISABLED

1 TAC §355.513

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §355.513, concerning Reimbursement Methodology for the Deaf-Blind with Multiple Disabilities Waiver Program. Section 355.513 is adopted without changes to the proposed text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3588). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

Title 42 Code of Federal Regulations §441.301(c)(4)(i) - (v), requires home and community-based settings in programs authorized by §1915(c) of the Social Security Act to have certain qualities, including being integrated into and supporting full access of individuals to the greater community. HHSC adopted rules in Title 26 Texas Administrative Code (TAC) Chapter 260 to implement individualized skills and socialization effective January 1, 2023.

The 2022-2023 General Appropriations Act (GAA), Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 23) authorized funding for the provision of individualized skills and socialization in the Home and Community-based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities (DBMD) programs. HHSC adopted rates for individualized skills and socialization based on the available appropriations, effective January 1, 2023.

The purpose of the adoption is to amend the reimbursement methodology for the DBMD Program to remove day habilitation services and establish rate methodologies for individualized skills and socialization services. The adopted amendment also clarifies the rate methodology for residential habilitation transportation, chore, and intervener services by replacing the "other direct care" cost area with an administration and facility cost area to align waiver rate methodology with other similar services.

COMMENTS

The 21-day comment period ended July 28, 2023.

During this period, HHSC received comments regarding the proposed rule from one commenter. A summary of comments relating to §355.513 and HHSC's responses follow:

Comment: One commenter asked HHSC to only consider amendments that will support and enhance the method by which these affected citizens receive reimbursement and not add to the difficulties this population faces.

Response: HHSC appreciates the comment received. HHSC believes these amendments ensure that an appropriate reimbursement rate methodology is used in the DBMD waiver program by establishing rate methodologies for individualized skills and socialization services and aligning the waiver rate methodology with other similar services.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

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

Filed with the Office of the Secretary of State on August 8, 2023.

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Karen Ray

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Texas Health and Human Services Commission

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Proposal publication date: July 7, 2023

For further information, please call: (512) 867-7817



SUBCHAPTER F. REIMBURSEMENT METHODOLOGY FOR PROGRAMS SERVING PERSONS WITH MENTAL ILLNESS OR INTELLECTUAL OR DEVELOPMENTAL DISABILITY

1 TAC §355.723

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §355.723, concerning Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs. Section 355.723 is adopted with changes to the proposed text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3591). This rule will be republished.

BACKGROUND AND PURPOSE

Title 42, Code of Federal Regulations, §441.301(c)(4)(i) - (v), requires home and community-based settings in programs authorized by §1915(c) of the Social Security Act to have certain qualities, including being integrated into and supporting full access of individuals to the greater community. HHSC adopted rules in Title 26 Texas Administrative Code (TAC) Chapters 262 and 263 to implement individualized skills and socialization effective January 1, 2023.

The 2022 - 2023 General Appropriations Act (GAA), Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 23) authorized funding for the provision of individualized skills and socialization in the Home and Community-Based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities Programs. HHSC adopted rates for individualized skills and socialization based on the available appropriations, effective January 1, 2023.

The purpose of the adoption is to amend the reimbursement methodology for the HCS and TxHmL Programs to remove day habilitation and establish rate methodologies for individualized skills and socialization. The adopted amendment also clarifies the rate methodology for each HCS and TxHmL waiver service and implements some recommendations in HHSC's legislative report, *Rates: Intermediate Care Facilities and Certain Waiver Providers*, required by the 2022 - 2023 GAA, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 30).

COMMENTS

The 21-day comment period ended July 28, 2023.

During this period, HHSC received comments regarding the proposed rule from three commenters: Providers Alliance for Community Services of Texas (PACSTX), Private Providers Association of Texas (PPAT), and Texas Council of Community Centers (Texas Council).

A summary of comments relating to §355.723 and HHSC's responses follow.

Comment: Multiple commenters expressed support for using a pro forma costing analysis when HHSC has insufficient cost data to establish the attendant compensation rate component. Due to current economic drivers, the commenters asked HHSC to use a pro forma costing analysis for HCS/TxHmL attendant compensation.

Response: The methodology for the attendant compensation rate component is outside the scope of this rule packet, as that component is established under §355.112. However, HHSC can rely on pro forma costing if it deems that available cost data is insufficient under §355.101(g); therefore no changes were made in response to these comments.

Comment: Multiple commenters shared concerns with modifications to subsection (f), Refinement and adjustment. The commenters said HHSC should not refine or adjust rates without consideration of the actual costs to deliver services. The commenters also said HHSC should not recategorize costs into other rate components simply because there is insufficient funding for certain components. Otherwise, the collection of data from cost reports will have no relationship to the rates and paint an inaccurate picture of the actual costs to deliver services.

Response: HHSC disagrees and declines to make a change in response to these comments. The amendment to §355.723(f) allows HHSC to modify and adjust modeled assumptions if new data or more accurate assumptions become available, particularly during HHSC's regular biennial fee review process. HHSC seeks to ensure that cost reports accurately reflect the provider's costs to deliver waiver services and that the rate methodology, modeled assumptions, and associated calculations accurately capture an economic and efficient provider's allowable costs. No changes were made in response to these comments.

A minor editorial change was made to §355.723(d)(3) replacing "subparagraph" with "subsection" to correctly reference subsection (c)(5)(A) of the section.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

§355.723. *Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs.*

(a) Prospective payment rates. The Texas Health and Human Services Commission (HHSC) sets payment rates to be paid prospectively to Home and Community-based Services (HCS) and Texas Home Living (TxHmL) providers.

(b) Levels of need.

(1) Variable rates. Rates vary by level of need (LON) for the following services:

- (A) host home/companion care (HH/CC);
- (B) individualized skills and socialization;
- (C) residential support services (RSS); and
- (D) supervised living (SL).

(2) Non-variable rates. Rates do not vary by LON for the following services:

- (A) audiology;
- (B) behavioral support;
- (C) cognitive rehabilitative therapy (CRT);
- (D) community first choice personal assistance services/habilitation (CFC PAS/HAB);
- (E) community support services transportation (CSS);
- (F) dietary;
- (G) employment assistance (EA);
- (H) in-home respite;
- (I) licensed vocational nurse (LVN);
- (J) occupational therapy (OT);
- (K) out-of-home respite (OHR);
- (L) physical therapy (PT);
- (M) registered nurse (RN);
- (N) social work;
- (O) speech therapy;
- (P) supported employment (SE); and
- (Q) supported home living transportation (SHL).

(c) Recommended rates. The recommended payment rates are determined for each HCS and TxHmL service listed in subsections (b)(1) and (2) of this section by type and, for services listed in subsection (b)(1) of this section, by LON to include the following cost areas.

(1) Attendant compensation cost area. The determination of the attendant compensation cost area is calculated as specified in §355.112 of this chapter (relating to Attendant Compensation Rate Enhancement). The attendant compensation cost area includes personal attendant staffing costs (wages, benefits, modeled staffing ratios for attendant staff, direct care trainers, and job coaches).

(2) Other direct care cost area. The other direct care cost area includes other direct service staffing costs (wages and benefits for direct care and attendant supervisors). The other direct care cost area is determined by calculating a median from allowable other direct care costs for each service, weighed by units of service for the applicable service from the most recently examined HCS/TxHmL cost report adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter (relating to Determination of Inflation Indices).

(A) For the following services, multiply the other direct care cost area as specified in this paragraph by 1.044:

- (i) EA;
- (ii) in-home respite;
- (iii) OHR in a camp;
- (iv) OHR in a respite facility;
- (v) OHR in a setting where HH/CC is provided;
- (vi) OHR in a setting that is not listed; and
- (vii) SE.

(B) For the following services, multiply the other direct care cost area as specified in this paragraph by 1.07:

- (i) individualized skills and socialization;
- (ii) in-home and out-of-home individualized skills and socialization;
- (iii) OHR in an individualized skills and socialization facility;
- (iv) OHR in a setting with SL or RSS is provided;
- (v) RSS; and
- (vi) SL.

(3) Administration and operations cost area. The administration and operation cost area includes:

- (A) administration and operation costs; and
- (B) professional consultation and program support costs, including:

- (i) allowable costs for required case management and service coordination activities; and
- (ii) service-specific transportation costs.

(4) Projected costs. Projected costs are determined by allowable administrative and operations costs from the most recently audited cost report adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter. The steps to determine projected costs are as follows.

(A) Step 1. Determine total projected administration and operation costs and projected units of service by service type using cost reports submitted by HCS and TxHmL providers in accordance with §355.722 of this subchapter (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).

(B) Step 2. Determine the HH/CC coordinator component of the HH/CC rate as follows: This component is determined by summing total reported HH/CC coordinator wages and allocated payroll taxes and benefits from the most recently available audited HCS cost report, inflating those costs to the rate period, and dividing the resulting product by the total number of host home units of service reported on that cost report.

(C) Step 3. Determine total HH/CC coordinator dollars as follows. Multiply the HH/CC coordinator component of the HH/CC rate from subparagraph (B) of this paragraph by the total number of HH/CC units of service reported on the most recently available, reliable audited HCS cost report database.

(D) Step 4. Determine total projected administration and operation costs after offsetting total HH/CC coordinator dollars as follows. Subtract the total HH/CC coordinator dollars from subparagraph (C) of this paragraph from the total projected administration and operation costs from subparagraph (A) of this paragraph.

(E) Step 5. Determine projected weighted units of service for each HCS and TxHmL service type as follows.

(i) SL and RSS in HCS. Projected weighted units of service for SL and RSS equal projected SL and RSS units of service times a weight of 1.00.

(ii) Individualized skills and socialization in HCS and TxHmL. Projected weighted units of service for individualized skills and socialization equal projected individualized skills and socialization units of service times a weight of 0.25.

(iii) HH/CC in HCS. Projected weighted units of service for HH/CC equal projected HH/CC units of service times a weight of 0.50.

(iv) SHL in HCS, high medical needs support in HCS, and CSS in TxHmL. For each service, projected weighted units of service equal projected units of service times a weight of 0.30.

(v) Respite in HCS and TxHmL. Projected weighted units of service for respite equal projected respite units of service times a weight of 0.20.

(vi) SE in HCS and TxHmL. Projected weighted units of service for SE equal projected units of service times a weight of 0.25.

(vii) Behavioral support in HCS and TxHmL. Projected weighted units of service for behavioral support equal projected behavioral support units of service times a weight of 0.18.

(viii) Audiology, CRT, OT, PT, and speech therapy in HCS and TxHmL. Projected weighted units of service for audiology, CRT, OT, PT, and speech therapy equal projected audiology, CRT, OT, PT, and speech therapy units of service times a weight of 0.18.

(ix) Social work in HCS. Projected weighted units of service for social work equal projected social work units of service times a weight of 0.18.

(x) Nursing in HCS and TxHmL and high medical needs nursing in HCS. Projected weighted units of service for nursing

and high medical needs nursing equal projected nursing and high medical needs nursing units of service times a weight of 0.25.

(xi) EA in HCS and TxHmL. Projected weighted units of service for EA equal projected EA units of service times a weight of 0.25.

(xii) Dietary in HCS and TxHmL. Projected weighted units of service for dietary equal projected dietary units of service times a weight of 0.18.

(F) Step 6. Calculate the total projected weighted units of service by summing the projected weighted units of service from subparagraph (E) of this paragraph.

(G) Step 7. Calculate the percent of total administration and operation costs to be allocated to the service type by dividing the projected weighted units for the service type from subparagraph (E) of this paragraph by the total projected weighted units of service from subparagraph (F) of this paragraph.

(H) Step 8. Calculate the total administration and operation cost to be allocated to the service type by multiplying the percent of total administration and operation costs allocated to the service type from subparagraph (G) of this paragraph by the total administration and operation costs after offsetting total HH/CC coordinator dollars from subparagraph (D) of this paragraph.

(I) Step 9. Calculate the administration and operation cost component per unit of service for each HCS and TxHmL service type by dividing the total administration and operation cost to be allocated to that service type from subparagraph (H) of this paragraph by the projected units of service for that service type from subparagraph (A) of this paragraph.

(J) Step 10. The final recommended administration and operation cost area per unit of service for each HCS and TxHmL service type is calculated as follows.

(i) For the following services, multiply the administration and operation cost area from this subparagraph by 1.044:

- (I) CFC PAS/HAB;
- (II) CSS;
- (III) EA;
- (IV) in-home individualized skills and socialization;
- (V) in-home respite;
- (VI) OHR in a camp;
- (VII) OHR in a respite facility;
- (VIII) OHR in a setting where HH/CC is provided;
- (IX) OHR in a setting that is not listed;
- (X) SE; and
- (XI) SHL.

(ii) For the following services, multiply the administration and operation cost area from this subparagraph by 1.07:

- (I) individualized skills and socialization;
- (II) in-home and out-of-home individualized skills and socialization;
- (III) OHR in an individualized skills and socialization facility;

(IV) RSS; and

(V) SL.

(5) The facility cost area. The facility cost area includes the following:

(A) room and board costs, including rent, mortgage interest, depreciation expenses, property taxes, property insurance, and food costs as defined in §355.103 of this chapter (relating to Specifications for Allowable and Unallowable Costs), unless excluded if unallowable under Federal Medicaid rules; and

(B) non-room and board costs not already reimbursed through the monthly amount collected from the individual receiving services as defined in 26 TAC §565.27(a).

(6) The facility cost area is determined by calculating a median cost for each service using allowable facility costs, weighted by units of service for the applicable service from the most recently audited cost report, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108.

(A) For the following services, multiply the facility cost component by 1.044:

(i) HH/CC;

(ii) OHR in a camp;

(iii) OHR in a respite facility; and

(iv) OHR in a setting where HH/CC is provided.

(B) For the following services, multiply the facility cost component by 1.07:

(i) individualized skills and socialization;

(ii) in-home and out-of-home DH;

(iii) OHR in a DH or individualized skills and socialization facility;

(iv) OHR in a setting where SL or RSS are provided;

(v) RSS; and

(vi) SL.

(d) Recommended payment rates are determined for each service by the following.

(1) CFC PAS/HAB. The recommended payment rate is calculated by summing the attendant compensation cost area and the administration and operations cost area as defined in subsection (c) of this section. The recommended rate for CFC PAS/HAB does not include a cost component for other direct care staffing costs.

(2) CRT. The recommended payment rate is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(3) HH/CC. The recommended payment rate is determined by summing the direct care worker component, HH/CC coordinator cost area, administration and operations component, and facility cost area. The direct care worker component is calculated using the median of allowable direct care worker costs, weighted by HH/CC units of service from the most recently examined cost report database. The result is adjusted for each LON. The HH/CC coordinator cost area and administration and operations components are calculated as determined

in subsection (c) of this section. The facility cost area is calculated as determined in subsection (c) of this section but does not include room and board costs as defined in subsection (c)(5)(A) of this section. If HHSC lacks reliable cost report data, the rate is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter.

(4) In-home respite. The recommended payment rate is calculated by summing the attendant compensation cost area and the administration and operations component as defined in subsection (c) of this section.

(5) Individualized skills and socialization. The recommended payment cost areas are adjusted using modeled staffing ratios to establish recommended rates for on-site and off-site rates by LON. The recommended rates are calculated by summing the attendant compensation cost area, other direct care cost area, the administration and operations component, and the facility cost component as defined in subsection (c) of this section. Transportation costs are calculated as a standalone component separate from the administration and operations component for off-site services. The enhanced staffing level one rate is equal to the LON 8 individualized skills and socialization off-site recommended rate. The enhanced staffing level two rate is modeled and assumes a one-staff-to-one-individual staffing ratio.

(6) Nursing services provided by an RN, nursing services provided by an LVN, physical therapy, occupational therapy, speech/language therapy, behavioral support services, audiology services, dietary services, EA, SE, and transition assistance services are determined based on §355.725 of this subchapter (relating to Reimbursement Methodology for Common Waiver Services in Home and Community-based Services (HCS) and Texas Home Living (TxHmL)).

(7) OHR. The recommended payment cost areas may be adjusted using modeled direct care worker hour-per-unit ratios for similar services to calculate OHR rates that vary by setting where the service is provided. The recommended payment rates are calculated by summing the attendant compensation cost area, other direct care cost area, the administration and operations component, and the facility cost component as defined in subsection (c) of this section.

(8) SHL and CSS. The recommended payment rates for SHL and CSS are calculated by summing the attendant compensation cost area and the administration and operations cost area as defined in subsection (c) of this section.

(9) SL and RSS. The recommended payment cost areas are adjusted using modeled direct care worker hour-per-unit ratios updated by actual hours reported on the most recently audited cost report to calculate variable rates by LON. The recommended rates are calculated by summing the attendant compensation cost area, other direct care cost area, and the administration and operations component as defined in subsection (c) of this section. The facility cost area is calculated as determined in subsection (c) of this section but does not include room and board costs defined in subsection (c)(5)(A) of this section.

(10) Social work. The recommended payment rate is calculated using the weighted median social worker hourly cost from the most recently audited cost report, and the administration and operations cost component as determined in subsection (c) of this section. If HHSC lacks reliable cost report data, the rate is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter.

(e) Other sources of cost information. If HHSC has determined that there is not sufficient reliable cost report data from which to set reimbursements and reimbursement ceilings for waiver services, reimbursements and reimbursement ceilings will be developed by using rates for similar services from other Medicaid programs, data from surveys, cost report data from other similar programs, consultation with other service providers or professionals experienced in delivering contracted services, and similar sources. If HHSC has insufficient cost data, the recommended payment rate for each service is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter.

(f) Refinement and adjustment. Refinement and adjustment of the rate components and model assumptions will be considered, as appropriate, by HHSC. All adopted rates are limited to available levels of appropriated state and federal funds as defined in §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid).

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

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Texas Health and Human Services Commission

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SUBCHAPTER H. BASE WAGE REQUIREMENTS FOR PERSONAL ATTENDANTS

1 TAC §355.7051

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §355.7051, concerning Base Wage for a Personal Attendant. Section 355.7051 is adopted with changes to the proposed text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3598). This rule will be republished.

BACKGROUND AND JUSTIFICATION

The amendment implements Rider 30(a) of the 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 30(a)). Rider 30(a) appropriates funds to HHSC to increase the minimum base wage paid to "personal attendants" from \$8.11 to \$10.60 per hour.

In response to Rider 30(a), HHSC must update its program requirements to require service providers to pay this updated minimum base wage. To ensure consistency and clarity, the amendment also adds additional services to the definition of "personal attendant," including assisted living and in-home respite, in the Home and Community-based Services - Adult Mental Health program. In addition, the amendment replaces day habilitation with individualized skills and socialization services.

COMMENTS

The 21-day comment period ended July 28, 2023.

During this period, HHSC received two comments regarding the proposed rule from three commenters. HHSC received comments from the following organizations: the Providers Alliance for Community Services of Texas (PACSTX), Private Providers Association of Texas (PPAT), and the Texas Council of Community Centers.

A summary of comments relating to §355.7051 and HHSC's responses follows:

Comment: Multiple commenters expressed opposition to including supervised living and residential support services to the definition of a personal attendant subject to the \$10.60 per hour base wage in §355.7051(a) because a direct care worker's pay includes room and board for live-in staff.

Response: HHSC agrees and revised the rule to exclude supervised living and residential support services (SL/RSS). HHSC acknowledges that reimbursement of attendants within a residential setting may combine payment for their room and board and wages; therefore, holding providers to a base wage for personal attendants would not be appropriate. HHSC assumes that attendants' reimbursement in these residential settings is equivalent to \$10.60 per hour, as supported with the intention of Rider 30(a) and adopted rate increases.

Comment: Multiple commenters expressed opposition to including individualized skills and socialization in the definition of personal attendant in 355.7051(a)(3)(A)(vii)(VI), (viii)(IV), and (ix)(IV) as the individualized skills and socialization services were not previously subject to the attendant base wage nor was there an appropriation for this service.

Response: HHSC disagrees and declines to exclude individualized skills and socialization from a personal attendant definition because attendants providing individualized skills and socialization are reimbursed based on an hourly wage. Rate actions were not proposed at this time since current reimbursement rates for the individualized skills and socialization services assume that attendants' base wages exceed \$10.60 per hour.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

§355.7051. *Base Wage for a Personal Attendant.*

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

(1) HHSC contractor--A person who has a written agreement with the Texas Health and Human Services Commission (HHSC) to provide a service to an individual in exchange for payment from HHSC.

(2) Managed care organization or MCO--Has the meaning assigned in §353.2 of this title (relating to Definitions).

(3) Personal attendant--

(A) An employee or subcontractor of an HHSC contractor, or an employee of an employer in the consumer directed services (CDS) option, who provides the following services, as described in 40 TAC §49.101 (relating to Application):

(i) services in the Community Attendant Services program;

(ii) services in the Family Care program;

(iii) services in the Primary Home Care program;

(iv) day activity and health services;

(v) residential care;

(vi) in the Community Living Assistance and Support Services Program:

(I) community first choice personal assistance services/habilitation (CFC PAS/HAB);

(II) habilitation (transportation); or

(III) in-home respite;

(vii) in the Deaf-Blind Multiple Disabilities Program:

(I) CFC PAS/HAB;

(II) residential habilitation (transportation);

(III) in-home respite;

(IV) licensed assisted living;

(V) licensed home health assisted living; or

(VI) individualized skills and socialization services;

Program:

(viii) in the Home and Community-based Services

(I) CFC PAS/HAB;

(II) supported home living (transportation);

(III) in-home respite; and

(IV) individualized skills and socialization services;

Program:

(ix) in the Texas Home Living Program:

(I) CFC PAS/HAB;

(II) community support services (transportation);

(III) in-home respite; or

(IV) individualized skills and socialization services.

(B) An employee or subcontractor of an HHSC contractor who provides the following services in the Home and Community-Based Services--Adult Mental Health program, as described in 26 TAC §307.51 (relating to Purpose and Application):

(i) assisted living services;

(ii) in-home respite; and

(iii) supported home living services.

(C) An employee or subcontractor of an HHSC contractor or an employee of an employer in the CDS option who provides:

(i) personal care services, as described in Chapter 363, Subchapter F of this title (relating to Personal Care Services); or

(ii) CFC habilitation (CFC HAB) or CFC personal assistance services (CFC PAS), as described in Chapter 354, Subchapter A, Division 27 (relating to Community First Choice).

(D) An employee or subcontractor of an HHSC contractor, or an employee of an employer in the CDS option or in the block grant option, who provides consumer managed personal attendant services as described in 26 TAC Chapter 275 (relating to Consumer Managed Personal Attendant Services (CMPAS) Program).

(E) A provider or an employee of an employer in the CDS option who provides:

(i) in the STAR+PLUS program and STAR+PLUS Home and Community-based Services (HCBS) program:

(I) assisted living;

(II) CFC PAS;

(III) CFC HAB;

(IV) day activity and health services;

(V) in-home respite care;

(VI) personal assistance services; or

(VII) protective supervision;

(ii) in the STAR Health program and Medically Dependent Children Program (MDCP):

(I) day activity and health services;

(II) CFC PAS;

(III) CFC HAB;

(IV) flexible family support;

(V) in-home respite; or

(VI) personal care services; or

(iii) in the STAR Kids program and MDCP:

(I) CFC PAS;

(II) CFC HAB;

(III) personal care services;

(IV) day activity and health services;

(V) flexible family support services; or

(VI) in-home respite.

(4) Provider--Has the meaning assigned in §353.2 of this title.

(b) An HHSC contractor, other than an HHSC contractor described in subsection (c) or (d) of this section, must pay a personal attendant a base wage of at least \$10.60 per hour.

(c) An HHSC contractor that has a contract for financial management services (FMS) must ensure that an employer in the CDS option, or designated representative, pays a personal attendant a base wage of at least \$10.60 per hour.

(d) An HHSC contractor that has a CMPAS contract must:

(1) pay a personal attendant who is an employee or subcontractor of the contractor in the traditional service option or block grant option a base wage of at least \$10.60 per hour; and

(2) ensure that an individual employer of a personal attendant under the block grant option or CDS option, or the individual's representative, pays a personal attendant a base wage of at least \$10.60 per hour.

(e) An MCO must require an MCO contractor, other than an MCO contractor described in subsection (f) of this section, to pay a personal attendant a base wage of at least \$10.60 per hour.

(f) An MCO must require that an MCO contractor that has a contract for FMS ensures that an employer in the CDS option or designated representative pays a personal attendant a base wage of at least \$10.60 per hour.

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

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

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For further information, please call: (512) 867-7817



SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8052

The Texas Health and Human Services Commission (HHSC) adopts amendments to §355.8052, concerning Inpatient Hospital Reimbursement. The amendment is adopted without changes to the proposed text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3601). The rule will not be republished.

BACKGROUND AND JUSTIFICATION

This amendment complies with the 2024-2025 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 8 and Rider 16). HHSC is required by H.B. 1, to the extent allowed by law, to increase Medicaid inpatient rural hospital labor and delivery rates. Additionally, the rural hospital definition is modified to reflect the population updates in the 2020 U.S. Census. In compliance with Senate Bill 170 (S.B. 170), 86th Legislature, Regular Session 2019, to the extent allowed by law, HHSC will calculate Medicaid rural hospital inpatient rates using a cost-based prospective reimbursement methodology. HHSC must calculate rates for rural hospitals once every two years using the most recent cost information available. HHSC previously published proposed rates to be effective September 1, 2023, and, with this legislative direction, will account for the updates in this rule and republish rates.

COMMENTS

The 21-day comment period ended July 28, 2023.

During this period, HHSC received comments regarding the proposed rule from one commenter.

A summary of comments relating to §355.8052 and HHSC's responses follow:

Comment: The Texas Hospital Association (THA) was strongly in support of the rule as proposed.

Response: HHSC appreciates the support for the proposed amendment.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), 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; and Texas Government Code §531.02194, which requires adoption of a prospective reimbursement methodology for the payment of rural hospitals.

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

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Texas Health and Human Services Commission

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TITLE 13. CULTURAL RESOURCES

PART 1. TEXAS STATE LIBRARY AND ARCHIVES COMMISSION

CHAPTER 3. STATE PUBLICATIONS DEPOSITORY PROGRAM

13 TAC §3.5, §3.6

The Texas State Library and Archives Commission (commission) adopts amendments to §3.5, Standard Exemptions for State Publications in All Formats, and §3.6, Special Exemptions. The commission adopts the amendments without changes to the proposed text as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3017). The rules will not be republished.

The adopted amendments are necessary to exempt additional types of publications not appropriate for retention in the State Publications Depository Program (program). Exempting these types of publications will ensure the program includes the types of publications that document the operations of state agencies

while easing state agencies' duties by reducing the number of publications they are required to submit to the program. In addition, exempting items that are not appropriate for inclusion in the program will allow the commission to maximize its use of record storage space.

The amendment to §3.5(11) adds course materials to the existing exemption for course schedules. This exemption covers university course schedules and courses offered by state agencies.

The amendment to §3.5(26) adds non-fiction university press publications not aligned with the commission's collection development policy to the list of exempted publications. One of the primary goals of the program is to capture all publications documenting the operation of a state agency. Non-fiction university press publications take up a considerable amount of space. If the commission were to accept all non-fiction publications, additional offsite storage would likely be necessary. Further, these titles are typically widely available at other libraries, particularly at the universities whose presses produce them. Exempting non-fiction university press publications that are not aligned with the commission's collection development priorities will ensure consistent application of the policy and that the program documents the university press function focusing on publications relating to Texas-related history and government.

The amendment to §3.5(37) adds a clarifying date to the exemption for rules and regulations. The new exemption will read "rules and regulations after 1976 (as compendia)." The State Law Library holds the complete collection of historic Texas Administrative Code (TAC) publications. The TAC from 1999 to present is available on the Secretary of State's website. Researching rules and regulations prior to 1976 can be more challenging as centralized resources such as the *Texas Register* and the TAC do not exist. Locating rules prior to 1976 may require archival research in the minutes or other records of a particular agency if published compendia are not available. If an agency did not include rule language in minutes or did not maintain or transfer records containing the text of adopted rules, there may be no other way to locate this information. For this reason, published collections of rules predating 1976 are important to the program to provide greater access to this information. However, rules and regulations after 1976 are not appropriate for the program.

The amendment to §3.5(42) adds training materials to the list of exempted publications. As with course materials, training materials that are distributed publicly do not typically document the operation of a state agency. For example, the State Bar of Texas produces course materials as part of their Continuing Legal Education programming. While these publications have historically been provided to the commission under the program, less than 1% of these publications have been requested since at least the year 2000. According to the commission's research, several other libraries maintain these materials, including the State Law Library, Legislative Reference Library, and at least five Texas law school libraries. Because these types of materials are readily available from multiple other sources and are not necessary for the program, the commission proposes to add "training materials" to the list of exempted items as §3.5(42).

Finally, amendments to §3.5 renumber the paragraphs to maintain the list in alphabetical order.

The amendments to §3.6 clarify that special exemptions are for types of publications not listed in §3.5.

The commission did not receive any comments on the proposed amendments.

STATUTORY AUTHORITY. The amendments are adopted under Government Code, §441.102, which requires the commission by rule to establish procedures for the distribution of state publications to depository libraries and for the retention of those publications; Government Code, §441.103, which requires a state agency to furnish copies of its state publications that exist in a physical format to the Texas State Library in the number specified by commission rules; Government Code, §441.104, which directs the commission to establish a program for the preservation and management of state publications; and Government Code, §441.105, which authorizes the commission to specifically exempt a publication or a distribution format from this subchapter.

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

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CHAPTER 9. TALKING BOOK PROGRAM

13 TAC §9.1

The Texas State Library and Archives Commission (commission) adopts the repeal of 13 TAC §9.1, Definitions. The repeal is adopted without changes to the proposed text as published in the May 5, 2023, issue of the *Texas Register* (48 TexReg 2308). The rule will not be republished.

The repeal is necessary because the commission identified several needed amendments to update and clarify the definitions. The commission is adopting new §9.1 to reflect these amendments in a separate notice also in this issue of the *Texas Register*.

No comments were received regarding the proposed repeal.

STATUTORY AUTHORITY. The repeal is adopted under §441.006, which directs the commission to govern the state library; and Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

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

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Texas State Library and Archives Commission
Effective date: August 29, 2023
Proposal publication date: May 5, 2023
For further information, please call: (512) 463-5460



13 TAC §§9.1 - 9.9, 9.11 - 9.18

The Texas State Library and Archives Commission (commission) adopts new §9.1, Definitions and amendments to §9.2, Administration; §9.3, Eligibility; §9.4, Application for Service; §9.5, Priority Service to Veterans; §9.6, Status of Users; §9.7, Playback Equipment; §9.8, Books and Magazines; §9.9, Availability of Materials; §9.11, Misuse of Service; §9.12, Notification of Potential Suspension; §9.13, Correction of Problem; §9.14, Suspension of Service; §9.15, Reinstatement of Service; §9.16, Termination of Service; §9.17, Transfer of Service; and §9.18, Reactivation of Accounts. The new section and amendments are adopted without changes to the proposed text as published in the May 5, 2023, issue of the *Texas Register* (48 TexReg 2309). The rules will not be republished.

The new section and amendments are necessary to update, modernize, and clarify the rules, improve grammar and readability, and align the rules with best practices.

New §9.1 updates the overall structure of the rule and makes non-substantive grammar edits throughout. Several definitions in the new rule are essentially the same as previously defined, with the only changes being minor and non-substantive. Other changes simplify and clarify the rule language, consolidating terms when appropriate, and eliminating defined terms that are not used. Finally, some of the changes reflect language updates, including updating the name of the National Library Service for the Blind and Print Disabled.

Amendments to §9.2 update and improve the language and a citation to the United States Code provision regarding mailing free matter for blind and other handicapped persons. Amendments to §9.3 update language based on the updated definitions, delete text that is no longer necessary, and explain how an account may be maintained in good standing. Amendments to §9.4 make general language and readability improvements, update language based on the updated definitions, and delete text that is no longer necessary. Amendments to §9.5 update the section title to "Priority for Veterans" and delete language that is no longer necessary. Amendments to §9.6 update the section title to "Status of Borrowers" and delete unnecessary language. Amendments to §9.7 update language based on the updated definitions and clarify what constitutes misuse of equipment in subparagraph (a)(10). Amendments to §9.8 update language based on the updated definitions and delete duplicative language found in other sections within the chapter. Amendments to §9.9 update language based on the updated definitions. Amendments to §9.11 update language based on the updated definitions. Amendments to §9.12 update language based on the updated definitions, improve readability, and add a citation to another section within the chapter. Amendments to §9.13 make minor wording changes and update language based on the updated definitions. Amendments to §9.14 update language based on the updated definitions and improve grammar and readability. Amendments to §9.15 update language based on the updated definitions and improve readability. Amendments to §9.16 up-

date and clarify language and clarify that a borrower who wishes to reinstate service after five years must file a new application. Amendments to §9.17 update language based on the updated definitions. Amendments to §9.18 update language based on the updated definitions and improve readability.

SUMMARY OF COMMENTS. The commission did not receive any comments on the proposed new section or proposed amendments.

STATUTORY AUTHORITY. The amendments and new rule are adopted under Government Code, §441.006, which directs the commission to govern the state library; and Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

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

Filed with the Office of the Secretary of State on August 9, 2023.

TRD-202302916
Sarah Swanson
General Counsel
Texas State Library and Archives Commission
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For further information, please call: (512) 463-5460



CHAPTER 10. ARCHIVES AND HISTORICAL RESOURCES

13 TAC §10.1, §10.5

The Texas State Library and Archives Commission (commission) adopts an amendment to §10.1, Definitions, and new §10.5, Transfer of State Agency Records to the State Archives. The commission adopts §10.1 with one correction to update the reference from subchapter to chapter. These rules will be republished. The commission adopts new rule §10.5 without changes to the proposed text as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3019). These rules will not be republished.

The adopted amendment and new rule are necessary to facilitate and streamline state agency transfers of archival state records to the commission and ensure the state archivist has the information necessary to properly identify, arrange, describe, catalog, preserve, and provide access to the archival state records in accordance with state statutes. The new rule will benefit state agencies by establishing a systemic approach with key requirements clearly specified to improve state agencies' ability to verify they are transferring only those records that should be transferred to the state archives. The new rule will also ensure more efficient use of the commission's resources needed for managing the appraisal, accession, processing, and cataloging of incoming state agency records.

The amendment to §10.1 adds a definition for "state archives" to ensure clarity in new §10.5.

New §10.5 (a) restates the purpose of the new rule as authorized by statute. New §10.5(b) and (c) provide that a state agency must use the forms and procedures available on the commis-

sion's website or on request to initiate a transfer of archival state records. Subsection (b) applies to archival state records in the physical possession of the agency and subsection (c) applies to archival state records stored in the State Records Center. Both subsections clarify that submission of the forms constitutes a formal request to transfer archival state records to the state archives. New §10.5(d) requires that archival state records be appropriately identified, packaged, and transferred according to the procedures available on the commission's website. New §10.5(e) requires that all transfers be accompanied by an inventory. New §10.5(f) provides that records storage equipment received with transfers of records will be retained or disposed of at the discretion of the State Archives unless the transferring agency requests the equipment's return.

The commission did not receive any comments on the proposed amendment or new rule.

STATUTORY AUTHORITY. The amendment and new rule are adopted under Government Code, §441.190, which authorizes the commission to adopt rules establishing standards and procedures for the protection, maintenance, and storage of state records. The statute further directs the commission to pay particular attention to the maintenance and storage of archival and vital state records and authorizes the commission to adopt rules as it considers necessary to protect those records. In addition, the amendment and new rule are adopted under Government Code, §441.199, which authorizes the commission to adopt rules it determines necessary for cost reduction and efficiency of record-keeping by state agencies and for the state's management and preservation of records.

§10.1. Definitions.

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

- (1) Accession--means the formal acceptance of an item or collection into the holdings of the State Archives and generally includes a transfer of title.
- (2) Agency--means the Texas State Library and Archives Commission as an agency of the state of Texas, including the staff, collections, archives, operations, programs, and property of the Texas State Library and Archives Commission.
- (3) Commission--means the seven-member governing body of the Texas State Library and Archives Commission.
- (4) Deaccession--means the permanent removal of an item or collection of items from the holdings of the State Archives.
- (5) Disposal--means the final disposition of an item or collection of items from the State Archives which may include transfer to another repository, sale, or destruction of the item or collection.
- (6) Item--means archival material, historical item, artifact, or museum piece in the custody of the State Archives, including the Sam Houston Regional Library and Research Center.
- (7) Reappraisal--means the review of items that have been previously appraised, which may result in the identification of materials that no longer merit permanent preservation and that are candidates for deaccessioning.
- (8) State archives--means the program of the Archives and Information Services Division of the Texas State Library and Archives Commission for the continued preservation of archival state records and historical resources.

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

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TRD-202302913

Sarah Swanson

General Counsel

Texas State Library and Archives Commission

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For further information, please call: (512) 463-5460

TITLE 16. ECONOMIC REGULATION

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 59. CONTINUING EDUCATION REQUIREMENTS

16 TAC §59.3

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to an existing rule at 16 Texas Administrative Code (TAC), Chapter 59, §59.3, regarding the Continuing Education Requirements, without changes to the proposed text as published in the April 7, 2023, issue of the *Texas Register* (48 TexReg 1795). These rules will not be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 59, implement Texas Occupations Code, Chapter 51, Texas Department of Licensing and Regulation.

The adopted rule is necessary to implement rules being concurrently adopted which removed the requirement for registered accessibility specialists to meet continuing education requirements with an approved course provider. The adopted rules modify the list of occupations which are subject to the continuing education requirements of 16 TAC, Chapter 59, by removing registered accessibility specialists.

SECTION-BY-SECTION SUMMARY

The adopted rule amends §59.3, to remove registered accessibility specialists from the list of licensees that must comply with continuing education provider requirements.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the April 7, 2023, issue of the *Texas Register* (48 TexReg 1795). The public comment period closed on May 8, 2023. The Department did not receive any comments from interested parties on the proposed rules.

COMMISSION ACTION

At its meeting on August 1, 2023, the Commission adopted the proposed rules as published in the *Texas Register*.

STATUTORY AUTHORITY

The adopted rule is adopted under Texas Occupations Code, Chapter 51, and Texas Government Code, Chapter 469, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rule are those set forth in Texas Occupations Code, Chapter 51, and Texas Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted rule.

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

Filed with the Office of the Secretary of State on August 11, 2023.

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Doug Jennings

General Counsel

Texas Department of Licensing and Regulation

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For further information, please call: (512) 475-4879



CHAPTER 68. ELIMINATION OF ARCHITECTURAL BARRIERS

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 68, Subchapter H, §68.90; adopts new rules at Subchapter A, §68.11 and §68.12; Subchapter B, §68.22 and §68.31; and Subchapter C, §68.40; and adopts the repeal of existing rules at §§68.31, 68.51 - 68.54, 68.73, 68.74, 68.79, 68.100, and 68.101, regarding the Elimination of Architectural Barriers program; and the addition of subchapter titles to the existing chapter, without changes to the proposed text as published in the April 7, 2023, issue of the *Texas Register* (48 TexReg 1797). These rules will not be republished.

The Commission also adopts amendments to existing rules at 16 TAC Chapter 68, Subchapter A, §68.10; Subchapter B, §68.20 and §60.30; Subchapter D, §68.50; and Subchapter F, §§68.70, 68.75 and 68.76; and Subchapter H, §68.93; and adopts new rules at Subchapter B, §68.21; Subchapter C, §68.41 and §68.42; Subchapter D, §§68.51 - 68.53; and Subchapter F, §§68.73, 68.74 and 68.77, regarding the Elimination of Architectural Barriers program, with changes to the proposed text as published in the April 7, 2023, issue of the *Texas Register* (48 TexReg 1797). These rules will be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 68, implement Texas Government Code, Chapter 469.

The adopted rules implement changes suggested during the internal four-year rule review, incorporate department procedures for registered accessibility specialists, amend outdated rule language, and restructure the existing rules for better organization for the reader. The adopted rules also update the topics required and allowed for continuing education hours to provide additional options for licensees.

The adopted rules are necessary to establish requirements regarding accessibility to the public, registered accessibility specialists, building and facility owners, and design professionals.

SECTION-BY-SECTION SUMMARY

The adopted rules create new Subchapter A, General Provisions, which includes §68.1 and §§68.10 - 68.12.

The adopted rules amend §68.10, Definitions. The adopted rules add the definitions "day," "Department," "person," "project file," and "Texas Architectural Barriers Online System (TABS);" and amend the definitions of "owner" and "public entity" for clarity. The adopted rules also remove definitions that are not used in the chapter or otherwise have common meanings, including "commerce," "contract provider," "registered building or facility," "rules," "state agency," and "variance application." The adopted rules include Advisory Committee recommended changes to the published rule text at paragraph (5); the Committee recommended that the proposed changes to the term "completion of construction" not be adopted. The adopted rules also include Advisory Committee recommended changes to the published rule text at paragraphs (28) and (29) to correct numbering.

The adopted rules add new §68.11, Technical Standards and Technical Memoranda. The adopted rules adopt by reference the 2012 Edition of the Texas Accessibility Standards and authorize the department to publish memoranda for clarification of technical matters. The adopted rule was previously in §68.100, "Technical Standards and Technical Memoranda," which is adopted for repeal.

The adopted rules add new §68.12, Forms. The adopted rules provide that only forms issued by the department and submitted as prescribed will be accepted. The adopted rules also provide the limitations and penalties for use of non-authorized forms submitted to the department.

The adopted rules create new Subchapter B, Registration Requirements; Exemptions, which includes §§68.20 - 68.22, 68.30 and 68.31.

The adopted rules amend §68.20, Buildings and Facilities Subject to Compliance with the Texas Accessibility Standards (TAS). The adopted rules retitle the section to "Buildings and Facilities Subject to Compliance," update the language to reflect current terminology and also adds (c)(13) related to residential amenity spaces open to the public and (c)(14) related to temporary and emergency construction. The adopted rules add subsection (a) to clarify that all buildings or facilities listed in §68.20 are subject to compliance; move the exemption for establishments occupied as a related to primary residences to §68.30, Exemptions; and move the option to registration and review of projects with an estimated cost of less than \$50,000 to adopted new §68.21, Registration of Project or Lease Required. The adopted rules include Advisory Committee recommended changes to the published rule text at former proposed subsection (c)(14) to remove provisions related to pedestrian elements.

The adopted rules add new §68.21, Registration of Project or Lease Required. The adopted rules centralize the registration requirements for all projects and state leases subject to the Act. As discussed above, the adopted rules provide the option to register projects with an estimated construction cost of less than \$50,000.

The adopted rules add new §68.22, State Leases. The adopted rules relocate the requirements from §68.101, which is adopted for repeal. The adopted rules include subsection (a) to pro-

vide that state leased buildings or facilities with annual lease expenses of \$12,000 or more must be registered with the Department; subsection (b) to indicate the requirements that a leased building must comply with; and subsection (c) to prohibit a registered accessibility specialist from performing inspection services on a building subject to a state lease.

The adopted rules amend §68.30, Exemptions. The adopted rules add paragraph (5) to create an exemption for establishments that serve as the primary residence of the proprietor.

The adopted rules repeal current §68.31, Variance Procedures, and add new §68.31, with the same section title. The adopted rules clarify the process an owner or owner's designated must follow to apply for a variance or appeal the denial of a variance request.

The adopted rules create new Subchapter C, Owner Responsibilities, which include §§68.40 - 68.42.

The adopted rules add new §68.40, Owner Responsibilities. The adopted rules include section (a) which requires an owner to comply with the Act, TAS, and the chapter, if the owner has a construction project with an estimated construction cost of \$50,000 or more; (b) centralize the responsibilities of an owner in subsection to notify the department of changes; (c) report a change in the estimated date of completion; (d) submit a response to an inspection report when corrective modifications are required and complete them in a prescribed time; and (e) submit construction documents, if applicable.

The adopted rules add new §68.41, Inspection Required. The adopted rules require an owner to (a) have a project inspected by a registered accessibility specialist no later than a year from completion of construction; (b) request an inspection in writing; and (c) be present or have an agent or representative onsite during the inspection.

The adopted rules add new §68.42, Designated Agent. The adopted rules (a) specify the process an owner must follow to designate an agent and (b) clarify the role of a designated agent who is authorized to act on behalf of the owner. The adopted rules include Advisory Committee recommended changes to the published rule text at subsections (a) and (b) to combine the subsections; the remaining subsections have been re-lettered.

The adopted rules create new Subchapter D, Construction Documents; Inspections; and Compliance, which includes §§68.50 - 68.53.

The adopted rules amend §68.50, Submission of Construction Documents. The adopted rules amend the rules for clarity; eliminate requirements which are now unnecessary due to the online registration system; and add subsection (d) to provide notice that construction documents submitted to the department are department property. The adopted rules also include Advisory Committee recommended changes to the published rule text at subsection (b) to clarify that an owner must submit construction documents to a registered accessibility specialist prior to commencement of construction in unincorporated areas (extraterritorial jurisdictions) that don't issue building permits.

The adopted rules repeal §68.51, Review of Construction Documents, and add new §68.51, Plan Review Requirements. The new adopted rules (a) establish the requirements for a registered accessibility specialist to perform a review; (b) specify the process for review of revised or supplemental documents submitted by an owner; (c) set the timeline for providing plan review findings; and (d) outline the items that must be in a plan review or

plan revision review report. The adopted rules include Advisory Committee recommended changes to the published rule text at subsections (a), (b), and (d), to correct the term "plan revision review." The adopted rules also include Advisory Committee recommended changes to the published rule text at subsection (b) to require an owner to verify the date of construction completion in writing at the time of submission of revised or supplemental documents.

The adopted rules repeal §68.52, Inspections, and add new §68.52, Inspections and Corrective Modifications. The adopted rules (a) set requirements a registered accessibility specialist must comply with prior to an inspection, (b) specify requirements for an inspection to be valid, (c) set the items that must be included in an inspection report, (d) outline steps an owner must take if corrective modifications are required, and (e) set the time a response must be submitted in TABS. The adopted rules include Department recommended changes to published rule text at subsection (d) to clarify that the owner must submit the response to the inspection report directly to the registered accessibility specialist.

The adopted rules repeal §68.53, Corrective Modifications Following Inspection, and add new §68.53, Transmittal Letters. The adopted rules (a) set the timeline for providing a transmittal letter to an owner and (b) specify the items that must be included in a transmittal letter.

The adopted rules repeal §68.54, as the text is duplicative to provisions in adopted new §68.52, Inspections and Corrective Modifications.

The adopted rules create new Subchapter E, Advisory Committee, which includes §68.65.

The adopted rules create new Subchapter F, Registered Accessibility Specialists, which includes §68.70 and §§68.73 - 68.77. The adopted rules include Advisory Committee recommended changes to the published rule text to make a clerical correction to the title of the new Subchapter F.

The adopted rules amend §68.70, Registered Accessibility Specialists--Qualifications for Certification, with a change to the title of the section to Registered Accessibility Specialist Certification--Eligibility Qualifications, and Application Requirements. The adopted rules standardize the language and form for certification with other department rules.

The adopted rules repeal §68.73, Registration Requirements-Renewal, and replace it with new §68.73, Registered Accessibility Specialist Certification--Renewal Requirements. The adopted rules prescribe the process for renewal of a certification and standardize language and form for renewals with other department rules. The adopted rules include Advisory Committee recommended changes to the published rule text at subsection (a)(3) to correct a clerical error.

The adopted rules repeal §68.74, Continuing Education, and add new §68.74, with the same section title. The adopted rules provide (a) that a registered accessibility specialist must complete four hours of continuing education prior to license renewal, (b) the list of topics that meet eligibility requirements for continuing education, (c) that a registered accessibility specialist must certify completion of hours at the time of renewal, and (d) the timeline for completion of continuing education hours prior. The adopted rules also (e) limit credit for continuing education to completion of a course once per one-year period, (f) require a registered accessibility specialist to maintain a copy of their

records of completion, and (g) set an effective date for application of the rule. The adopted rules also include Department recommended changes to the published text at subsections (c)-(g) to correct numbering.

The adopted rules amend §68.75, Responsibilities of the Registered Accessibility Specialist. The adopted rules (a) set the deadline for a registered accessibility specialist to submit received fees to the department, (b) require a registered accessibility specialist to secure written authorization prior to performing services, (c) set records retention timelines, and (d) prescribe timelines for uploading a change to the estimated date of completion of construction. The adopted rules include Department recommended changes to the published rule text at subsection (e) to clarify the registered accessibility specialist's duty.

The adopted rules amend §68.76, Standards of Conduct. The adopted rules update language throughout the section, and clarify the requirements in subsections (b) and (c). The adopted rules also include Advisory Committee recommended changes to the published rule text at subsection (c)(3) which provide that non-design related review services are not consulting or professional services.

The adopted rules add new §68.77, Shared Services. The adopted rules (a) authorize a registered accessibility specialist to engage another registered accessibility specialist to assist in providing services to an owner and (b) outline the requirements each must comply with under the section.

The adopted rules repeal §68.79, Contract Providers, as this license type is not issued by the department.

The adopted rules create new Subchapter G, Fees, which includes §68.80.

The adopted rules create new Subchapter H, Enforcement, which includes §68.90 and §68.93.

The adopted rules amend §68.90, Administrative Sanctions or Penalties. The adopted rules remove the term "procedures" from subsection (a); and remove the terms "contract provider" and "department employee" in subsection (b).

The adopted rules amend §68.93, Complaints, Investigations, and Audits. The adopted rules amend subsection (b) by removing the term "contract providers," and adding that owners are also subject to the Act and chapter 68. The adopted rules update subsection (c) to reflect technological changes related to TABS and provide that records may be submitted in a time prescribed by the department.

The adopted rules repeal §68.100, Technical Standards and Technical Memoranda, which has been repropoed and renumbered as discussed above.

The adopted rules create new Subchapter I, General Technical Requirements, which includes §§68.102-68.104.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the April 7, 2023, issue of the *Texas Register* (48 TexReg 1797). The public comment period closed on May 8, 2023. The Department received comments from eight interested parties on the proposed rules. The public comments are summarized below.

Comment: The Department received a comment submitted by an individual opposed to §68.52 but was otherwise in support of

the proposed rules. The individual submitted a question regarding a definition in §68.52(b) regarding the presence of a representative of an owner. Specifically, the individual opposed the requirement in §68.52(d) for the owner to submit a response to the inspection report to the registered accessibility specialist as it may cause issues with monitoring if an owner fails to comply.

Department Response: The Department thanks the individual for their support and comments. The Department will not respond to the question presented by the individual regarding §68.52(b) but is available to provide technical assistance. The Department has updated the language in §68.52(d) to reflect that the responsibility of submitting the form is on the owner. The Department will continue to maintain discussions with the industry and owners to ensure that the intent of the rule is met.

Comment: The Department received a comment submitted by an individual regarding §68.76(c), conflict of interest provisions. The individual expressed concerns about the fact that a registered accessibility specialist is often engaged by multiple parties at different stages of a project and subsection (2) would require disclosure to each party. Additionally, the individual proposed that subsection (3) should be clarified or removed from the proposed changes due to the potential limitations it may place on a registered accessibility specialist who reviews reports for a project.

Department Response: The Department appreciates the individual's concerns and suggestions. Subsection 68.76(c)(3) has been changed to clarify that non-design related review services are not consulting or professional services for purposes of this section.

Comment: The Department received a submission an individual that was non-responsive to the substance of the proposal.

Department Response: The Department notes that the individual's comment is unrelated to the proposal and will not be addressed in this preamble. The Department did not make any changes to the proposed rules in response to this submission.

Comment: The Department received three comments from an individual regarding §§68.20, 68.73, and 68.76.

The individual submitted comments regarding §68.20(c)(14), pedestrian elements. The individual suggested requiring compliance with TAS for all rights of ways and easements for public use, regardless of when they become public property, which can be unclear.

The individual submitted comments regarding the number of hours required for continuing education in §68.73(a)(3).

The individual submitted comments regarding §68.76(c)(3) related to the prohibition on independent third-party consulting. The individual suggested that consulting enhances public safety and should not be prohibited.

Department Response: The Department thanks the individual for their comments. The Department will address each comment in order, separately.

The Department appreciates the industry insight on the application of the addition of pedestrian elements of the proposed rules. The Department has withdrawn former proposed §68.20(c)(14), related to pedestrian elements, from the proposed rules to allow further discussion with industry stakeholders and the Advisory Committee.

The Department appreciates the comment regarding the hours required for continuing education and has made an administrative correction to the proposed rules to change the number of hours required from eight to four to ensure consistency with new proposed §68.74.

The Department appreciates the insight on the application of §68.76(c)(3) and the use of third-party consultants as they apply to the proposed rules. As noted above, §68.76(c)(3) has been changed to clarify that non-design related review services are not consulting or professional services for purposes of this section.

Comment: The Department received five comments from an individual regarding §§68.10, 68.42, 68.50, 68.51, and 68.76. The individual also commented regarding the misspelling of the title of "Subchapter F. Registered Accessibility Specialists."

The individual submitted a comment regarding the term of "completion of construction" as defined in §68.10(5). Specifically, the individual notes that the proposed language will limit options and recourse in the event violations are discovered after a contractor has been paid.

The individual submitted non-substantive formatting suggestions regarding §68.42.

The individual submitted comments regarding §68.50(b), Submission of Construction Documents. The individual notes that clarification is needed in the event there is not a design professional and there is no authority with jurisdiction that issues building permits.

The individual submitted comments regarding §68.51, Plan Review Requirements, related to the use of the term "review" in conjunction with "plan revision."

The individual noted that the title of Subchapter F is misspelled.

Department Response: The Department thanks the individual for their comments. The Department will address each comment in order, separately.

The Department appreciates insight on the application of the proposed change to the definition of "completion of construction." The Department has withdrawn proposed changes to §68.10(5) to allow further discussion with industry stakeholders and the Advisory Committee.

The Department appreciates the comments regarding §68.42 and has changed the proposed rule to reflect the formatting suggestions and renumbered the rule accordingly.

The Department appreciates insight on the application of the proposed rule text at §68.50(b) and has made changes to address situations when there is an unincorporated portion of a county that does not issue building permits.

The Department appreciates the suggestion regarding the use of the term "plan revision review" and has made non-substantive changes throughout §68.51 to correct references to the proposed term "plan revision."

The Department thanks the commenter for their observation and has made the correction to the title of Subchapter F.

Comment: The Department received a comment from the Accessibility Professionals Association (APA). The APA's comment included multiple subparts regarding §§68.10, 68.11, 68.20, 68.40, 68.52, 68.73, 68.74, and 68.76. Additionally, the APA commented regarding the Department's local employment

impact statement; public benefit statement; and fiscal impact on small businesses, micro-businesses, and rural communities, all of which are contained in the preamble of the proposed rules.

The APA states that reducing continuing education units (CEUs) will have a financial impact on companies providing continuing education.

The APA states that reducing the number of hours will result in persons who perform at a lower quality and removing the requirement for approval of CEUs will open the door to fraud and eliminate quality control.

The APA states that reducing CEUs will impact the economy of continuing education providers.

The APA submitted comments regarding the term of "completion of construction" in §68.10(5), noting that the time of final payment may be hard to track and is not publicly available to all parties.

The APA submitted comments regarding §68.11, recommending that all technical memorandums be reviewed by the Advisory Committee prior to issuance.

The APA submitted comments regarding §68.20(14) related to pedestrian elements. Specifically, the APA points out that it is difficult to ascertain future ownership at the time of registration making compliance problematic.

The APA submitted questions seeking clarification regarding §68.40, related to an owner's responsibilities.

The APA submitted a comment regarding §68.52, Inspections and Corrective Modifications, specifically recommending that a contractor, tenant, or other individual who may not represent the owner but is onsite be authorized to sign as a witness during an inspection.

The APA submitted comments regarding the number of hours required for continuing education in §68.73(a)(3).

The APA submitted a comment on §68.74 recommended that the number of required continuing education hours in the proposed rule text be increased to eight hours.

The APA submitted a comment regarding §68.76(c)(2). The APA expressed concerns about the fact that a registered accessibility specialist is often engaged by multiple parties at different stages of a project and subsection (2) would require disclosure to each party.

The APA submitted multiple observations and questions regarding §68.76(c)(3) relating to conflict of interest.

Department Response: The Department thanks APA for its extensive review and comments. The Department will address each comment in order, separately.

The Department appreciates industry input and understands that companies may be impacted but disagrees with this comment; however, this number cannot be quantified and registered accessibility specialists will still be required to obtain four hours of continuing education credits. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates industry input but disagrees with this comment. Registered accessibility specialists will have the opportunity to seek training from a broader number of providers based on the selected topics listed in §68.74. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates the contribution that continuing education providers have on the EAB community, however it disagrees with the comment based on its analysis. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates insight on the application of the proposed change to the definition of "completion of construction." As noted above, the Department has withdrawn proposed changes to §68.10(5) to allow further discussion with industry stakeholders and the Advisory Committee.

The Department recognizes the need for industry input when drafting guidance, rules, and other technical documents. The Department works closely with workgroups and consults with its Advisory Committee members, as needed. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates the industry insight on the application of the addition of pedestrian elements of the proposed rules. As stated above, Department has withdrawn former proposed §68.20(c)(14), related to pedestrian elements, to allow further discussion with industry stakeholders and the Advisory Committee.

The Department notes that the APA's submission regarding §68.40 is not a comment on the proposal but a request for clarification. Technical guidance will be provided by program staff. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates the comment regarding §68.52 related to persons authorized to sign a Proof of Inspection Form but disagrees with the suggested change. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates the comment regarding the hours required for continuing education and as noted above, has made an administrative correction to the proposed rules to change the number of hours required from eight to four to ensure consistency with new proposed §68.74.

The Department appreciates the recommendation submitted by the APA regarding the number of continuing education hours in §68.74, however it disagrees with this change. The technical workgroup and Advisory Committee discussed and approved of the recommendation to reduce the required CEU hours. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates the APA's concerns regarding §68.76(c)(2). The Advisory Board's recommended changes to proposed text at §68.76(c)(3) to clarify that non-design related review services are not consulting or professional services for purposes of this section incorporate the concerns of the APA.

The Department appreciates the analysis and review of the APA regarding §68.76. As noted above §68.76(c)(3) has been changed to clarify that non-design related review services are not consulting or professional services for purposes of this section.

Comment: The Department received a comment an individual which included multiple subparts regarding §§68.10, 68.52, 68.73, 68.75, and 68.76.

The individual submitted comments regarding the term of "completion of construction" in §68.10(5). The individual rec-

ommended the use of the definition of "substantial completion" used by the AIA when defining completion of construction.

The individual submitted a question regarding application of §68.52(d).

The individual submitted comments regarding the number of hours required for continuing education in §68.73(a)(3).

The individual submitted a question regarding §68.75(c).

The individual submitted a question regarding §68.75(e).

The individual submitted a comment regarding §68.76(c)(2). The individual expressed concerns that a registered accessibility specialist is often engaged by multiple parties at different stages of a project and subsection (2) would require disclosure to each party.

The individual submitted comments regarding §68.76(c)(3) related to the prohibition on independent third-party consulting.

Department response: The Department thanks the individual for their review and comments. The Department will address each comment in order, separately.

The Department appreciates the individual's suggestion regarding the definition of "completion of construction." As noted above, the Department has withdrawn proposed changes to §68.10(5) to allow further discussion with industry stakeholders and the Advisory Committee.

The Department notes that the individual's submission is not a comment on the proposal but a request for clarification regarding §68.52. Technical guidance will be provided by program staff. The Department did not make any changes to the proposed rules in response to this submission.

The Department appreciates the comment regarding the hours required for continuing education and as noted above, has made an administrative correction to the proposed rules to change the number of hours required from eight to four to ensure consistency with new proposed §68.74.

The Department notes that the individual's submission is not a comment on the proposal but a request for clarification regarding §68.75(c). Technical guidance will be provided by program staff. The Department did not make any changes to the proposed rules in response to this submission.

The Department notes that the individual's submission is not a comment on the proposal but a request for clarification regarding §68.75(e). However, the Department appreciates the request and did make an administrative change to the rule to clarify the responsibility of the registered accessibility specialist to update their own contact information.

The Department appreciates the individual's concerns regarding §68.76(c)(2). As noted above, proposed text at §68.76(c)(3) has been changed in the adopted rules to clarify that non-design related review services are not consulting or professional services for purposes of this section.

The Department appreciates the insight on the application of §68.76(c)(3) and the use of third-party consultants as they apply to the proposed rules. As noted above, §68.76(c)(3) has been changed in the adopted rules to clarify that non-design related review services are not consulting or professional services for purposes of this section.

ADVISORY COMMITTEE RECOMMENDATIONS AND COMMISSION ACTION

The Elimination of Architectural Barriers Advisory Committee met on June 7, 2023, to discuss the proposed rules and the public comments received. The Advisory Committee recommended that the Commission adopt the proposed rules as published in the *Texas Register* with changes to existing rules at 16 TAC Chapter 68, Subchapter A, §68.10; Subchapter B, §68.20; Subchapter D, §68.50; and Subchapter F, §68.75 and §68.76; and adopts new rules at Subchapter C, §68.41 and §68.42; Subchapter D, §68.51 and §68.52; and Subchapter F, §68.73 and §68.74 made in response to public comment, Advisory Committee, and Department recommendations. At its meeting on August 1, 2023, the Commission adopted the proposed rules with changes as recommended by the Advisory Committee.

16 TAC §§68.31, 68.51 - 68.54, 68.73, 68.74, 68.79, 68.100, 68.101

STATUTORY AUTHORITY

The adopted repeals are adopted under Texas Occupations Code, Chapter 51, and Government Code, Chapter 469, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted repeals are those set forth in Texas Occupations Code, Chapters 51, and Texas Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted repeals.

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

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SUBCHAPTER A. GENERAL PROVISIONS

16 TAC §§68.10 - 68.12

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51, and Government Code, Chapter 469, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51, and Texas Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted rules.

§68.10. Definitions.

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

(1) Act--Texas Government Code, Chapter 469, Elimination of Architectural Barriers.

(2) Alteration-- A renovation, modification, or change to a building or facility that affects or could affect the usability of the building or facility or portion thereof. Re-roofing, painting, or wallpapering, or changes to mechanical and electrical systems are not alterations unless they affect the usability of the building or facility.

(3) Building--Any structure located in the State of Texas used or intended for supporting or sheltering any use or occupancy.

(4) Commencement of Construction--The date of placement of engineering stakes, delivery of lumber or other construction materials to the job site, erection of batter boards, formwork, or other construction related work.

(5) Completion of Construction--The date when a construction project results in occupancy or the issuance of a certificate of occupancy. For public roadway projects, completion of construction occurs upon final payment and release of the contractor performing the work or, if the work is performed by public employees, removal of barricades and opening of all traffic lanes for use.

(6) Construction Documents--Drawings, specifications, addenda, change orders, construction change directives and other supplemental documents prepared for the purpose of regulatory approval, permitting, or construction.

(7) Crosswalk--That part of a roadway where motorists are required to yield to pedestrians crossing, as defined by state and local regulations, whether marked or unmarked.

(8) Curb Line--A line that represents the extension of the face of the curb and marks the transition between the sidewalk and the gutter or roadway at a curb ramp or flush landing.

(9) Day--A calendar day.

(10) Department--The Texas Department of Licensing and Regulation.

(11) Designated Agent--An individual designated in writing by the owner to act on the owner's behalf.

(12) Element--An architectural or mechanical component of a building, facility, space, or site, e.g., telephone, curb ramp, door, drinking fountain, seating, water closet, or public right-of-way.

(13) Estimated Construction Cost--Includes all costs for construction of a project except site acquisition, architectural, engineering and consulting fees, furniture, and equipment unless the equipment is part of the mechanical, electrical, or plumbing systems.

(14) Facility--All or any portion of buildings, structures, site improvements, elements, and pedestrian routes or vehicular ways located on a site e.g. complexes, equipment, roads, walks, passageways, parking lots, or other real property subject to the Act.

(15) Housing at a Place of Education--Public or privately funded housing operated by or on behalf of an elementary, secondary, undergraduate, or postgraduate school, or other place of education, including dormitories, suites, apartments, or other places of residence.

(16) Issue--To mail, deliver, transmit, or otherwise release plans or specifications to an owner, lessee, contractor, subcontractor, or any other person acting for an owner or lessee for the purpose of construction, applying for a building permit, or obtaining regulatory approval after such plans have been sealed by an architect, registered interior designer, landscape architect, or engineer. In the case of a state-funded or other public works project, it is the time at which plans or specifications are publicly posted for bids, after such plans or speci-

fications have been sealed by an architect, registered interior designer, landscape architect, or engineer.

(17) Overall Responsibility--The level of responsibility held by an architect, registered interior designer, landscape architect or engineer who prepares construction documents and coordinates the various aspects of the design of a building or facility.

(18) Owner--The person(s) that hold(s) title to the building or facility subject to compliance with the Act, TAS, and this chapter.

(19) Pedestrian Access Route--A continuous and unobstructed path of travel provided for pedestrians with disabilities within or coinciding with a pedestrian circulation path.

(20) Pedestrian Elements--Components that make up a pedestrian access route including, but not limited to walking surfaces, ramps, curb ramps, crosswalks, pedestrian overpasses and underpasses, automated pedestrian signals, elevators, and platform lifts.

(21) Person--An individual, corporation, partnership, or other legal entity, including a state agency or governmental subdivision.

(22) Project File--Records retained, uploaded, or submitted to TABS.

(23) Public Entity--Any state government agency or unit of local government or special purposes district.

(24) Public Right-of-Way--Public land or property, usually in interconnected corridors, that is acquired for or dedicated to transportation purposes.

(25) Registered Accessibility Specialist--An individual who is certified by the department to perform review and inspection functions of the department.

(26) Religious Organization--An organization that qualifies for an exemption from taxation, as a religious organization as provided in Texas Tax Code, Chapter 11, §11.20(c).

(27) Sidewalk--That portion of an exterior circulation path that is improved for use by pedestrians and usually paved.

(28) Texas Accessibility Standards (TAS)--The collection of scoping and technical requirements for accessibility to sites, facilities, buildings, and elements by individuals with disabilities, periodically adopted by the Texas Commission of Licensing and Regulation.

(29) Texas Architectural Barriers Online System (TABS)--The online database for the registration of projects subject to the TAS and maintenance of project records.

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

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SUBCHAPTER B. REGISTRATION REQUIREMENTS; EXEMPTIONS

16 TAC §§68.20 - 68.22, 68.30, 68.31

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51, and Government Code, Chapter 469, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51, and Texas Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted rules.

§68.20. Buildings and Facilities Subject to Compliance.

(a) All buildings or facilities listed under this section are subject to compliance with the Act, TAS, and this chapter, regardless of the estimated cost of construction, unless exempted under §68.30.

(b) The following buildings and facilities are subject to compliance with the Act, TAS, and this chapter:

(1) A building or facility used by a public entity if it is constructed, renovated, or modified, in whole or in part, on or after January 1, 1970, using funds from the state or a county, municipality, or other political subdivision of the state.

(2) A building or facility leased for use or occupied, in whole or in part, by the state under a lease or rental agreement entered into on or after January 1, 1972, except as modified under §68.22.

(c) The following private buildings and facilities constructed, renovated, or modified on or after January 1, 1992, and defined as a "public accommodation" by Section 301, Americans with Disabilities Act of 1990 (42 U.S.C. Section 12181), and its subsequent amendments are subject to the Act, TAS, and this chapter:

(1) A place of lodging that includes guest rooms for short-term stays of 30 days or less where the occupant does not have the right to return to a specific room or unit after the conclusion of their stay, and under conditions and with amenities similar to a hotel, motel, or inn.

(A) Amenities include:

(i) on or off-site management and reservations service;

(ii) rooms available on a walk-up or call-in basis;

(iii) available housekeeping or linen service; and

(iv) acceptance of reservations for a guest room type without guaranteeing a particular unit or room until checking in, and without prior lease or security deposit.

(B) A place of transient lodging with no more than five rooms for rent or hire that is occupied by the proprietor as the proprietor's primary residence as provided under §68.30 is not subject to this section.

(2) an establishment that serves food or drinks, including a restaurant or bar;

(3) a sports or entertainment venue, including a movie theater, concert hall, stadium, or other place of exhibition or entertainment;

- (4) a public gathering venue, including an auditorium, convention center, or lecture hall;
- (5) a retail establishment or shopping center;
- (6) a service establishment, including a laundromat, dry-cleaner, bank, barber shop, salon, gas station, professional office, medical facility, health care provider, or hospital;
- (7) a public transportation station, including a terminal or depot;
- (8) a place of recreation, including a park, zoo, or amusement park;
- (9) a place of public display or collection, including a museum, library or gallery;
- (10) a place of education, including a day care center, elementary, secondary, undergraduate, or postgraduate private school;
- (11) a social service center establishment, including a senior citizen center, homeless shelter, food bank, or adoption agency;
- (12) a place of exercise or recreation, including a gymnasium, health spa, bowling alley, or golf course;
- (13) a residential amenity space open to the public which is used, leased, or rented to residents, members, non-residents, or non-members; and
- (14) a building or facility that is constructed, renovated, or modified on a temporary or emergency basis including workforce housing, man camps, fixed furniture systems, wall systems, and exhibit areas.

(d) A commercial facility is subject to the Act, this chapter, and compliance with TAS if it is intended for non-residential use by a private entity and its operations will affect commerce, except for railroad locomotives, railroad freight cars, railroad cabooses, commuter or intercity passenger rail cars or any other railroad cars described in the Americans with Disabilities Act (ADA) §242, or covered under the ADA, Title III, railroad rights-of-way, or facilities that are covered or expressly exempted from coverage under the federal Fair Housing Act of 1968.

(e) A building or facility of a religious organization is subject to the Act, this chapter, and compliance with TAS except for areas as provided under §68.30.

§68.21. Registration of Project or Lease Required.

(a) Projects registration required. A building or facility being constructed, renovated, or modified with an estimated construction cost of \$50,000 or more that is subject to compliance with the Act, the TAS, and this chapter must be registered with the department. To register a construction project, an owner must submit:

- (1) an application on a form as prescribed by the department; and
 - (2) the required fee in §68.80.
- (b) State lease registration required. A new or renewal lease agreement for an agency of the state of Texas with annual lease expense \$12,000 or more must be registered with the department. To register a lease, a state agency must submit:
- (1) an application on a form as prescribed by the department; and
 - (2) the required fee in §68.80.
- (c) Project registration optional. A building or facility being constructed, renovated, or modified with an estimated construction cost

of less than \$50,000 or that is not subject to the Act may be registered with the department and reviewed and/or inspected by a registered accessibility specialist.

§68.30. Exemptions.

The following buildings, facilities, spaces, or elements are exempt from the provisions of the Act:

- (1) Federal Property. Buildings or facilities owned, operated, or leased by the federal government;
- (2) Places Used Primarily for Religious Rituals. An area within a building or facility of a religious organization used primarily for religious ritual as determined by the owner or occupant. To facilitate the plan review, the owner or occupant shall include a clear designation of such areas with the plans submitted for review. This exemption does not apply to the following: parking facilities, accessible routes, walkways, hallways, toilet facilities, entrances, public telephones, drinking fountains, and exits;
- (3) Van Accessible Parking at Garages Constructed Prior to April 1994. Parking garages where construction was started before April 1, 1994, and the existing vertical clearance of the garage is less than 98", are exempted from requirements to have van-accessible parking spaces located within the garage. If additional surface parking is provided, the required van accessible parking spaces shall be located on a surface lot in closest proximity to the accessible public entrance serving the facility;
- (4) Residential Facilities. Those portions of public or privately funded apartments, condominiums, townhomes, and single-family dwellings used exclusively by residents and their guests; and
- (5) Places of Primary Residence. An establishment or place of lodging that does not have more than five rooms for rent or hire and that is occupied by the proprietor as their primary residence.

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

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SUBCHAPTER C. OWNER RESPONSIBILITIES

16 TAC §§68.40 - 68.42

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51, and Government Code, Chapter 469, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51, and Texas

Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted rules.

§68.41. Inspection Required.

(a) The owner of a building or facility with a project required to be registered under §68.21 must obtain an inspection by a registered accessibility specialist no later than one year from the date of the completion of construction.

(b) A request for inspection must be in writing and submitted to a registered accessibility specialist.

(c) The owner, the owner's designated agent, or an individual representing the owner is required to be physically onsite with the registered accessibility specialist during the inspection. A physical or electronic signature must be provided by the owner or designated agent who was present during the inspection on a form prescribed by the department.

§68.42. Designated Agent.

(a) An owner may designate an agent to act on their behalf by submitting a form prescribed by the department. To be valid, the form must be complete and signed by the owner or an individual employed by the owner. A parent or other person associated with the owner is not authorized to submit or sign the form on behalf of the owner.

(b) A designated agent is authorized to:

- (1) submit project information changes;
- (2) request a waiver or variance;
- (3) make a request for inspection;

(4) communicate with the department on behalf of the owner about the registered project;

(5) receive communications from a registered accessibility specialist; and

(6) submit verification of corrections to a registered accessibility specialist and the department.

(c) A designated agent's failure to comply with the requirements of this chapter on behalf of an owner does not excuse the owner from compliance with the Act, this chapter, and the TAS.

(d) A form must be submitted for each project registered to designate the agent, regardless of whether all the projects are in the same building.

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

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**SUBCHAPTER D. CONSTRUCTION
DOCUMENTS; INSPECTIONS; COMPLIANCE
16 TAC §§68.50 - 68.53**

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51, and Government Code, Chapter 469, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51, and Texas Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted rules.

§68.50. Submission of Construction Documents.

(a) If the estimated construction cost is \$50,000 or more, all plans and specifications for the construction of or alteration to a building or facility subject to §469.101 of the Act must be submitted by a design professional along with a form prescribed by the department to a registered accessibility specialist not later than the twentieth day after the plans and specifications are issued. In computing time under this section, Saturday, Sunday, and legal holidays are not included. All plans may be submitted in electronic format.

(b) When there is not a design professional with overall responsibility, the owner of a building or facility must submit the construction documents to a registered accessibility specialist prior to filing an application for building permit or commencement of construction in an unincorporated portion of a county that does not issue building permits.

(c) An owner or design professional may submit revised construction documents to a registered accessibility specialist to review, including change orders, addenda, or letters.

(d) Construction documents provided to the department become the property of the department and will not be returned.

§68.51. Plan Review Requirements.

(a) Prior to performing a plan review or plan revision review, a registered accessibility specialist must have project construction documents for the building or facility.

(b) An owner may submit revised or supplemental construction documents for review. Upon receipt, a registered accessibility specialist must verify the date of construction completion in writing with the owner. Revised or supplemental construction documents submitted to the registered accessibility specialist:

(1) prior to the recorded estimated completion of construction must be reviewed as part of a plan revision; or

(2) after completion of construction based on the estimated completion of construction are not required to be reviewed but must be uploaded in the TABS project file.

(c) After review of construction documents, the registered accessibility specialist must provide the owner or the owner's designated agent and the design professional making the submission the plan review findings no later than 30 days from the date of the report. All plan review findings must be uploaded in TABS.

(d) A plan review or plan revision review report must be type-written and include, at a minimum:

(1) a title indicating whether the report is a "Plan Review Report" or "Plan Revision Review Report;"

(2) the name and certification number of the registered accessibility preparing the report;

(3) date of the report;

- (4) TABS project number issued by the department;
- (5) facility name;
- (6) project name and address; and
- (7) a detailed list of each deficiency, including a reference to the TAS section number, if applicable.

§68.52. *Inspections and Corrective Modifications.*

(a) Prior to performing an inspection, a registered accessibility specialist must have access to the project in TABS and a written request for inspection from the owner or the owner's designated agent.

(b) To be valid, the owner, the owner's designated agent, or an individual representing the owner is required to be present during the inspection. The individual onsite during the inspection must provide a physical or electronic signature on the inspection form prescribed by the department.

(c) A registered accessibility specialist must complete an inspection report no later than 30 days from the date of the inspection. An inspection report must be:

- (1) provided to the owner within 30 days of the date of the report;
- (2) uploaded in TABS;
- (3) typewritten and include, at a minimum:
 - (A) heading titled "Inspection Report;"
 - (B) the name and certification number of the registered accessibility preparing the report;
 - (C) date of the report;
 - (D) date of the inspection;
 - (E) TABS project number issued by the department;
 - (F) facility name;
 - (G) project name and address; and
 - (H) violations cited in detailed, followed by the TAS section number, including specific information identifying the location of each violation.

(d) If corrective modifications are required to achieve compliance the owner must:

- (1) respond to the inspection report by submitting a form prescribed by the department to the registered accessibility specialist not later than the 30th day of the date of the inspection report; and
- (2) complete corrective modifications by the 270th day after the date of the inspection report.

(e) The owner's corrective modification response must be uploaded in TABS not later than the 30th calendar day after receipt.

§68.53. *Transmittal Letters.*

(a) A transmittal letter must be provided to an owner no later than the 30th day after the completion of a plan review, plan revision, or inspection and uploaded in TABS.

(b) A transmittal letter must be typewritten and include, at a minimum:

- (1) date of the report;
- (2) the name and certification number of the registered accessibility preparing the letter;
- (3) owner name and address;

- (4) TABS project number issued by the department;
- (5) project name, facility name, and address;
- (6) results paragraph, as applicable;
- (7) owner action paragraph, as applicable; and
- (8) disclaimer paragraph, as applicable.

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SUBCHAPTER F. REGISTERED ACCESSIBILITY SPECIALISTS

16 TAC §§68.70, 68.73 - 68.77

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51, and Government Code, Chapter 469, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51, and Texas Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted rules.

§68.70. *Registered Accessibility Specialist Certification--Eligibility, Qualifications, and Application Requirements.*

(a) A person may not perform or offer to provide plan review or inspection services unless the person is a certified registered accessibility specialist. To be certified, an individual must:

- (1) meet one of the following qualifications:

(A) hold a degree in architecture, engineering, interior design, landscape architecture, or equivalent, and at least one year experience related to building inspection, building planning, accessibility design or review, accessibility inspection, or equivalent;

(B) have at least eight years of experience related to building inspection, building planning, accessibility design or review, accessibility inspection, or equivalent; or

(C) have at least four years of experience related to building inspection, building planning, accessibility design or review, accessibility inspection, or equivalent, and certification by a model building code organization as an accessibility inspector or plans examiner;

- (2) pass an examination approved by the department;

- (3) successfully pass a criminal history background check;

and

(4) submit the required fee under §68.80.

(b) An applicant must submit the following required documentation in a manner prescribed by the department:

(1) a complete application on a department approved form; and

(2) verifiable evidence that the applicant meets the requirements in subsection (a)(1).

(c) Each applicant who satisfies all requirements will be provided a wallet card and a wall certificate. The wallet card is the actual certificate of registration.

(d) An applicant must complete all requirements, including passing the examination in subsection (a)(2), no later than one year from the date the application is submitted. After that year the applicant will be required to submit a new application and all required materials in addition to paying a new application fee.

§68.73. Registered Accessibility Specialist Certification--Renewal Requirements.

(a) To renew a certification, a registered accessibility specialist must:

(1) submit a complete renewal application in a manner prescribed by the department;

(2) successfully pass a criminal history background check;

(3) complete four hours of continuing education as required under §68.74; and

(4) submit the required fee under §68.80.

(b) A registered accessibility specialist with an expired certification shall not perform work requiring registration under the Act.

(c) A certification will not be renewed until continuing education requirements have been met.

§68.74. Continuing Education.

(a) To renew a certification, a registered accessibility specialist must complete four hours of continuing education as provided in this section.

(b) To meet the requirements of this section, continuing education hours must include instruction in one or more of the following topics:

(1) Texas Government Code, Chapter 469, Elimination of Architectural Barriers;

(2) 16 Texas Administrative Code, Chapter 68 - Administrative Rules;

(3) 2012 Texas Accessibility Standards;

(4) technical memoranda published by the department;

(5) 2010 Standards for Accessible Design or other accessibility guidelines proposed or adopted by the Access Board or United States Department of Justice;

(6) Americans with Disabilities Act;

(7) International Code Council/American National Standards Institute (ANSI) A117.1 Standard on Accessible and Usable Buildings and Facilities; or

(8) life safety codes related to egress.

(c) A registered accessibility specialist must certify completion of continuing education hours at the time of renewal in a manner prescribed by the department.

(d) Continuing education hours must have been completed within the term of the current certification, in the case of a timely renewal. For a late renewal, the continuing education hours must have been completed within the one-year period immediately prior to the date of renewal.

(e) A registered accessibility specialist will not receive continuing education credit for attending the same course more than once during the one-year period in which the course is offered.

(f) A registered accessibility specialist must retain a copy of the certificate of completion for a course for three years after the date of completion. In conducting an inspection or investigation of a registered accessibility specialist, the department may examine the registered accessibility specialist's records to determine compliance with this section.

(g) This section applies to certifications that expire on or after September 1, 2023.

§68.75. Responsibilities of the Registered Accessibility Specialist.

(a) A registered accessibility specialist may set and collect fees for services rendered but must submit to the department fees received on behalf of the department no later than 30 days after receipt.

(b) A registered accessibility specialist must secure written authorization:

(1) from an owner prior to performing a plan review, inspection, or related activity of a building or facility with an estimated construction cost of less than \$50,000 or that is not subject to the Act; and

(2) from the department prior to performing a plan review, inspection, or related activity for a building or facility that will be leased or occupied by an agency of the State of Texas.

(c) A registered accessibility specialist must maintain project files for a period of one year following the closure of the project in TABS.

(d) A registered accessibility specialist is required to upload a change in the estimated date of completion of construction within 30 days of receipt from the owner.

(e) A registered accessibility specialist must provide written notification to the department of changes to their contact information within 30 calendar days of a change occurring.

§68.76. Standards of Conduct.

(a) Competency. A registered accessibility specialist shall ensure compliance, be knowledgeable of, and adhere to the Act, the TAS, and this chapter. A registered accessibility specialist shall exercise reasonable judgment and skill in the performance of plan reviews, inspections, and related activities.

(b) Integrity. A registered accessibility specialist shall not:

(1) be deceitful or make misrepresentations, whether by acts of commission or omission, in the performance of plan review, inspection, and related activities; or

(2) commit acts or practices that constitute threats, coercion, or extortion.

(c) Conflict of Interest.

(1) If a registered accessibility specialist has any business association or financial interest which might reasonably appear to influence the individual's judgment in connection with the performance of a professional service and thereby jeopardize an interest of the registered accessibility specialist's current or prospective client or employer,

the registered accessibility specialist shall promptly inform the client or employer in writing of the circumstances of the business association or financial interest.

(2) A registered accessibility specialist shall not solicit or accept, directly or indirectly, any financial or other valuable consideration, material favor, or other benefit of any substantial nature, financial or otherwise, from more than one party in connection with a single project or assignment unless the circumstances are fully disclosed in writing to all parties.

(3) A registered accessibility specialist shall not perform plan reviews, inspections, or related activities, such as preliminary plan reviews or pre-construction site assessments, while also providing consulting or other professional services on the same registered project. Non-design related review services are not consulting or professional services for the purposes of this section.

(d) Specific Rules of Conduct. A registered accessibility specialist shall not:

(1) participate, whether individually or in concert with others, in any plan, scheme, or arrangement attempting or having as its purpose the evasion of any provision of the Act, the rules, or the TAS;

(2) knowingly furnish inaccurate, deceitful, or misleading information to the department, a building owner, or other person involved in a plan review, inspection, or related activity;

(3) state or imply that the department will approve a variance;

(4) engage in any activity that constitutes dishonesty, misrepresentation, or fraud while performing a plan review, inspection, or related activity;

(5) perform a plan review, inspection, or related activity in a negligent or incompetent manner;

(6) perform a plan review, inspection, or related activity on a building or facility in which the registered accessibility specialist is an owner, either in whole or in part, or an employee of a full or partial owner;

(7) perform a plan review, inspection, or a related activity on a building or facility that is or will be leased or occupied by an agency of the State of Texas, when the registered accessibility specialist is an employee of the state agency that will occupy the facility;

(8) perform a plan review, inspection, or related activity on a building or facility wherein the registered accessibility specialist participated in creating the overall design of the current project; or

(9) represent himself or herself as an employee of the department or as a person hired by the department.

§68.77. Shared Services.

(a) A registered accessibility specialist may engage the services of another registered accessibility specialist to perform services on their behalf.

(b) Each registered accessibility specialist engaged in shared services must:

(1) be actively certified with the department;

(2) complete the assigned plan review or inspection within 30 days of accepting the project in TABS; and

(3) not alter the work product of the other registered accessibility specialist, which includes making amendments to a plan review, inspection report, or corrective modification letter.

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

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Doug Jennings

General Counsel

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For further information, please call: (512) 475-4879



SUBCHAPTER H. ENFORCEMENT

16 TAC §68.90, §68.93

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51, and Government Code, Chapter 469, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51, and Texas Government Code, Chapter 469. No other statutes, articles, or codes are affected by the adopted rules.

§68.93. Complaints, Investigations, and Audits.

(a) Complaints. A complaint may be filed against an owner if there is reason to believe that a building or facility is not in compliance with the Act, the rules, or the TAS. A complaint may be filed against a registered accessibility specialist if there is reason to believe that the registered accessibility specialist has violated the Act, the rules, procedures, or the TAS.

(b) Investigations and Audits. Owners of buildings and facilities subject to compliance with the Act, TAS, and this chapter, are subject to investigation by the department. Registered accessibility specialists are subject to investigation and audit by the department.

(c) Inspection of Records. Records pertaining to a project for which plan review, inspection, or related activities have been or will be performed, must be made available by the registered accessibility specialist for inspection upon request. Records must be uploaded in TABS within 14 calendar days of receiving a written request from the department, or within a time prescribed by the department.

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

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CHAPTER 73. ELECTRICIANS

16 TAC §73.100

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to an existing rule at 16 Texas Administrative Code (TAC), Chapter 73, §73.100, regarding the Electricians program, without changes to the proposed text as published in the April 28, 2023, issue of the *Texas Register* (48 TexReg 2172). These rules will not be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 73, implement Texas Occupations Code, Chapter 1305, Electricians.

The adopted rule is necessary to adopt the 2023 National Electrical Code (NEC) as required by statute. Texas Occupations Code §1305.101(a) requires the Commission to adopt, every three years, the revised NEC as the electrical code for the state. The current rule references the 2020 edition of the NEC.

SECTION-BY-SECTION SUMMARY

The adopted rule amends §73.100, Technical Requirements, by adopting the 2023 edition of the NEC effective September 1, 2023, and repealing subsection (b) of the current rule.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the April 28, 2023, issue of the *Texas Register* (48 TexReg 2172). The public comment period closed on May 30, 2023. The Department received comments from four interested parties on the proposed rules. The public comments are summarized below.

Comment: One commenter stated support for the proposed repeal of §73.100(b).

Department Response: The department appreciates the comment. The Department did not make any changes to the proposed rules based on this comment.

Comment: One commenter had a question about examination procedures.

Department Response: The comment was forwarded to the Customer Service division for response. The Department did not make any changes to the proposed rules based on this comment.

Comment: One commenter had a question about the status of an application.

Department Response: The comment was forwarded to the Customer Service division for response. The Department did not make any changes to the proposed rules based on this comment.

Comment: One commenter submitted a certificate showing completion of a continuing education course.

Department Response: The comment was forwarded to the Customer Service division for response. The Department did not make any changes to the proposed rules based on this comment.

ADVISORY BOARD RECOMMENDATIONS AND COMMISSION ACTION

The Electrical Safety and Licensing Advisory Board met on June 26, 2023, to discuss the proposed rules and the public comments

received. The Advisory Board recommended that the Commission adopt the proposed rules as published in the *Texas Register*. At its meeting on August 1, 2023, the Commission adopted the proposed rules as recommended by the Advisory Board.

STATUTORY AUTHORITY

The adopted rule is adopted under Texas Occupations Code, Chapters 51 and 1305, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rule are those set forth in Texas Occupations Code, Chapters 51 and 1305. No other statutes, articles, or codes are affected by the adopted rule.

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

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Doug Jennings

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CHAPTER 75. AIR CONDITIONING AND REFRIGERATION

16 TAC §75.100

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to an existing rule at 16 Texas Administrative Code (TAC), Chapter 75, §75.100, regarding the Air Conditioning and Refrigeration Contractors (ACR) program, without changes to the proposed text as published in the April 28, 2023, issue of the *Texas Register* (48 TexReg 2173). These rules will not be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 75, implement Texas Occupations Code, Chapter 1302, Air Conditioning and Refrigeration Contractors.

The adopted rule is necessary to remove outdated language related to the 2020 National Electrical Code (NEC) that was included in the ACR program rules. Texas Occupations Code §1305.101(a) requires the Commission to adopt, every three years, the revised NEC as the electrical code for the state. The Department proposed rules under the Electricians program to adopt the 2023 NEC (see separate rulemaking). The language related to the 2020 NEC is no longer necessary to be included in the ACR program rules.

SECTION-BY-SECTION SUMMARY

The adopted rule amends §75.100, Technical Requirements, by repealing subsection (a)(5).

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules

were published in the April 28, 2023, issue of the *Texas Register* (48 TexReg 2173). The public comment period closed on May 30, 2023. The Department received comments from two interested parties on the proposed rules. The public comments are summarized below.

Comment: One commenter expressed confusion about the rule and sought clarification regarding whether the proposed rule would require licensees to take additional continuing education courses.

Department Response: The Department appreciates the comment. The proposed rule will not require licensees to take any additional continuing education courses. The Department did not make any changes to the proposed rules based on this comment.

Comment: One commenter stated that all electrical work should be completed by a licensed and qualified professional electrician.

Department Response: The Department appreciates the comment. The Department did not make any changes to the proposed rules based on this comment.

COMMISSION ACTION

At its meeting on August 1, 2023, the Commission adopted the proposed rules as published in the *Texas Register*.

STATUTORY AUTHORITY

The adopted rule is adopted under Texas Occupations Code, Chapters 51 and 1302, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rule are those set forth in Texas Occupations Code, Chapters 51 and 1302. No other statutes, articles, or codes are affected by the adopted rule.

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

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CHAPTER 97. MOTOR FUEL METERING AND QUALITY

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 97, Subchapter A, §97.3; Subchapter B, §97.23; Subchapter D, §97.56; Subchapter E, §97.70 and §97.74; and the repeal of Subchapter G, §§97.90 - 97.95, regarding the Motor Fuel Metering and Quality program, without changes to the proposed text as published in the March 24, 2023, issue of the *Texas Register* (48 TexReg 1612). These rules will not be republished.

The Commission also adopts amendments to existing rules at 16 TAC, Chapter 97, Subchapter A, §97.2; Subchapter B, §97.25, and §97.29; Subchapter D, §97.59; and adopts new rules at Subchapter B, §97.30 and §97.31, regarding the Motor Fuel Metering and Quality program, with changes to the proposed text as published in the March 24, 2023, issue of the *Texas Register* (48 TexReg 1612). These rules will be republished.

Included elsewhere in this issue of the *Texas Register*, the Commission also withdraws proposed amendments to existing rules at 16 TAC, Chapter 97, Subchapter B, §§97.20 - 97.22, and §97.27; and withdraws proposed new rules at Subchapter B, §97.32 and §97.33 as published in the March 24, 2023, issue of the *Texas Register* (48 TexReg 1612).

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 97, implement Texas Occupations, Chapter 2310, Motor Fuel Metering and Quality.

The adopted rules update definitions applicable to the program, clarify the standards applicable to fuel quality, and add merchant and consumer protections from card fraud. The adopted rules are necessary to implement legislative changes from House Bill (HB) 2106, 87th Legislature, Regular Session (2021), related to payment card skimmers on motor fuel devices.

SECTION-BY-SECTION SUMMARY

The adopted rules amend §97.2, Definitions. The adopted rules add a definition for "tamper-evident security label." The adopted rules include Advisory Board recommended changes to the published rule text at paragraphs (11) and (14) to remove proposed amendments to the definition of "merchant," and removal of the proposed term "operator," respectively. The rules have been renumbered accordingly.

The adopted rules amend §97.3, Adoption by Reference. The adopted rules update and clarify the standards applicable to motor fuel.

The adopted rules amend §97.23, Device Performance Review Requirements. The adopted rules clarify that a device performance review may only be performed by a licensed service company and removes references to the September 1, 2020, the effective date of the section included when the rules were adopted after the program was transferred to the department.

The adopted rules amend §97.25, Consumer Information Sticker. The adopted rules remove the reference to the December 1, 2020, effective date for implementation of the section that was originally included when the rules were adopted following the program transfer. The adopted rules include Department recommended changes to the published rule text at subsection (b) to replace the proposed term "merchant" with the original phrase "owner or operator."

The adopted rules amend §97.29, Discovery of Payment Card Skimmers. The adopted rules retitle the section to "Detection and Reporting of Payment Card Skimmers," and prescribe the timeline and process a merchant must follow for reporting the discovery of a skimmer to law enforcement and the department after the discovery. The adopted rules include Department recommended changes to the published rule text at subsections (a), (b), and (c) to replace the proposed term "merchant" with the original phrase "owner or operator." The adopted rules also include Advisory Board recommended changes to the published rule text at subsection (a)(3) to clarify the process for submitting law enforcement report case numbers to the department; and

(a)(4) to specify how to place a device out of order pending removal of a skimmer.

The adopted rules add new §97.30, Unauthorized Removal of Skimmers Prohibited. The adopted rules prohibit the removal of a skimmer unless instructed to do so by law enforcement or the department and include requirements for how the skimmer must be removed. The adopted rules include Department recommended changes to the published rule text at subsections (a), (b), and

(d) to replace the proposed term "merchant" with the phrase "owner or operator." The adopted rules include further changes to the published rule text at subsection (b) to simplify the proposed language and provide that a skimmer may be removed 48 hours after notifying the Department.

The adopted rules add new §97.31, Device Security for Motor Fuel Devices. The adopted rules require an owner or operator to take measures to protect each device using at least two preventative measures. The adopted rules include Department recommended changes to the published rule text to replace the proposed term "merchant" with the phrase "owner or operator." The adopted rules also include Advisory Board recommended changes to the published rule text at paragraph (2)(C) to remove the requirement to document and maintain inspection logs, and at paragraph (6)(A) to require an owner or operator utilizing video camera systems to record video of the forecourt at all times.

The adopted rules amend §97.56, Service Technician License Requirements-Renewal. The adopted rules standardize the terminology for license holders with other department rules.

The adopted rules amend §97.59, Inspection for Payment Card Skimmers. The adopted rules prohibit the removal of a skimmer unless instructed to do so by law enforcement or the department and include requirements for how the skimmer must be removed. The adopted rules include Department recommended changes to the published rule text which replace the terms "merchant," and "dealer" from subsection (b)(1), and the term "merchant" from subsection (d) with the phrase "owner or operator." This change was made throughout the chapter for consistency. The adopted rules also include Department recommended changes to the published rule text at subsection (e) which replaces the term "individual" with "service technician" to clarify who is subject to the section.

The adopted rules also include Advisory Board recommended changes to the published rule text at subsection (d) to simplify proposed language and provide that a skimmer may be removed 48 hours after notifying the Department.

The adopted rules amend §97.70, Device Fees, to correct a clerical error.

The adopted rules amend §97.74, Fee Policy, to standardize formatting for consistency with other department rules.

The adopted rules repeal §97.90, Definitions, by removing common definitions not used in the chapter and relocates applicable definitions into §97.2, Definitions.

The adopted rules repeal §97.91, Policies, Procedures, and Training, which have been incorporated into §97.33, Fraud Awareness Training, as discussed above.

The adopted rules repeal §97.92, Minimum Practices for Prevention of Skimmers, which have been incorporated into §97.29, Detection and Reporting of Payment Card Skimmers, and §97.31, Device Security for Motor Fuel Devices, §97.32, Inspection and

Maintenance Logs, and §97.33, Fraud Awareness Training, as discussed above.

The adopted rules repeal §97.93, Additional Practices for the Prevention of Skimmers at Medium-risk Places of Business, which removes requirements that add practices for medium-risk places of business as well as punitive and onerous tasks, creating a financial burden, for example by requiring the installation of electronic monitoring devices by merchants who are victims of skimmer fraud, instead shifting efforts proactively to prevent unauthorized device access and installation of skimmers.

The adopted rules repeal §97.94, Additional Practices for the Prevention of Skimmers at High-risk Places of Business, which removes requirements that add practices for high-risk places of business as well as punitive and onerous tasks, creating a financial burden by requiring the installation of video cameras and lights around each device for merchants who are victims of skimmer fraud, instead shifting efforts proactively to prevent unauthorized device access and installation of skimmers.

The adopted rules repeal §97.95, which has been incorporated into §97.29, Detection and Reporting of Payment Card Skimmers, as discussed above.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the March 24, 2023, issue of the *Texas Register* (48 TexReg 1612). The public comment period closed on April 24, 2023. The Department received comments from three interested parties on the proposed rules.

Comment: The Department received two comments submitted by the same individual regarding options for compliance with the fraud awareness training requirements in the proposed rules. Specifically, one of the submitted comments inquired whether the Department would authorize an organization to conduct its own training and maintain its own documentation.

Department Response: The Department thanks the individual for their questions regarding the proposed rules. The Department notes that it has withdrawn the proposed rule.

Comment: The Department received a question from an individual that was non-responsive to the substance of the proposal.

Department Response: The Department notes that the individual's question is issue-specific and will not be addressed in this preamble. The Department did not make any changes to the proposed rules in response to this comment.

Comment: The Department received comments from the Texas Food and Fuel Association (TFFA). TFFA submitted comments regarding §§97.2, 97.29, 97.30, and §§97.32 - 97.33.

TFFA submitted comments regarding proposed §97.2, stating that the removal of the term "operator" could be detrimental to regulation due to the complexity of relationships between owners and operators. TFFA requested that the rule be withdrawn.

TFFA submitted comments regarding the use of the amended definition of "merchant" throughout proposed §97.29 in relation to the responsibility for compliance with detection and reporting of skimmers. TFFA noted that a skimmer may only be removed by a "licensed technician" hired by the "merchant." Finally, TFFA commented that the 72-hour timeline that a pump must remain out of service could be a deterrent for compliance with the rule.

TFFA submitted comments regarding §97.30 which align with their concerns presented regarding §97.29. TFFA states that often law enforcement agencies are unable or unwilling to respond to reports of skimmers, leaving them out of business for up to 72 hours prior to the skimmer being removed.

TFFA commented that §97.32 regarding Inspection and Maintenance Logs is unnecessary as many owners currently have technology in place to detect and notify in the event that a breach occurs.

TFFA submitted its comment in opposition of §97.33, relating to Fraud Awareness Training. While they are not opposed to the training overall, TFFA's is opposed to the rule based on the lack of detail regarding what will be required as part of the training program.

Department Response: The Department thanks the TFFA for their comments. The Department will address each comment in order, separately.

The Department agrees with the comments and appreciates the insight on the fuel industry's use of the terms "owner" and "operator" as they apply to the proposed rules. The Department agrees with the suggestion to withdraw the proposed amendment to the definition of "merchant" in §97.2(11), to allow further discussion with industry stakeholders and the Advisory Board. The Department has withdrawn proposed changes to §97.2(11) and §97.2(14), which would have amended the definition of "merchant" and removed the term "operator," respectively.

The Department has withdrawn proposed amendments to §97.2 regarding the term "merchant." No additional changes have been made to §97.29, Detection and Reporting of Payment Card Skimmers, in response to TFFA's comment regarding responsibility for merchants. To ensure consistency throughout the chapter, the Department has removed the requirement limiting removal of a skimmer to a "licensed service technician." The Department appreciates the insight regarding the timeline prior to removal of a skimmer after reporting to the Department and law enforcement. To ensure compliance with the rule and the spirit of the law to preserve the chain of custody to the extent possible, the timeline for an owner or operator to remove a skimmer has been reduced to 48-hours to allow sufficient time for the Department or law enforcement to respond while ensuring they can resume business operations in a reasonable amount of time.

The Department appreciates the TFFA's concern regarding the timeline prior to removal of a skimmer presented in §97.30. To ensure compliance with the rule and the spirit of the law to preserve the chain of custody to the extent possible, the timeline for an owner or operator to remove a skimmer has been reduced to 48-hours to allow sufficient time for the Department or law enforcement to respond while ensuring they can resume business operations in a reasonable amount of time.

The Department agrees with TFFA's suggestion regarding §97.32, Inspection and Maintenance Logs, and will work with the Advisory Board and stakeholders to continue the dialogue regarding this issue and has withdrawn the rule.

The Department agrees with TFFA's suggestion regarding §97.33, relating to Fraud Awareness Training, and will work with the Advisory Board and stakeholders to continue the dialogue regarding this issue and has withdrawn the rule.

ADVISORY BOARD RECOMMENDATIONS

The Motor Fuel Metering and Quality Advisory Board met on May 16, 2023, to discuss the proposed rules and the public comments received. The Motor Fuel Metering and Quality Advisory Board recommended that the Commission adopt the proposed rules as published in the *Texas Register* with changes to §§97.2, 97.25, 97.29, 97.30, 97.31, and 97.59, made in response to public comment and Department recommendations as explained in the Section-by-Section Summary.

SUBCHAPTER A. GENERAL PROVISIONS

16 TAC §97.2, §97.3

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapters 51 and 2310, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51 and 2310. No other statutes, articles, or codes are affected by the adopted rules.

§97.2. Definitions.

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

(1) ASTM--ASTM International; the national voluntary consensus standards organization formed for the development of standards on characteristics and performance of materials, products, systems and services and the promotion of related knowledge.

(2) Code--The Texas Occupations Code, Chapter 2310, "Motor Fuel Metering and Quality."

(3) Commission--Texas Commission of Licensing and Regulation.

(4) Controlling person--an individual who:

(A) is a sole proprietor;

(B) is a general partner of a partnership;

(C) is a controlling person of a business entity that is a general partner of a partnership;

(D) possesses direct or indirect control of at least 25 percent of the voting securities of a corporation;

(E) is the president, the secretary, or a director of a corporation; or

(F) possesses the authority to set policy or direct the management of a business entity.

(5) Department--Texas Department of Licensing and Regulation.

(6) Device--A commercial weighing or measuring device used for motor fuel sales, also defined as a motor fuel metering device by §2310.001(7) of the Code.

(7) Device performance review (DPR)--The comprehensive inspection and testing of a motor fuel metering device to ensure it is calibrated and operating according to NIST and Manufacturer specifications.

(8) Gasoline--A liquid or combination of liquids blended together, offered for sale, sold, used, or capable of use as fuel for a gasoline-powered engine. The term includes gasohol, aviation gaso-

line, and blending agents, but does not include compressed natural gas, liquefied natural gas, racing gasoline, diesel fuel, aviation jet fuel, or liquefied gas, as defined in §162.001(29) of the Texas Tax Code.

(9) GPM--Gallons per minute.

(10) ISO--International Organization for Standardization; an independent, non-governmental organization that develops voluntary international standards to facilitate world trade by providing common standards among nations.

(11) Merchant--A person whose business includes the sale of motor fuel through motor fuel metering devices, as defined by §607.001(4) of the Texas Business and Commerce Code.

(12) Motor fuel--Gasoline, diesel fuel, gasoline blended fuel, compressed natural gas, liquefied natural gas, and other products that are offered for sale, sold, used, or capable of use as fuel for a gasoline-powered engine or a diesel-powered engine, as defined in §162.001(42) of the Texas Tax Code.

(13) NIST--The National Institute of Standards and Technology; a non-regulatory federal agency under the United States Department of Commerce, which certifies and provides standard reference materials used to perform instrument calibrations, verifies the accuracy of specific measurements and supports the development of new measurement methods.

(14) Operator--A person in possession or control of a weighing or measuring device, as defined in 2310.001(8) of the Code.

(15) Skimmer--A wire or electronic device that is capable of unlawfully intercepting electronic communications or data to perpetrate fraud, as defined by §607.001(8) of the Texas Business and Commerce Code.

(16) Tamper-evident security label--A label or tape that, once applied to a surface, cannot be removed without self-destructing, or otherwise leaving a clear indication that the label or tape has been removed.

(17) Test standard--A certified weight or measure used to test a device for accuracy.

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

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SUBCHAPTER B. MOTOR FUEL METERING DEVICES

16 TAC §§97.23, 97.25, 97.29 - 97.31

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapters 51 and 2310, which authorize the Texas Commission

of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51 and 2310. No other statutes, articles, or codes are affected by the adopted rules.

§97.25. *Consumer Information Sticker.*

(a) A consumer information sticker with the department's contact information and current motor fuel tax rates, must be placed on each face of all motor fuel dispensers.

(b) If any part of the information on the sticker is no longer fully legible and in plain sight of the consumer, it must be replaced within 30 days of the date the owner or operator discovers the condition.

(c) A consumer information sticker must not be placed in a manner that affects the accuracy, readability, or lawful operation of a device.

(d) This section does not apply to a device on a transport vehicle.

§97.29. *Detection and Reporting of Payment Card Skimmers.*

(a) An owner or operator who discovers or is notified of the presence of a skimmer by a service technician or employee must:

(1) immediately make a report to local law enforcement that a skimmer has been discovered and is still installed in the device;

(2) notify the department within 24 hours of the discovery on a form prescribed by the department;

(3) request the law enforcement report or case number and submit it in a manner prescribed by the department; and

(4) place each affected device out of service and block access to the dispenser to prevent tampering with evidence until the skimmer has been removed as authorized under this chapter.

(b) The owner or operator must cooperate with law enforcement, the department, and the Center in the investigation of a suspected or discovered skimmer.

(c) The owner or operator must provide a copy of available photographic and/or video surveillance of the retail facility to law enforcement.

§97.30. *Unauthorized Removal of Skimmers Prohibited.*

(a) In order to preserve evidence and the chain of custody, an owner or operator, retail facility employee, or unlicensed service technician is prohibited from removing a skimmer unless instructed to do so by law enforcement or the department.

(b) If neither law enforcement nor the department has arrived to remove a skimmer within 48 hours after the owner or operator has notified the department as required by §97.29(a)(2), the skimmer may be removed in accordance with subsection (c).

(c) When removing a skimmer under this section, an individual must:

(1) wear sterile gloves while removing the skimmer(s);

(2) place each skimmer in a clear plastic bag, seal the bag, and label the sealed bag with the date and time the skimmer was removed and bagged, along with the initials of the person removing the skimmer; and

(3) transfer the skimmer(s) to local law enforcement and request the law enforcement case or report number.

(d) The owner or operator must provide the law enforcement case or report number to the department in a manner prescribed by the department following transfer of the skimmer to law enforcement.

§97.31. Device Security for Motor Fuel Devices.

By January 1, 2024, an owner or operator is required to take two or more of these measures to protect each device:

(1) replace each factory installed universal locking mechanism with a locking device that utilizes a unique device-specific or site-specific key code or combination;

(2) utilize tamper-evident security labels. Tamper-evident security labels must:

(A) be placed over each panel opening that provides access to an interior portion of the device from which the payment terminal or the device can be accessed;

(B) have a unique serial number or unique custom label or easily identifiable custom label or graphic; and

(C) be replaced if damaged, perforated, or peeled;

(3) install a physical barrier, lock, or other physical securing device that restricts access to the electronic financial transaction compartment of the device;

(4) install and maintain monitoring devices or sensors on all doors or panels providing access to an interior portion of the device and associated payment terminal components which emit an audible alarm and/or disable the device when unauthorized access is attempted;

(5) retrofit, upgrade, or replace each device with an enabled EMV-compliant payment terminal that meets the security, interoperability, and functionality specifications issued by EMVCo, LLC; or

(6) install and maintain a high-resolution video camera system and forecourt lighting. To meet the requirements of this section:

(A) the video camera system must record the forecourt area at all times, and the system must retain all videos for 30 days or more. Cameras must be positioned to record:

(i) each device;

(ii) the license plates of vehicles approaching or departing the immediate area around each device; and

(iii) any person interacting with each device at a pixel density of at least 50 pixels per foot; and

(B) lighting must be bright enough to ensure a minimum illumination of 10 lumens per square foot at grade.

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

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Doug Jennings

General Counsel

Texas Department of Licensing and Regulation

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For further information, please call: (512) 463-7750

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SUBCHAPTER D. SERVICE COMPANIES
AND SERVICE TECHNICIANS

16 TAC §97.56, §97.59

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapters 51 and 2310, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51 and 2310. No other statutes, articles, or codes are affected by the adopted rules.

§97.59. Inspection for Payment Card Skimmers.

(a) A service technician must inspect for the presence of a skimmer:

(1) during a device performance review; and

(2) each time a motor fuel dispenser is opened to perform device maintenance activities.

(b) A service technician or the service company that employs the technician must report the finding of a skimmer:

(1) immediately to the owner or operator; and

(2) within 24 hours to the department on a form prescribed by the department.

(c) In order to preserve evidence and the chain of custody, a service technician must not remove a skimmer unless instructed by law enforcement or the department.

(d) If neither law enforcement nor the department has arrived to remove a skimmer within 48 hours after the owner or operator has notified the department as required by §97.29, the skimmer may be removed in accordance with subsection (e).

(e) When removing a skimmer under this section, an individual must:

(1) wear sterile gloves while removing the skimmer(s);

(2) place each skimmer in a clear plastic bag, seal the bag, and label the sealed bag with the date and time the skimmer was removed and bagged, along with the initials of the person removing the skimmer; and

(3) transfer the skimmer(s) to local law enforcement and request the law enforcement case or report number.

(f) The service technician must provide the law enforcement case or report number to the department in a manner prescribed by the department following transfer of the skimmer to law enforcement.

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

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SUBCHAPTER E. FEES

16 TAC §97.70, §97.74

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapters 51 and 2310, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51 and 2310. No other statutes, articles, or codes are affected by the adopted rules.

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

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SUBCHAPTER G. SKIMMERS

16 TAC §§97.90 - 97.95

STATUTORY AUTHORITY

The adopted repeals are adopted under Texas Occupations Code, Chapters 51 and 2310, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt repeals as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted repeals are those set forth in Texas Occupations Code, Chapters 51 and 2310. No other statutes, articles, or codes are affected by the adopted repeals.

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

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CHAPTER 115. MIDWIVES

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 115, §§115.1, 115.4, 115.5, 115.13 - 115.15, 115.20, 115.21, 115.23, 115.25, 115.70, 115.80, 115.100, and 115.120; new rules at §§115.2, 115.12, 115.16, and 115.121; and the repeal of existing rules at §§115.2, 115.16, and 115.121; regarding the Midwives program, without changes to the proposed text as published in the April 14, 2023, issue of the *Texas Register* (48 TexReg 1936). These rules will not be republished.

The Commission also adopts a new rule at §115.22, with changes to the proposed text as published in the April 14, 2023, issue of the *Texas Register* (48 TexReg 1936). This rule will be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC Chapter 115 implement Texas Occupations Code, Chapter 203, Midwives.

The adopted rules implement changes recommended by Department staff as a result of the four-year rule review conducted under Texas Government Code §2001.039. The adopted rules update requirements relating to approval of basic midwifery education courses, preceptor supervision of student clinical experience, informed client choice and disclosure statements, and retired midwife licenses. The adopted rules also make updates to reflect current Department procedures and remove obsolete or unnecessary language.

The Notice of Intent to Review for Chapter 115 was published in the October 9, 2020, issue of the *Texas Register* (45 TexReg 7281). The public comment period closed on November 9, 2020. At its meeting on March 3, 2021, the Texas Commission of Licensing and Regulation (Commission) readopted Chapter 115 in its entirety without changes. The readoption notice was published in the March 26, 2021, issue of the *Texas Register* (46 TexReg 2050). In response to the Notice of Intent to Review for Chapter 115 that was published, the Department received comments from one interested party requesting rule changes that would not be possible without statutory changes. Therefore, the adopted rules do not include any changes in response to public comments, and all the changes are based on recommendations by Department staff.

SECTION-BY-SECTION SUMMARY

The adopted rules amend §115.1, Definitions, by changing the term "approved midwifery education courses" to "basic midwifery education course" and updating its definition to provide clarity and consistency with Occupations Code §203.151; removing the definition for "Code" because the term is not used elsewhere in the rule chapter; adding a definition for "compensation" to provide clarity; adding a definition for "CPR certification" to streamline multiple references throughout the chapter; adding a definition for "direct supervision" to provide clarity; adding a defini-

tion for the acronym "MANA" to streamline multiple references to the Midwives Alliance of North America; adding a definition for the acronym "MEAC" to streamline multiple references to the Midwifery Education Accreditation Council; adding a definition for the acronym "NARM" to streamline multiple references to the North American Registry of Midwives; adding a definition for "preceptor" to provide clarity; removing the definition of "Program" because the term is not used elsewhere in the rule chapter; updating the definition of "retired midwife" to provide clarity and remove the age requirement; correcting a rule reference in the definition of "standing delegation orders"; adding a definition for "student" to provide clarity; and renumbering the remaining definitions accordingly.

The adopted rules repeal current §115.2 and replace it with new §115.2, License Required, to prohibit the unlicensed practice of midwifery.

The adopted rules amend §115.4, Advisory Board Membership, by amending paragraph (1) to provide consistency with Occupations Code §203.052.

The adopted rules amend §115.5, "Terms; Vacancies", by amending subsections (a) and (b) to provide consistency with Occupations Code §203.055.

The adopted rules add new §115.12, General Application Requirements, to streamline requirements for all applications submitted to the Department; add new subsection (a) consisting of language relocated from current §115.13(a) and (a)(1); and add new subsection (b) to require that original or certified copies of documents must be provided upon request by the Department.

The adopted rules amend §115.13, Initial Application for Licensure, by relocating language from subsections (a) and (a)(1) to new §115.12(a); removing subsections (a)(1)(A) through (a)(1)(E), which consist of application details that can instead be addressed in the application forms approved by the Department; updating subsection (a)(2) to provide clarity and correct grammar; relocating and reorganizing the language in current subsection (a)(2) to become new subsection (a)(3); relabeling current subsection (a)(3) to become new subsection (a)(4) and removing the language that repeats the new definition for "CPR certification" in §115.1; relabeling current subsection (a)(4) to become new subsection (a)(5) and adding language to allow the Department to approve a certification that is equivalent to the certification in neonatal resuscitation from the American Academy of Pediatrics; relabeling current subsection (a)(5) to become new subsection (a)(6) and reorganizing its language for clarity; relabeling current subsection (a)(6) to become new subsection (a)(7) and removing unnecessary language; relabeling current subsection (a)(7) to become new subsection (a)(8) and rephrasing its language for clarity and consistency; rephrasing subsection (b) for clarity and consistency; and creating new subsection (f) consisting of language relocated from current §115.2(b). The Advisory Board made a change to subsection (a)(3)(B) by adding "and passing" to clarify that the course and exam must be passed.

The adopted rules amend §115.14, License Renewal, by adding to subsection (a) the word "midwife" to clarify the section's applicability to renewal of a midwife license; removing from subsection (a)(3) language that repeats the new definition for "CPR certification" in §115.1; and adding new subsection (e) to provide that each applicant for renewal of a midwife license must successfully pass a criminal history background check.

The adopted rules amend §115.15, Late Renewal, by rephrasing for clarity and adding references to other Department rules applicable to late renewals.

The adopted rules repeal current §115.16 and replace it with new §115.16, Retired Voluntary Charity Care Status License, consisting of subsection (a) to explain the applicability of the section; subsection (b) to provide the eligibility requirements for a retired voluntary charity care status license; subsection (c) to provide the requirements for an initial application for a voluntary charity care status license; subsection (d) to provide the limitations on the practice of a person holding a retired voluntary charity care status license; subsection (e) to detail the actions for which a person holding a retired voluntary charity care status license will be subject to disciplinary action; subsection (f) to provide for the two-year license term of a retired voluntary charity care status license; subsection (g) to provide the renewal application requirements, the procedures for late renewal, and the prohibition on unlicensed activity for a voluntary charity care status license; and subsection (h) to provide the requirements for a person who holds a retired voluntary charity care status license and wants to return to active status.

The adopted rules amend §115.20, Basic Midwifery Education, by amending the section title for clarity; rephrasing and restructuring the rule language to remove the need for subsection labels; relocating from current subsection (a) to new paragraph (1) the requirement for a course to have a course administrator and site in Texas; relabeling current subsection (b)(2) to become new paragraph (2) and rephrasing its language for clarity; relabeling current subsection (b)(3) to become new paragraph (3) and replacing the names of entities with their corresponding acronyms defined in §115.1; relabeling current subsection (b)(4) to become new paragraph (4) and rephrasing its language for clarity; relabeling current subsection (b)(5) to become new paragraph (5) and rephrasing its language for clarity; relabeling current subsection (b)(6) to become new paragraph (6) and amending its language to provide consistency with the clinical experience requirements for certification by the North American Registry of Midwives (NARM); relabeling current subsection (b)(7) to become new paragraph (7) and removing unnecessary language that repeats the new definition for "preceptor" in §115.1; relabeling current subsection (c) to become new paragraph (8), rephrasing its language for clarity, and removing the language that repeats the new definition for "CPR certification" in §115.1.

The adopted rules amend §115.21, Education Course Approval, by amending the section title for clarity and consistency; rephrasing subsection (a)(1) for clarity and consistency; modifying subsection (a)(1)(D) to require that the financial statement or balance sheet must demonstrate the ability to provide refunds to any students who enroll and removing the requirement to disclose any bankruptcy within the last five years; in subsection (a)(1)(E), adding the requirement for written policies to include entrance requirements, a list of all fees, and the notice required by Occupations Code §53.152 and removing requirements for language and accessibility covered by other state and federal laws; in subsection (a)(2), changing the time period for retention of student files from five years to "three years after the student is no longer enrolled in the course" to provide a more definite time period, clarifying that student files must include CPR certification and progression of course work; amending subsection (a)(3) to clarify the process for initial course approval; rephrasing subsections (a)(4) through (a)(6) for clarity; amending subsection (b) to clarify the approval of courses accredited by MEAC; amending subsection (c) to clarify the duration of course approval and the

process for obtaining a new approval period; amending subsection (d) to require a substantive change in a course to be approved before the change is implemented; and adding new subsection (e) to allow courses to accept transfer hours from other courses and clinical hours earned under a NARM-certified preceptor.

The adopted rules add new §115.22, Preceptor Supervisory Responsibilities, consisting of new subsection (a) to provide the requirements relating to clinical experience activities performed by a student, including direct supervision by a preceptor and informed consent by the client; new subsection (b) to clarify that the student is not practicing midwifery; and new subsection (c) to provide that a licensed midwife acting as a preceptor is responsible for the actions of the student. In response to a recommendation by its Education and Examination workgroup, the Midwives Advisory Board recommended adding language to subsection (a) to clarify that students must always be directly supervised regardless of whether the activities performed are being counted toward the student's education.

The adopted rules amend §115.23, Jurisprudence Examination, by adding new subsection (d) to address administration of the examination, examination fees, reexamination, and notice of examination results, as required by Occupations Code §203.2555(b).

The adopted rules amend §115.25, Continuing Education, by rephrasing and reorganizing for clarity and removing accessibility requirements covered by other state and federal laws.

The adopted rules amend §115.70, Standards of Conduct, by removing the language in current paragraph (1)(L), which authorizes administrative action due to "a lack of personal or professional character in the practice of midwifery" because the standard is vague and subjective; renumbering the remaining provisions in paragraph (1) accordingly; and updating paragraph (3) to clarify that course approval may be suspended or revoked, add loss of MEAC accreditation as a reason for course suspension or revocation, and make cleanup changes for clarity.

The adopted rules amend §115.80, Fees, by updating the names of fees for clarity and consistency and reducing the retired voluntary charity care status license fees in paragraphs (4) and (5) from \$275 to \$0.

The adopted rules amend §115.100, Standards for the Practice of Midwifery in Texas, by making cleanup changes to subsections (a) and (c) for clarity and consistency.

The adopted rules amend §115.120, Newborn Screening, to clarify the requirements relating to a midwife who chooses to collect blood specimens for newborn screening tests, including the required training and submission of the appropriate form to the Department, and removing unnecessary language.

The adopted rules repeal current §115.121 and replace it with new §115.121, Informed Choice and Disclosure Statement, which adds new subsection (a) to require a midwife to use the form prescribed by the Department; adds new subsection (b) to require a midwife to provide the content of the form to a prospective client in both oral and written form before providing any midwifery service; and adds new subsection (c) to require a student performing clinical experience activities to first obtain the informed consent required by new §115.22.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the April 14, 2023, issue of the *Texas Register* (48 TexReg 1936). The public comment period closed on May 15, 2023. The Department did not receive any comments from interested parties on the proposed rules.

ADVISORY BOARD RECOMMENDATIONS

The Midwives Advisory Board met on June 12, 2023, to discuss the proposed rules and the public comments received. The Advisory Board recommended that the Commission adopt the proposed rules as published in the *Texas Register* with changes to §115.22, made in response to a recommendation by the Education and Examination workgroup of the Advisory Board, as explained in the Section-by-Section Summary.

16 TAC §§115.1, 115.2, 115.4, 115.5, 115.12 - 115.16, 115.20 - 115.23, 115.25, 115.70, 115.80, 115.100, 115.120, 115.121

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapters 51 and 203, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Government Code, Chapter 411, Subchapter F, and Texas Occupations Code, Chapters 51 and 53, which establish the Department's statutory authority to conduct criminal history background checks on an applicant for or a holder of a license, certificate, registration, title, or permit issued by the Department. The adopted rules are also adopted under Texas Occupations Code, Chapter 112, which requires the adoption of rules providing for reduced fees and continuing education requirements for a retired health care practitioner whose only practice is voluntary charity care.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51 and 203, and Texas Government Code, Chapter 411, Subchapter F. No other statutes, articles, or codes are affected by the adopted rules.

§115.22. *Preceptor Supervisory Responsibilities.*

(a) All clinical experience activities performed by a student must be under the direct supervision of a preceptor in accordance with this section.

(1) The student must always be directly supervised regardless of whether the activities are being counted toward the student's education.

(2) The student must perform only the activities authorized by the preceptor.

(3) The student must not advertise, or represent to the public in any way, that the student is a midwife.

(4) The student must not receive compensation from a client for performing supervised activities.

(5) Before any service involving a student is provided to a client:

(A) the client must be informed in writing of:

(i) the requirements of this section;

(ii) the identity and license status of the preceptor and the student;

(iii) the services that will be provided under direct supervision to the client; and

(B) the client must consent in writing to the services being provided under direct supervision.

(b) A student acting under direct supervision in accordance with this section is not practicing midwifery in violation of the requirement to hold a license.

(c) A licensed midwife providing direct supervision of a student is responsible for all actions and liabilities of the student.

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

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Doug Jennings

General Counsel

Texas Department of Licensing and Regulation

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16 TAC §§115.2, 115.16, 115.121

STATUTORY AUTHORITY

The adopted repeals are adopted under Texas Occupations Code, Chapters 51 and 203, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted repeals are also adopted under Texas Government Code, Chapter 411, Subchapter F, and Texas Occupations Code, Chapters 51 and 53, which establish the Department's statutory authority to conduct criminal history background checks on an applicant for or a holder of a license, certificate, registration, title, or permit issued by the Department. The adopted repeals are also adopted under Texas Occupations Code, Chapter 112, which requires the adoption of rules providing for reduced fees and continuing education requirements for a retired health care practitioner whose only practice is voluntary charity care.

The statutory provisions affected by the adopted repeals are those set forth in Texas Occupations Code, Chapters 51 and 203, and Texas Government Code, Chapter 411, Subchapter F. No other statutes, articles, or codes are affected by the adopted repeals.

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

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TITLE 22. EXAMINING BOARDS

PART 3. TEXAS BOARD OF CHIROPRACTIC EXAMINERS

CHAPTER 80. COMPLAINTS

22 TAC §80.5

The Texas Board of Chiropractic Examiners (Board) adopts the repeal of 22 TAC §80.5 (Expert Review Process) without changes as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3615), and thus will not be republished. The Board will adopt a new §80.5 (Peer Review Process) in a separate rulemaking. This rulemaking action will clarify language relating to the Board's authority to conduct standard of care reviews during complaint investigations.

The Board received no comments from the public concerning the repeal.

The repeal is adopted under Texas Occupations Code §201.152, which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic, and Texas Occupations Code and §201.210, which authorizes the Board to adopt rules to develop a review process for complaints requiring additional chiropractic expertise.

No other statutes or rules are affected by this repeal.

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

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Christopher Burnett

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For further information, please call: (512) 305-6700



22 TAC §80.5

The Texas Board of Chiropractic Examiners (Board) adopts new 22 TAC §80.5 (Peer Review Process) without changes to the text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3616), and thus will not be republished. The current §80.5 is being repealed in a separate rulemaking.

Texas Occupations Code §201.210 requires the Board to set up a system where the Board may draw on outside chiropractic expertise (an "expert" reviewer of patient records) to help in investigations involving standard of care allegations. The Board adopted such a system through §80.5.

However, the use of the term "expert" in both the statute and the Board's current rule has caused confusion for some complainants as to the exact role and authority of the reviewer. Some complainants have thought that the reviewer's job is to assign legal liability for any injury the complainant may have suffered as the result of a licensee's failure to meet the profession's standard of care; in effect, some complainants believe that the reviewer

is the same as an expert witness in a trial court who is called upon to render an opinion as to causation (and thus assign legal liability). That is not the case with the Board's reviewers.

Unlike an expert witness, a Board reviewer does not examine any patient; the reviewer only performs a review of records. Also, a Board reviewer is not statutorily authorized to render an opinion as to causation, only whether the standard of care for chiropractic was met; those are different standards. An opinion on causation is within the purview of the courts, not the Board.

The adopted §80.5 keeps the Board's current system of outside standard of care review, but clarifies to both reviewers hired by the Board and complainants that the reviewer is not authorized to make a legal opinion as to any violation of statutes or rules under the Board's jurisdiction, nor authorized to make a legal opinion as to the liability for any injury possibly sustained by the complainant. To that end, the rule has been retitled as "Peer Review Process" to eliminate the perception that a Board reviewer is the same as an expert witness.

The Board received no comments regarding the new rule.

The rule is adopted under Texas Occupations Code §201.152 (which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic), and §201.210 (which requires the Board to develop a review process of complaints filed with the Board that require additional chiropractic expertise).

No other statutes or rules are affected by this adopted rule.

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

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22 TAC §80.8

The Texas Board of Chiropractic Examiners (Board) adopts new 22 TAC §80.8 (Board Member and Staff Initiated Complaints) without changes to the text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3618), and thus will not be republished. This action puts into rule the Board's current policy for processing complaints initiated by Board members and staff.

As practicing chiropractors, Board members interact with other licensees. On occasion, a Board (or staff) member may become aware of facts that indicate that another licensee may be in violation of the statutes and rules under the Board's jurisdiction and thus need to file a formal complaint. The adopted rule formalizes the Board's procedures for processing those complaints.

The intent is transparency: the licensee who is the subject of a complaint under this rule will know the identity of the Board or staff member making the complaint; know that the allegations were considered independently by the Board's executive director before the complaint is forwarded to the Board's enforcement

director; and know that any Board member filing a complaint will be prohibited from voting on or considering the results of any investigation or subsequent administrative action taken by the Board on the complaint.

The Board received no comments regarding this rulemaking.

The rule is adopted under Texas Occupations Code §201.152 (which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic), §201.2205 (which requires the Board to adopt rules concerning the investigation of a complaint), and §201.2065 (which prohibits the Board from accepting anonymous complaints).

No other statutes or rules are affected by this adopted rule.

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

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CHAPTER 82. INTERNAL BOARD PROCEDURES

22 TAC §82.7

The Texas Board of Chiropractic Examiners (Board) adopts new 22 TAC §82.7 (Employee Equity Salary Adjustments) without changes to the text as published in the July 7, 2023, issue of the *Texas Register* (48 TexReg 3619), and thus will not be republished. The General Appropriations Act (GAA) authorizes an agency executive director to make employee equity salary adjustments only if the agency has adopted a rule permitting that action. The adopted rule, which is compliant with the terms of the GAA (Article IX, §3.07, 87th Legislature - Regular Session, 2021 (or successor provisions)), permits the agency executive director to make such adjustments if necessary.

The Board received no comments regarding this rule.

The rule is adopted under Texas Occupations Code §201.152 (which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic) and the General Appropriations Act, Article IX, §3.07 (87th Legislature - Regular Session, 2021) or successor provisions (which authorizes the Board to adopt rules concerning employee equity salary adjustments).

No other statutes or rules are affected by this adopted rule.

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

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PART 14. TEXAS OPTOMETRY BOARD

CHAPTER 271. EXAMINATIONS

22 TAC §§271.2, 271.3, 271.5, 271.6

The Texas Optometry Board (Board) adopts amendments to 22 TAC Chapter 271, Examinations. The specific rules being amended include: §271.2 Applications; §271.3 Jurisprudence Examination Administration; §271.5 Licensure without Examination; and §271.6 National Board Examination. The Board adopts these rules without changes to the proposed text as published in the May 26, 2023, issue of the *Texas Register* (48 TexReg 2651). The amended rules will not be republished.

BACKGROUND AND JUSTIFICATION

The rules in Chapter 271 were reviewed by the Board's Administration and Licensing Committee in January 2023 to ensure the licensing and renewal process was efficient and effective. By updating rules relating to licensing, the Board can provide better customer service to its licensees.

The adopted amendments include non-substantive changes to all references from "board" to "Board" and from "executive director" to "Executive Director." Substantive changes to specific rules are outlined as follows.

In §271.2 Applications, the Board amends the title of the rule to read "Applications for Licensure as Therapeutic Optometrist"; updates the documents required for licensure; updates the statutory reference to Texas Occupations Code Chapter 53 as it relates to convictions that must be reported upon application; states that applications must be approved within one year of application submission or applicants will have to reapply; sets out requirements for applicants who are licensed in other states; and removes language related to scheduling the jurisprudence exam as the Board will allow an applicant to take the exam at any point.

In §271.3 Jurisprudence Examination Administration, the amends the title of the rule to read "Jurisprudence Examination"; clarifies the jurisprudence exam is an "open book" exam; removes language related to scheduling the jurisprudence exam as the Board will allow an applicant to take the exam at any point; states that jurisprudence exam scores are only valid for one year and if an applicant fails to get licensed in that year, applicants will have to retake the exam; and removes language related to the administration of the exam as the Board has outsourced the exam administration to another entity.

In §271.5 Licensure without Examination, the Board clarifies that the rule only applies to those applicants who have not taken Part III of the National Board of Examiners in Optometry and makes other non-substantive grammatical changes and references to statute.

In §271.6 National Board Examination, the Board removes language regarding the jurisprudence exam as it is referenced in

a separate rule; and makes other non-substantive grammatical changes and references to statute.

COMMENTS:

The 30-day comment period ended on June 25, 2023. The Board did not receive any comments.

STATUTORY AUTHORITY

These rules are adopted under the Texas Optometry Act, Texas Occupations Code, §351.151 and Texas Occupations Code Chapter 351, Subchapter F - License Requirements.

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

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Janice McCoy

Executive Director

Texas Optometry Board

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For further information, please call: (512) 305-8500



CHAPTER 273. GENERAL RULES

22 TAC §§273.7, 273.8, 273.12, 273.14, 273.15

The Texas Optometry Board (Board) adopts amendments to 22 TAC Chapter 273, General Rules. The specific rules being amended include: §273.7 - Inactive Licenses and Retired License for Volunteer Charity Care (to include splitting one rule into two separate rules for clarification purposes), §273.8 - Renewal of License, §273.12 - Profile Information, and §273.14 - License Applications for Military Service Member, Military Veteran, and Military Spouse. The Board adopts a new rule titled §273.15 - Retired License for Volunteer Charity Care. The Board adopts these rules with changes to the proposed text as published in the June 2, 2023, issue of the *Texas Register* (48 TexReg 2813). The amended rules will be republished.

BACKGROUND AND JUSTIFICATION

The rules in Chapter 273 were reviewed by the Board's Administration and Licensing Committee in January 2023 to ensure the licensing and renewal process was efficient and effective. By updating rules relating to licensing, the Board can provide better customer service to its licensees.

The adopted amendments include non-substantive changes to all references from "board" to "Board" and from "executive director" to "Executive Director." Substantive changes to specific rules are outlined as follows.

In §273.7 - Inactive Licenses and Retired License for Volunteer Charity Care, the Board split the rule into two separate rules - one related to Inactive Licenses and one related to Retired License for Volunteer Charity Care. Splitting the rule provides ease of understanding the differences between inactive and retired licenses. In the new §273.7 - Inactive Licenses, the rule eliminates the ability to place a license on inactive status at any time and instead allows it only at renewal.

In the new §273.15 - Retired License for Volunteer Charity Care, the rule moves language previously outlined in §273.7 and also

ensures only therapeutic optometrists can update an expired license to a retired license.

In §273.8 - Renewal of License, the Board updates the process to reflect the full transition to the biennial renewal system, clarifies the process for expired licenses to be reinstated under certain circumstances. It ensures the Board's consideration of convictions are in compliance with Chapter 53 of the Occupations Code, and makes other clarifying corrections to ensure the renewal process is both efficient and effective for licensees and Board staff.

In §273.12 - Profile Information, the Board removes the requirement that licensees provide certain information to the Board upon renewal as the Board no longer collects and disseminates this information. It adds the requirement that a licensee provide a personal email address at renewal.

In §273.14 - License Applications for Military Service Member, Military Veteran, and Military Spouse, the Board updates the definition of "Armed Forces of the United States" to update statutory language, to update the application requirements to ensure military applicants provide the same information as a regular applicant, and changes the initial expiration date of a military license to be the same as a regular applicant. Finally, with the changes to the jurisprudence exam occurring in Chapter 271 - Examination, the Board is requiring military applicants to take the jurisprudence exam prior to licensure instead of prior to the first renewal as waiting to take the jurisprudence exam no longer creates a barrier to expedited licensure.

COMMENTS

The 30-day comment period ended on July 3, 2023. The Board did not receive any comments.

CHANGES TO TEXT AS PROPOSED

In §273.14(e), the Board adds the term "military service member" or "service member's" in front of every mention of "military spouse" or "spouse's." This change is a direct result of legislation that passed during the 88th Legislative Session (SB422 by Senator Angela Paxton) that extended the authority of the Board to issue a license under Texas Occupations Code §55.0041 from just military spouses to include military service members.

Section (e) now reads: "(e) Alternate licensing procedure for military service member or military spouse..."

Section (e)(1)(A) now reads: "(A) The military service member or military spouse applicant..."

Section (e)(1)(B) now reads: "The military service member or military spouse..."

Section (e)(1)(B)(i) now reads: "proof of the service member's or spouse's..."

Section (e)(2)(A)(ii) now reads: "the date when the military service member or military spouse..."

STATUTORY AUTHORITY

These rules are adopted under the Texas Optometry Act, Texas Occupations Code, §351.151, Texas Occupations Code Chapter 351, Subchapter F - License Requirements and Subchapter G - License Renewal, and Texas Occupations Code Chapter 55.

§273.7. *Inactive Licenses.*

(a) Placing a license on inactive status. A person who is licensed by the Board to practice optometry but who is not engaged in

the practice of optometry in this state may place the license on inactive status at the time of license renewal as follows. The licensee shall:

(1) complete and submit before the expiration date a license renewal application provided by the Board;

(2) state on the renewal application that the license is to be placed on inactive status and that the licensee shall not practice optometry in Texas while the license is inactive; and

(3) pay the fee for renewal of license as specified in §273.4 of this title (relating to Fees (Not Refundable)). Penalty fees as provided by Section 351.304 of the Act, will apply to those received after December 31 of the applicable renewal period.

(b) Reactivation of an Inactive License. A holder of a license that is on inactive status may return the license to active status by:

(1) applying for active status on a form prescribed by the Board;

(2) providing proof of completion certificates from approved continuing education programs as specified in Chapter 275 of this title (relating to Continuing Education Requirements) for the number of hours that would otherwise have been required for the renewal of the license. Approved continuing education earned within the two years prior to the licensee applying for the return to active status may be applied toward the continuing education requirement; and

(3) paying the license renewal fee specified in §273.4 of this chapter (relating to Fees (Not Refundable)).

(c) Prohibition against practicing optometry in Texas. A holder of a license that is on inactive status shall not practice optometry in this state. The practice of optometry by a holder of a license that is on inactive status constitutes the practice of optometry without a license.

§273.8. *Renewal of License.*

(a) Expired license.

(1) If a license is not renewed on or before the expiration date, it becomes expired. All licenses renew on a biennial basis. Initial licenses expire on the second January 1 after the date the license is first issued.

(2) If a person's license has been expired for 90 days or less, the person may renew the license by paying to the Board the amount of one and one-half times the renewal fee.

(3) If a person's license has been expired for longer than 90 days but less than one year, the person may renew the license by paying to the Board the amount of two times the renewal fee.

(4) If a person's license has been expired for one year or longer, the person may not renew the license but may obtain a new license by reapplying and passing the jurisprudence exam and complying with the requirements and procedures for obtaining an initial license. However, the Board may reinstate a license without requiring reapplication and reexamination of the jurisprudence examination an expired license of a person who was previously licensed in Texas, is currently licensed in another state, and has been in practice for two years immediately preceding application for reinstatement. The person shall be required to furnish documentation of continuous practice for the two-year period and pay the renewal fee as established by subsection (a)(3) of this section. The person must furnish license verifications from each state in which the person is currently or previously licensed. A license renewal under this section is subject to the same requirements of §351.501 of the Act as a license applicant.

(5) For licenses expired for more than one year, if the person was not licensed as a therapeutic optometrist when the license expired, the person must also complete the requirements for therapeutic license in §§280.1 - 280.3 of this title (relating to Application for Certification Required; Education; Certified Therapeutic Optometrist Examination, respectively) prior to obtaining a new license.

(6) A licensee receiving a felony or misdemeanor criminal conviction as outlined under Occupations Code Chapter 53 shall report the conviction on the next license renewal. This requirement is in addition to the 30 day reporting requirement in §277.5 of this title (relating to Convictions). This paragraph does not require the reporting of a Class C Misdemeanor traffic violation. The failure of a licensee to report a criminal conviction is deceit, dishonesty and misrepresentation in the practice of optometry and authorizes the Board to take disciplinary action under §351.501 of the Act. The licensee shall furnish any document relating to the criminal conviction as requested by the Board.

(7) Only an active licensee who has provided a complete fingerprint criminal history report to the Board is eligible to renew a license.

(b) Mandatory Continuing Education for Renewal of License.

(1) The Board may not issue a renewal license to a licensee who has not complied with the mandatory continuing education requirements unless an exemption provided by §275.1 of this title (relating to General Requirements) is applicable.

(2) If a licensee has not fulfilled the required continuing education requirements prior to the license renewal date, the license shall expire. To renew that expired license, the licensee may obtain and provide the Board with certified records that the licensee has, since the expiration of the license, completed sufficient hours of approved continuing education courses to satisfy any deficiency. Education obtained for renewal of an expired license cannot be applied toward subsequent renewal of license.

(3) The licensee cannot practice optometry until such time as education is obtained and the expired license has been renewed.

(4) The licensee must pay to the Board the license renewal fee with a late penalty fee authorized by §351.304 of the Act, plus a penalty authorized by §351.308 of the Act.

(5) The Executive Director shall determine if all requirements for renewal of license have been fulfilled, and will notify the licensee when the practice of optometry can resume.

(6) To practice optometry with an expired license shall constitute the practice of optometry without a license.

(c) Outstanding Administrative Penalty or Failure to Comply with Board Condition.

(1) The Board may refuse to renew a license to a person who has:

(A) not paid an administrative penalty owed to the Board at the time of renewal; or

(B) not complied with a term or condition of a disciplinary order or agreement issued by the Board.

(2) The Board may refuse to renew a license, until such time as:

(A) every administrative penalty payable on or before the time of renewal is paid; or

(B) all terms or conditions of a disciplinary order or agreement issued by the Board are satisfied.

§273.12. Profile Information.

(a) All licensees shall provide, on each application for renewal of license, the information listed in subsection (b). New licensees shall provide the information listed in subsection (b) prior to receiving a license.

(b) Each license holder is required to furnish:

(1) the name of the license holder and the address and telephone number of the license holder's primary practice location; and

(2) a personal email address.

§273.14. License Applications for Military Service Member, Military Veteran, and Military Spouse.

(a) Definitions.

(1) "Military service member" means a person who is on active duty.

(2) "Military spouse" means a person who is married to a military service member.

(3) "Military veteran" means a person who has served on active duty, who was discharged or released from active duty, and who was not dishonorably discharged.

(4) "Active duty" means current full-time military service in the armed forces of the United States or active duty military service as a member of the Texas military forces, as defined by §437.001, Government Code, or similar military service of another state.

(5) "Armed forces of the United States" means the army, navy, air force, space force, coast guard, or marine corps of the United States or a reserve unit of one of those branches of the armed forces.

(b) License eligibility requirements for applicants with military experience.

(1) Verified military service, training, or education will be credited toward the licensing requirements, other than an examination requirement, of an applicant who is a military service member or military veteran.

(2) This subsection does not apply if the applicant holds a restricted license issued by another jurisdiction or has an unacceptable criminal history.

(c) Alternate licensing procedure authorized by Texas Occupations Code §55.004 and §55.005.

(1) Applicants currently licensed in another state.

(A) Application.

(i) The military service member, military veteran or military spouse applicant must be licensed in good standing as a therapeutic optometrist or the equivalent in another state, the District of Columbia, or a territory of the United States that has licensing requirements that are substantially equivalent to the requirements of the Act.

(ii) The military service member, military veteran or military spouse applicant shall submit a completed Military application, including the submission of proof of the applicant's status as a military service member, military veteran or military spouse along with all documents required under §271.2 of this title.

(iii) A military service member, military veteran, or military spouse licensed in another state is exempt from the application fee in §273.4 of this chapter (relating to Fees (Not Refundable)). Such an applicant is not exempt from exam administration fees charged

for an exam administered by an organization or person other than the Board.

(iv) A license issued under this subsection shall be a license to practice therapeutic optometry with the same obligations and duties required of a licensed therapeutic optometrist and subject to the same disciplinary requirements for that license.

(B) License Renewal.

(i) Initial military licenses expire on the second January 1 after the date the license is first issued. If the initial license is timely renewed, the licensee may thereafter renew the license by paying the renewal fee prior to the expiration date set in §273.8 of this chapter.

(ii) The requirements for renewing the license are the same as the requirements for renewing an active license.

(2) Requirements for license for military requirements for renewing an active service member, military veteran or military spouse applicant not currently licensed to practice optometry who was licensed in Texas within five years of the application submission.

(A) Application.

(i) The military service member, military veteran or military spouse applicant shall submit a completed Military application, including the submission of proof of the applicant's status as a military service member, military veteran or military spouse along with all documents required under §271.2 of this title.

(ii) An application fee in the same amount as the application fee set out in §273.4 of this chapter must be submitted with the application.

(iii) A license issued under this subsection shall be a license to practice therapeutic optometry with the same obligations and duties required of a licensed therapeutic optometrist and subject to the same disciplinary requirements for that license.

(B) License Renewal.

(i) Initial military licenses expire on the second January 1 after the date the license is first issued. If the initial license is timely renewed, the licensee may thereafter renew the license by paying the renewal fee prior to the expiration date set in §273.8 of this chapter.

(ii) The requirements for renewing the license are the same as the requirements for renewing an active license.

(d) Alternative method to demonstrate competency. To protect the health and safety of the citizens of this state, a license to practice optometry requires the licensee to obtain a doctorate degree in optometry and passing scores on lengthy and complex nationally accepted examinations. An alternative method to demonstrate competency is not available at this time.

(e) Alternate licensing procedure for military service member or military spouse authorized by Texas Occupations Code §55.0041.

(1) Application.

(A) The military service member or military spouse applicant must be licensed in good standing as a therapeutic optometrist or the equivalent in another state, the District of Columbia, or a territory of the United States that has licensing requirements that are substantially equivalent to the requirements of the Act. For purposes of this subsection, the Board finds that every state and territory that issues a therapeutic license to a graduate of an accredited optometry school has

licensing requirements that are substantially equivalent to the requirements of the Act.

(B) The military service member or military spouse applicant shall submit:

(i) proof of the service member's or spouse's residency in this state and a copy of the service member's or spouse's military identification card;

(ii) a completed Federal Bureau of Investigation fingerprint card provided by the Board;

(iii) an official license verification from the state in which the applicant is licensed that has licensing requirements substantially equivalent to the Act; and

(iv) application form.

(2) License.

(A) A license issued under this subsection:

(i) shall be a license to practice therapeutic optometry with the same obligations and duties required of a licensed therapeutic optometrist and subject to the same disciplinary requirements for that license,

(ii) will expire three years after the license is issued, or if occurring prior to the expiration of the three-year period, the date when the military service member or military spouse is no longer stationed at a military installation in this state, and

(iii) may not be renewed.

(B) The application and license is exempt from the Texas Jurisprudence Examination and the application fee and initial license fee in §273.4 of this chapter.

§273.15. *Retired License for Volunteer Charity Care.*

(a) Retired License. The Board may issue a Retired License to optometrists or therapeutic optometrists whose only practice is volunteer charity care pursuant to this section.

(b) Application. An optometrist holding a current license may apply for a Retired License by submitting to the Board a completed application with the license fee required by §273.4 of this chapter (relating to Fees (Not Refundable)). There is no charge to apply. A Retired License will not be issued to applicants subject to current or pending disciplinary action. In determining whether to grant retired status, the board shall consider the age, years of practice, and status of the license holder at the time of the application. Applicants must supply proof that the continuing education requirements for a Retired License have been met in §275.1(g)(1) of this title (relating to General Requirements).

(c) Application by Expired Licensee. A former therapeutic optometrist whose license has expired for one year or more may apply for a Retired License by submitting to the Board a completed application with the license fee required by §273.4 of this chapter. There is no charge to apply. A Retired License will not be issued to applicants subject to current or pending disciplinary action. Applicants must supply proof of having met the continuing education requirements of §275.1(g)(2) of this title. An applicant for a Retired License whose license has been expired for five years or more must supply proof of a passing score on the jurisprudence examination taken within the one year period prior to the submission of the application. In determining whether to grant retired status, the Board shall consider the age, years of practice, and status of the license holder at the time of the application.

(d) Scope of License. The holder of a Retired License may practice optometry or therapeutic optometry in the same manner as an

active licensee of the Board, subject to the restrictions contained in this section. A holder of a Retired License may only practice optometry or therapeutic optometry when such practice is without compensation or expectation of compensation (except for the reimbursement of travel and supply expenses) as a direct service volunteer of a charitable organization.

(e) Charitable Organization. A charitable organization includes any bona fide charitable, religious, prevention of cruelty to children or animals, youth sports and youth recreational, neighborhood crime prevention or patrol, or educational organization (excluding fraternities, sororities, and secret societies), or other organization organized and operated exclusively for the promotion of social welfare by being primarily engaged in promoting the common good and general welfare of the people in a community, including these types of organizations with a §501(c)(3) or (4) exemption from federal income tax, some chambers of commerce, and volunteer centers certified by the Department of Public Safety.

(f) Renewal. A Retired License expires on the same date as a regular license. Prior to renewing the license, the licensee must supply proof that the continuing education requirements for a Retired License have been met. The license renewal fee is set in §273.4 of this chapter.

(g) Penalty. The holder of a Retired License shall not receive compensation for the practice of optometry. To do so constitutes the practice of optometry without a license and subjects the optometrist or therapeutic optometrist to the penalties imposed for this violation.

(h) Reinstatement of an Active License by a Holder of a Retired License. Retired licensees may apply for reinstatement by submitting to the Board a completed application with the application fee required by §273.4 of this chapter. Applicants must supply proof that the continuing education requirements for an active license have been met.

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

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Janice McCoy

Executive Director

Texas Optometry Board

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For further information, please call: (512) 305-8500



PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 283. LICENSING REQUIREMENTS FOR PHARMACISTS

22 TAC §283.4

The Texas State Board of Pharmacy adopts amendments to §283.4, concerning Internship Requirements. These amendments are adopted without changes to the proposed text as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3033). The rule will not be republished.

The amendments extend the period that internship hours may be used for licensure from two years to three years from the date the internship is completed.

No comments were received.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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

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Julie Spier, R.Ph.

President

Texas State Board of Pharmacy

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22 TAC §283.6

The Texas State Board of Pharmacy adopts amendments to §283.6, concerning Preceptor Requirements and Ratio of Preceptors to Pharmacist-Interns. These amendments are adopted without changes to the proposed text as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3035). The rule will not be republished.

The amendments remove the condition that a pharmacist preceptor must have six months of residency training if the pharmacist-intern's residency program is accredited by the American Society of Health System Pharmacists.

No comments were received.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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

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CHAPTER 291. PHARMACIES

SUBCHAPTER A. ALL CLASSES OF PHARMACIES

22 TAC §291.24

The Texas State Board of Pharmacy adopts the repeal of §291.24, concerning Pharmacy Residency Programs. The repeal is adopted without changes to the proposed repeal as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3038). The rule will not be republished.

The repeal of §291.24 removes standards for a statutory program that no longer exists.

No comments were received.

STATUTORY AUTHORITY

The repeal is adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by the adopted repeal: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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

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22 TAC §291.27

The Texas State Board of Pharmacy adopts amendments to §291.27, concerning Confidentiality. These amendments are adopted without changes to the proposed text as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3039). The rule will not be republished.

The amendments correct a misspelled word.

No comments were received.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing

the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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

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SUBCHAPTER G. SERVICES PROVIDED BY PHARMACIES

22 TAC §291.121

The Texas State Board of Pharmacy adopts amendments to §291.121, concerning Remote Pharmacy Services. These amendments are adopted without changes to the proposed text as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3040). The rule will not be republished.

The amendments allow remote pharmacy services to be provided using an automated pharmacy system to be provided at healthcare facilities regulated under Chapter 534, Health and Safety Code.

The Board received comments from Angela Babin, BPharm, MBA, with The Harris Center, in support of the amendments.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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

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SUBCHAPTER H. OTHER CLASSES OF PHARMACY

22 TAC §291.151

The Texas State Board of Pharmacy adopts amendments to §291.151, concerning Freestanding Emergency Medical Care Facility (Class F). These amendments are adopted without changes to the proposed text as published in the June 16, 2023, issue of the *Texas Register* (48 TexReg 3051). The rule will not be republished.

The amendments clarify that a pharmacist must verify the completeness and reconciliation of the perpetual inventory of controlled substances for an FEMCF pharmacy.

No comments were received.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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

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PART 23. TEXAS REAL ESTATE COMMISSION

CHAPTER 535. GENERAL PROVISIONS

SUBCHAPTER D. THE COMMISSION

22 TAC §535.46

The Texas Real Estate Commission (TREC) adopts new 22 TAC §535.46, Broker Responsibility Advisory Committee, in Chapter 535, General Provisions, without changes, as published in the June 9, 2023, issue of the *Texas Register* (48 TexReg 2925) and will not be republished.

The new rule establishes an advisory committee called the Broker Responsibility Advisory Committee (BRAC), which is tasked with advising TREC as to issues surrounding broker responsibility within the real estate industry. This committee will also make recommendations to TREC regarding possible legislative and rule changes associated with broker responsibility issues impacting both the real estate industry and the consumer.

Nine comments were received. Two comments were unrelated to the proposed new rule. Five comments were in favor of the new rule and the creation of BRAC. Some commenters noted the importance of a diverse group of members that represent all brokers. One commenter believed the new committee should also include sales agents, which the Executive Committee did not think necessary in light of the BRAC's stated objective of examining broker responsibility. Another commenter asked what criteria would be used to select members and whether the position would be paid. The Executive Committee noted the criteria for membership is listed in the rule and that considerations related to geographic region would be made by the selection committee. The Executive Committee also noted that a committee member would not be paid for serving. After reviewing the comments, the Executive Committee declined to recommend any changes to the rule as published.

The new rule is adopted under Texas Occupations Code, §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102 and ensure compliance with Chapters 1101 and 1102.

The statute affected by this adoption is Texas Occupations Code, Chapter 1101, specifically section 1101.158. No other statute, code or article is affected by the new rule.

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

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Vanessa E. Burgess

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Texas Real Estate Commission

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For further information, please call: (512) 936-3284



SUBCHAPTER I. LICENSE RENEWAL

22 TAC §535.92

The Texas Real Estate Commission (TREC) adopts amendments to 22 TAC §535.92, Continuing Education Requirements, in Chapter 535, General Provisions, without changes, as published in the June 9, 2023, issue of the *Texas Register* (48 TexReg 2926) and will not be republished.

The amendments to §535.92 include expand a real estate license holder's opportunity to earn up to four hours of continuing education elective credit for attendance at a single Commission meeting and clarify that such credit may only be awarded for attendance at one Commission meeting per renewal cycle. The remainder of the changes are either updates to terminology or form for consistency throughout the chapter or are made to reflect updated processes.

Thirteen comments were received. One comment asked for clarification regarding credit for meetings attended remotely, which the Executive Committee noted the rule language specifically prohibits. Another commenter supported the change but made other suggestions related to course work for license holders.

One commenter requested clarification regarding the number of hours that can be earned, which the Executive Committee also noted was detailed in the rule language itself. One commenter misunderstood that this rule change does not increase the number of continuing education hours a license holder must take. Some commenters expressed concern that continuing education should be classroom based only. Other commenters thought the change to allow license holders more opportunity to obtain continuing education credit was very beneficial because Commission meetings are very informative. After reviewing the comments, the Executive Committee declined to recommend any changes to the rule as published.

The amendments are adopted under Texas Occupations Code, §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102 and ensure compliance with Chapters 1101 and 1102.

The statute affected by this adoption is Texas Occupations Code, Chapter 1101. No other statute, code or article is affected by the adopted amendments.

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

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 15. TEXAS VETERANS COMMISSION

CHAPTER 450. VETERANS COUNTY SERVICE OFFICERS CERTIFICATE OF TRAINING

40 TAC §450.1, §450.3

The Texas Veterans Commission (Commission) adopts amendments to Chapter 450, §450.1 and §450.3, of Title 40, Part 15, Chapter 450 of the Texas Administrative Code concerning Veterans County Service Officers Certificate of Training without changes to the proposed text as published in the May 26, 2023, issue of the *Texas Register* (48 TexReg 2688) and will not be republished.

The amended rules are adopted to change the definitions in existing language to reflect the language in Title 38 of the Code of Federal Regulations (CFR) and to correct grammatical errors.

No comments were received regarding the proposed rule amendments.

The amended rules are adopted under Texas Government Code §434.010, which authorizes the Commission to establish rules it considers necessary for its administration, and Texas Government Code §434.038, which authorizes the Commission to establish rules governing the training and certification for Veteran County Service Officers and Assistant Veterans County Service Officers.

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

Filed with the Office of the Secretary of State on August 11, 2023.

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Kathleen Cordova

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Texas Veterans Commission

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CHAPTER 451. VETERANS COUNTY SERVICE OFFICERS ACCREDITATION

40 TAC §451.1, §451.3

The Texas Veterans Commission (Commission) adopts amendments to Chapter 451, §451.1 and §451.3, Veterans County Service Officers Accreditation with nonsubstantive changes to the proposed text as published in the May 26, 2023, issue of the *Texas Register* (48 TexReg 2689) and will be republished.

The amended rules are adopted to change existing language to be consistent with the terms found in Title 38 of the Code of Federal Regulations (CFR).

No comments were received regarding the proposed rule amendments.

The amended rules are adopted under Texas Government Code §434.010, which authorizes the Commission to establish rules it considers necessary for its administration, and Texas Government Code §434.039, which authorizes the Commission to develop a plan for encouraging service officers to become accredited by the United States Department of Veterans Affairs.

§451.1. Definitions.

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

(1) Accreditation--Recognition by the United States Department of Veterans Affairs (VA) of representatives, attorneys, and agents to represent claimants.

(2) Accredited representative of the Texas Veterans Commission--A representative of the Texas Veterans Commission approved by the secretary for the preparation, presentation, and prosecution of claims under laws administered by the secretary.

(3) Certificate of training--Documentation that an officer has met the requirements of §450.3 of this title (relating to General Provisions).

(4) Commission--The Texas Veterans Commission which is a "Recognized Veterans Service Organization" by the United States Department of Veterans Affairs.

(5) Credit hour--Unit of measuring credit earned for attending a classroom or virtual training courses provided by the commission or other commission approved training.

(6) Initial training--Introductory training completed by newly appointed officers as defined in Chapter 450 of this title (relating to Certificate of Training).

(7) Officer--Veterans County Service Officer or assistant veterans county service officer appointed by a county commissioners court.

(8) Recognized Veterans Service Organization--An organization accredited by the United States Department of Veterans Affairs to represent claimants.

(9) Recommendation-- the procedure by which the commission indicates to the secretary that it desires an officer to become an accredited representative of the Texas Veterans Commission and certifies that the officer meets the requirements of 38 C.F.R. § 14.629(a).

(10) Representative--Person who has been recommended by a Recognized Veterans Service Organization and accredited by the United States Department of Veterans Affairs.

(11) Secretary--The secretary of the United States Department of Veterans Affairs.

(12) Training event -- Training or testing conducted by the commission.

§451.3. General Provisions.

(a) The commission shall provide all officers information concerning accreditation when the commission receives information is received indicating notice that an officer has been appointed by a county commissioners court.

(b) Officers must meet the following minimum standards as set forth in 38 Code of Federal Regulations §14.629 for recommendation:

(1) is a paid employee of the county working for it not less than 1,000 hours annually;

(2) has successfully completed a course of training and an examination which have been approved by the appropriate VA district counsel within the state; and

(3) will receive annual training to ensure continued qualification as a representative in the claims' process.

(c) To receive recommendation, the officer must hold a current certificate of training from the commission under the provisions of §450.3 of this title (relating to General Provisions), have attained at least 24 credit hours after completion of initial training requirements, and pass a proficiency exam.

(d) All officers must submit a formal written application for recommendation to the commission, which shall review the application for eligibility and approval.

(e) Credit hours may be earned by attending training sponsored or conducted by organizations other than the commission in accordance with §450.3 of this title.

(f) The commission may pay for an officer's attendance to one commission conducted training event per fiscal year to meet the offi-

cer's annual training requirement. However, if an officer has met the 12 hours required annually, then the commission shall not pay for the officer to attend subsequent training events.

(g) Examinations for the initial recommendation and examinations to maintain recommendation will be administered by the commission at a location and time designated by the commission.

(h) Officers must agree to follow procedures promulgated by the commission.

(i) When all criteria have been met by the officer, the commission will request accreditation from the United States Department of Veterans Affairs via VA Form 21.

(j) To maintain the recommendation of the commission, an officer must successfully pass, at least annually, a proficiency exam and hold a current certificate of training under the provisions of §450.3 of this title.

(k) Inquiries concerning accreditation shall be directed to and answered by the commission Claims Department Director. Disputes shall be reviewed and a decision rendered by the commission Claims Department Director or designee. Disputes which remain unresolved shall be referred to the executive director of the commission or the executive director's designee. The decision of the executive director or the executive director's designee shall be final.

(l) The executive director of the commission or the executive director's designee will request that the secretary:

(1) revoke the accreditation of the officer upon termination of the officer;

(2) suspend or revoke the accreditation of an officer for the officer's failure to:

(A) maintain commission annual training requirements;
(B) maintain the commission annual testing requirements;

(C) maintain the VA's annual training requirements; or

(D) maintain active use of the VA's database systems;

and

(3) suspend or revoke the accreditation of the officer for any situation in which the action is deemed appropriate.

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

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