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 2. TEXAS ETHICS COMMISSION

CHAPTER 18. GENERAL RULES CONCERNING REPORTS

1 TAC §18.17

The Texas Ethics Commission (the Commission) adopts amendments to Texas Ethics Commission rules in Chapter 18. Specifically, the Commission adopts amendments to §18.17, regarding Report Must Be Filed. The amendments are adopted with changes to the proposed text as published in the July 2, 2021, issue of the *Texas Register* (46 TexReg 3995) to add a small clarification; it will be republished.

Under current rules, late fines continue to accrue until a report is filed, and the Commission will not consider a request for waiver or reduction of the fine until the late report is filed. 1 Texas Administrative Code §18.17 ("The payment of a civil or criminal fine for failure to file a report, or for filing a report late, does not satisfy a filer's obligation to file the report. Late fines continue to accrue until the report is filed."); §18.21(a) ("A filer must file a complete report before the executive director or commission will consider a request to waive or reduce a fine assessed for failure to file a timely report."). Consequently, when a filer becomes incapacitated or passes away, under current law, his/her estate is still responsible for filing any missing or late reports for that filer. This adopted amendment would deem a report filed on the date the filer either passes away or is deemed partially or totally mentally incapacitated by a court.

The adopted amendment adds the phrase "other than the treasurer of a political committee" to subsection (b).

No public comments were received on this amended rule.

The amendment is adopted under Texas Government Code §571.062, which authorizes the Commission to adopt rules to administer Title 15 of the Election Code.

The adopted amended rule affects Title 15 of the Election Code.

§18.17. Report Must be Filed.

(a) The payment of a civil or criminal fine for failure to file a report, or for filing a report late, does not satisfy a filer's obligation to file the report. Late fines continue to accrue until the report is filed.

(b) A filer, other than the treasurer of a political committee, who dies or becomes incapacitated is considered to have filed the report on the date of the filer's death or the date the filer is determined to be incapacitated, as applicable, for purposes of this chapter. In this subsection, "incapacitated" means determined by a judgment of a court exercising probate jurisdiction to be either partially mentally incapacitated without the right to vote or totally mentally incapacitated.

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 September 2, 2021.

TRD-202103464
J. R. Johnson
General Counsel
Texas Ethics Commission
Effective date: September 22, 2021
Proposal publication date: July 2, 2021
For further information, please call: (512) 463-5800

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CHAPTER 34. REGULATION OF LOBBYISTS SUBCHAPTER D. LOBBY ACTIVITY REPORTS

1 TAC §34.82

The Texas Ethics Commission (the Commission) adopts a new Texas Ethics Commission rule in Chapter 34. Specifically, the Commission adopts new rule §34.82, regarding Modified Reporting Threshold. The new rule is adopted without changes to the proposed text as published in the July 2, 2021, issue of the *Texas Register* (46 TexReg 3995). The rule will not be republished.

The Commission has received numerous inquiries recently regarding whether mass media communications should be included in the expenditure threshold that determines whether a lobbyist files monthly or annually. See Tex. Gov't Code § 305.0063(d). This rule would make public the Commission's understanding that "expenditures" as used in section 305.0063(d) refers to all reportable expenditures, not only those reportable under section 305.006(b).

No public comments were received on this new rule.

The new rule is adopted under Texas Government Code §571.062, which authorizes the Commission to adopt rules to administer Chapter 305 of the Government Code.

The adopted new rule affects Chapter 305 of the Government Code.

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

Filed with the Office of the Secretary of State on September 2, 2021.

TRD-202103465
J. R. Johnson
General Counsel
Texas Ethics Commission
Effective date: September 22, 2021
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For further information, please call: (512) 463-5800

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PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8052

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §355.8052, concerning Inpatient Hospital Reimbursement. The amendment to §355.8052 is adopted with changes to the proposed text as published in the June 25, 2021, issue of the *Texas Register* (46 TexReg 3785). The rule will be republished.

BACKGROUND AND JUSTIFICATION

The amendment to §355.8052 is adopted to comply with Senate Bill 170 (S.B. 170), 86th Legislature, Regular Session, 2019 and Senate Bill 1621 (S.B. 1621), 86th Legislature, Regular Session, 2019, and to make other amendments to enhance clarity, consistency, and specificity. HHSC is required by S.B. 170, to the extent allowed by law, to calculate Medicaid rural hospital inpatient rates using a cost-based prospective reimbursement methodology. Additionally, HHSC must calculate rates for rural hospitals once every two years, using the most recent cost information available. The current rule does not require a biennial review of the rural hospital rates. Rates have not been realigned or rebased since state fiscal year (SFY) 2014. Previously, HHSC converted the rural hospital reimbursement from the methodology described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to the prospective payment All Patient Refined Diagnosis Related Group (APR-DRG) methodology.

Pursuant to S.B. 1621 and S.B. 170, HHSC's managed care contracts require managed care organizations (MCO) to reimburse rural hospitals using a minimum fee schedule for services delivered through the Medicaid managed care program. The proposed amendment adds subsection (e)(4), requiring a Medicaid minimum fee schedule for all rural hospitals, to conform the rule to the current law.

Presently, §355.8052 explains the standard dollar amount (SDA) rate setting process by concurrently addressing the multiple hospital types (rural, urban, and children's). The proposed amendment arranges the rule by hospital type to enhance clarity, consistency, and specificity. The amendment adds and modifies definitions, including "rebasing" and "realignment." The proposed amendment also specifies a policy for updating DRG statistical calculations to align with 3M™ Grouper changes.

COMMENTS

The 31-day comment period ended July 26, 2021. During this period, HHSC received the following comments regarding the amendment from four commenters and three entities: Texas Organization of Rural and Community Hospitals (TORCH), Texas Children's Hospital (TCH), and Texas Hospital Association (THA). A summary of comments relating to the rule and HHSC's responses follow.

Comment: All commenters expressed support for the proposed rule amendment.

Response: HHSC appreciates the commenters' support of the rule amendment. No changes were necessary in response to this comment.

Comment: Multiple commenters stated that HHSC should explain the difference between "rebasing" and "realignment."

Response: HHSC modified the definition of "realignment" in subsection (b)(28) and "rebasing" in subsection (b)(29) to enhance clarity in response to the comment.

Comment: Multiple commenters stated that HHSC should specify the timing of a rebasing or realignment for non-rural hospitals.

Response: HHSC used specific language for the rural hospital timing of rate reviews per legislative direction in S.B. 170. Future updates for realignment or rebasing will occur based on legislative direction. No changes were made to the rule text as a result of this comment.

Comment: Multiple commenters stated that HHSC would specify a delayed implementation date of grouper changes to the beginning of the following SFY to allow providers to review the changes. Commenters also stated that the proposed rule should contain language to address the changes.

Response: HHSC intends to implement updates to the grouper statistics annually. A rate hearing will be held prior to implementation. No changes were made to the rule text as a result of this comment.

Comment: One commenter suggested that HHSC consider separating the inpatient rule into different rules based on provider type.

Response: HHSC appreciates the suggestion of separating the inpatient rule into different rules and will take it into consideration in future amendments. No changes were made to the rule text as a result of this comment.

Comment: One commenter requested that HHSC replace the term "recalculate" with "realign" to improve specificity in all instances where "realign" is now meant.

Response: The term "recalculate" does not mean the same thing as "realign." HHSC verified that the term "recalculate" is used properly and no changes were made to the rule text as a result of this comment.

Comment: One commenter pointed out several references in the rule that required an update.

Response: HHSC updated the references in the rule text as a result of the comment. Updates were made as follows.

In subsection (b)(3), a reference to subsection (c) was added.

In subsection (c)(2)(A), the reference to paragraph (1)(A)(ii) was updated to paragraph (1)(C).

In subsections (d)(2)(A) and (d)(2)(B), the reference to paragraph (1)(A)(ii) was updated to paragraph (1)(B).

In subsection (g)(1)(B)(i), the reference to subsection (c) was updated to subsection (d).

In subsection (h)(4)(A), the reference to paragraph (2) was updated to paragraph (3).

In subsection (i)(3)(A)(iv), a reference to subsection (h)(3) was added.

In subsection (i)(3)(B)(i), the phrase "and rural base year stays" was added for clarification.

In subsection (i)(5)(B)(ii), a reference to subsection (h)(3) was added.

In subsection (l)(2)(A), a reference to subsection (h)(2)(B)(iii) was added.

Comment: One commenter asked whether managed care encounters are included in the identification of base year claims in subsection (b)(5).

Response: Managed care encounters are not currently included in the base year claim data for urban or children SDA rates. HHSC made a change related to this comment for future changes to the base rates to include MCO encounter data.

Comment: One commenter suggested the removal of "rural hospitals" from the definition of "base year claims," as the calculation of the rural hospital SDA no longer uses this term, in subsection (b)(5)(F).

Response: HHSC agrees with this suggestion and updated the definition as suggested. Based on this change, HHSC also modified subsection (h) to indicate that rural hospital information will be included in future grouper reviews calculations.

Comment: One commenter suggested removing definitions for "Final Settlement," "Interim payment," and "Tentative settlement" because they are no longer used in the rule.

Response: HHSC did not remove the definitions at this time because they may be referenced in other rules. HHSC will review the definitions in future rule changes. No changes were made in response to this comment.

Comment: One commenter suggested that language be inserted in the rule to state when legislative direction is required.

Response: HHSC added clarifying language to the definitions of "rebasing" and "realignment" in subsection (b) and inserted additional language in subsection (h) to indicate when legislative direction is required.

Comment: One commenter requested a copy of the data supporting the impact statement from the preamble for the statement, "one rural hospital owned by a municipality with fewer than 25,000 persons that will have its rates decrease with the adoption of this rule. The adverse economic impact in the first two SFYs the rule is in effect is projected to be $2,930 in SFY 2023 and $3,001 in SFY 2023."

Response: HHSC reviewed the preamble information and determined that the original statement was incorrect. The proposed preamble should have stated "one rural hospital owned by a municipality with fewer than 25,000 persons that will have its rates decrease with the adoption of this rule. The adverse economic impact in the first two SFYs the rule is in effect is projected to be $1,651 in SFY 2023 and $1,691 in SFY 2024."

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; 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; and Texas Government Code §531.02194, which requires adoption of a prospective reimbursement methodology for the payment of rural hospitals.

§355.8052. Inpatient Hospital Reimbursement.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate reimbursement for a covered inpatient hospital service.

(b) Definitions.

(1) Add-on--An amount that is added to the base Standard Dollar Amount (SDA) to reflect high-cost functions and services or regional cost differences.

(2) Adjudicated--The approval or denial of an inpatient hospital claim by HHSC.

(3) Base standard dollar amount (base SDA)--A standardized payment amount calculated by HHSC, as described in subsections (c) and (d) of this section, for the costs incurred by prospectively paid hospitals in Texas for furnishing covered inpatient hospital services.

(4) Base year--For the purpose of this section, the base year is a state fiscal year (September through August) to be determined by HHSC.

(5) Base year claims--For the purposes of rate setting (including Diagnosis-related group (DRG) relative weights, Mean length of stay (MLOS) and Days Thresholds, and rebasing or realignment of base rates) effective September 1, 2021, and after HHSC includes Medicaid inpatient fee-for-service (FFS) and Managed Care Organization (MCO) encounters that meet the criteria in subparagraphs (A) - (F) of this paragraph in the Base Year claims data. For base rates set prior to September 1, 2021, individual sets of base year claims are compiled for children's hospitals and urban hospitals for the purposes of rate setting and realignment. All Medicaid inpatient fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by an urban or children's hospital that:

(A) had a date of admission occurring within the base year;

(B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such claims that had zero inpatient days;

(C) were not claims for patients who are covered by Medicare;

(D) were not Medicaid spend-down claims;

(E) were not claims associated with military hospitals, out-of-state hospitals, state-owned teaching hospitals, and freestanding psychiatric hospitals; and

(F) individual sets of base year claims are compiled for children's hospitals and urban hospitals for the purposes of rate setting and rebasing.

(6) Children's hospital--A Medicaid hospital designated by Medicare as a children's hospital and exempted by Centers for Medicare and Medicaid Services (CMS) from the Medicare prospective payment system.

(7) Cost outlier payment adjustment--A payment adjustment for a claim with extraordinarily high costs.

(8) Cost outlier threshold--One factor used in determining the cost outlier payment adjustment.

(9) Day outlier payment adjustment--A payment adjustment for a claim with an extended length of stay.

(10) Day outlier threshold--One factor used in determining the day outlier payment adjustment.

(11) Diagnosis-related group (DRG)--The classification of medical diagnoses as defined in the 3M™ All Patient Refined Diagnosis Related Group (APR-DRG) system or as otherwise specified by HHSC. Each DRG has four digits. The last digit of the Diagnosis-Related Group is the Severity of Illness (SOI). SOI indicates the seriousness of the condition on a scale of one to four: minor, moderate, major, or extreme. SOI may increase if secondary diagnoses are present, in addition to the primary diagnosis.

(12) Final settlement--Reconciliation of Medicaid cost in the CMS form 2552-10 hospital fiscal year end cost report performed by HHSC within six months after HHSC receives the cost report audited by a Medicare intermediary, or HHSC.

(13) Final standard dollar amount (final SDA)--The rate assigned to a hospital after HHSC applies the add-ons and other adjustments described in this section.

(14) Geographic wage add-on--An adjustment to a hospital's base SDA to reflect geographical differences in hospital wage levels. Hospital geographical areas correspond to the Core-Based Statistical Areas (CBSAs) established by the federal Office of Management and Budget in 2003.

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

(16) Impact file--The Inpatient Prospective Payment System (IPPS) Final Rule Impact File that contains data elements by provider used by the CMS in calculating Medicare rates and impacts. The impact file is publicly available on the CMS website.

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

(18) Inpatient Ratio of cost-to-charge (RCC)--A ratio that covers all applicable Medicaid hospital costs and charges relating to inpatient care.

(19) In-state children's hospital--A hospital located within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(20) Interim payment--An initial payment made to a hospital that is later settled to Medicaid-allowable costs, for hospitals reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(21) Interim rate--The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's cost report, expressed as a percentage. The interim rate established during a cost report settlement for an urban hospital or a rural hospital reimbursed under this section excludes the application of TEFRA target caps and the resulting incentive and penalty payments.

(22) Managed Care Organization (MCO) Adjustment Factor--Factor used to estimate managed care premium tax, risk margin, and administrative costs related to contracting with HHSC. The estimated amounts are subtracted from appropriations.

(23) Mean length of stay (MLOS)--One factor used in determining the payment amount calculated for each DRG; the average number of inpatient days per DRG.

(24) Medical education add-on--An adjustment to the base SDA for an urban teaching hospital to reflect higher patient care costs relative to non-teaching urban hospitals.

(25) Military hospital--A hospital operated by the armed forces of the United States.

(26) New Hospital--A hospital that was enrolled as a Medicaid provider after the end of the base year and has no base year claims data.

(27) Out-of-state children's hospital--A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(28) Realignment--Recalculation of the base SDA and add-ons using current RCCs, inflation factors, and base year claims as specified by HHSC, or its designee, for one or more hospital types. Realignment will occur based on legislative direction.

(29) Rebasing--Calculation of all SDAs and add-ons, DRG relative weights, MLOS, and day outlier thresholds for all hospitals using a base period as specified by HHSC, or its designee. Rebasing will occur based on legislative direction.

(30) Relative weight--The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.

(31) Rural base year stays--An individual set of base year stays is compiled for rural hospitals for the purposes of rate setting and realignment. All inpatient FFS claims and inpatient managed care encounters for reimbursement filed by a rural hospital that:

(A) had a date of admission occurring within the base year;

(B) were adjudicated and approved for payment during the base year or the six-month period that immediately followed the base year, except for such stays that had zero inpatient days;

(C) were not stays for patients who are covered by Medicare; and

(D) were not Medicaid spend-down stays; and were not stays associated with military hospitals, out-of-state hospitals, state-owned teaching hospitals, and freestanding psychiatric hospitals.

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

(A) is located in a county with 60,000 or fewer persons according to the 2010 U.S. Census;

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

(C) meets all of the following:

(i) has 100 or fewer beds;

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

(iii) is located in an MSA.

(33) Safety-Net add-on--An adjustment to the base SDA for a safety-net hospital to reflect the higher costs of providing Medicaid inpatient services in a hospital that provides a significant percentage of its services to Medicaid and/or uninsured patients.

(34) Safety-Net hospital--An urban or children's hospital that meets the eligibility and qualification requirements described in §355.8065 of this division (relating to Disproportionate Share Hospital Reimbursement Methodology) for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

(35) Standard Dollar Amount (SDA)--A standardized payment amount calculated by HHSC for the costs incurred by prospectively-paid hospitals in Texas for furnishing covered inpatient hospital services.

(36) State-owned teaching hospital--Acute care hospitals owned and operated by the state of Texas.

(37) Teaching hospital--A hospital for which CMS has calculated and assigned a percentage Medicare education adjustment factor under 42 CFR §412.105.

(38) Teaching medical education add-on--An adjustment to the base SDA for a children's teaching hospital with a program approved by the Accreditation Council for Graduate Medical Education (ACGME) to reflect higher patient care costs relative to non-teaching children's hospitals.

(39) TEFRA target cap--A limit set under the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) and applied to a hospital's cost settlement under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA target cap is not applied to services provided to patients under age 21, and incentive and penalty payments associated with this limit are not applicable to those services.

(40) Tentative settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.

(41) Texas provider identifier (TPI)--A unique number assigned to a provider of Medicaid services in Texas.

(42) Trauma add-on--An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations. To be eligible for the trauma add-on, a hospital must be eligible to receive an allocation from the trauma facilities and emergency medical services account under Texas Health and Safety Code Chapter 780.

(43) Trauma hospital--An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation under 25 Texas Administrative Code §157.125 (relating to Requirements for Trauma Facility Designation).

(44) Universal mean--Average base year cost per claim for all urban hospitals.

(45) Urban hospital--Hospital located in a metropolitan statistical area and not fitting the definition of rural hospitals, children's hospitals, state-owned teaching hospitals, or freestanding psychiatric hospitals.

(c) Base children's hospitals SDA calculations. HHSC will use the methodologies described in this subsection to determine average statewide base SDA and a final SDA for each children's hospital.

(1) HHSC calculates the average base year cost per claim as follows.

(A) To calculate the total inpatient base year cost per children's hospital:

(i) sum the allowable inpatient charges by hospital for the base year claims; and

(ii) multiply clause (i) of this subparagraph by the hospital's inpatient RCC and the inflation update factors to inflate the base year cost to the current year.

(B) Sum the amount of all hospitals' base year costs from subparagraph (A) of this paragraph.

(C) Subtract an amount equal to the estimated outlier payment amount for the base year claims for all children's hospitals from subparagraph (B) of this paragraph.

(D) To derive the average base year cost per claim, divide the result from subparagraph (C) of this paragraph by the total number of base year claims.

(2) HHSC calculates the base children's SDA as follows.

(A) From the amount determined in paragraph (1)(C) of this subsection, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

(B) The amount remaining from paragraph (1)(C) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the sum of the relative weights for all children's base year claims to derive the base SDA.

(3) A children's hospital may receive increases to the base SDA for any of the following.

(A) Add-on amounts, which will be determined or adjusted based on the following.

(i) Impact files.

(I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and

(II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.

(ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.

(iii) Teaching medical education add-on during the fiscal year. If a hospital becomes eligible for the teaching medical education add-on, the hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.

(iv) Safety-net add-on during the fiscal year. The hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.

(v) New children's hospital teaching medical education add-on. If an eligible children's hospital is new to the Medicaid program and a cost report is not available, the teaching medical education add-on will be calculated at the beginning of the state fiscal year after a cost report is received.

(B) Geographic wage add-on.

(i) CBSA assignment. For claims with dates of admission beginning September 1, 2013, and continuing until the next realignment, the geographic wage add-on for children's hospitals will be calculated based on the corresponding CBSA in the impact file in effect on September 1, 2011.

(ii) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.

(iii) Wage index. To determine a children's hospital geographic wage add-on, HHSC first calculates a wage index for Texas as follows.

(I) HHSC identifies the Medicare wage index factor for each CBSA in Texas.

(II) HHSC identifies the lowest Medicare wage index factor in Texas.

(III) HHSC divides the Medicare wage index factor in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.

(iv) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (E) of this paragraph.

(v) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.

(vi) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (c)(2)(B) of this section, the wage index calculated in clause (iii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (v) of this subparagraph.

(C) Teaching medical education add-on.

(i) Eligibility. A teaching hospital that is a children's hospital is eligible for the teaching medical education add-on. Each children's hospital is required to confirm, under the process described in subparagraph (E) of this paragraph, that HHSC's determination of the hospital's eligibility for the add-on is correct.

(ii) Teaching medical education add-on calculation.

(I) For each children's hospital, identify the total hospital medical education cost from each hospital cost report or reports that cross over the base year.

(II) For each children's hospital, sum the amounts identified in subclause (I) of this clause to calculate the total medical education cost.

(III) For each children's hospital, calculate the average medical education cost by dividing the amount from subclause (II) of this clause by the number of cost reports that cross over the base year.

(IV) Sum the average medical education cost per hospital to determine a total average medical education cost for all hospitals.

(V) For each children's hospital, divide the average medical education cost for the hospital from subclause (III) of this clause by the total average medical education cost for all hospitals from subclause (IV) of this clause to calculate a percentage for the hospital.

(VI) Divide the total average medical education cost for all hospitals from subclause (IV) of this clause by the total base year cost for all children's hospitals from subsection (c)(1)(B) of this section to determine the overall teaching percentage of Medicaid cost.

(VII) For each children's hospital, multiply the percentage from subclause (V) of this clause by the percentage from subclause (VI) of this clause to determine the teaching percentage for the hospital.

(VIII) For each children's hospital, multiply the hospital's teaching percentage by the base SDA amount to determine the teaching medical education add-on amount.

(D) Safety-Net add-on.

(i) Eligibility. If a children's hospital meets the definition of a "safety-net hospital" as defined in subsection (b) of this section, it is eligible for a safety-net add-on.

(ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.

(I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:

(-a-) total allowable Medicaid inpatient days for fee-for-service claims;

(-b-) total allowable Medicaid inpatient days for managed care encounters;

(-c-) total relative weights for fee-for-service claims; and

(-d-) total relative weights for managed care encounters.

(II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of this subclause.

(III) Determine the hospital's percentage of total allowable days to the total in subclause (II) of this clause.

(IV) Determine the hospital's portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.

(V) For each hospital, multiply item (-d-) of this subclause by the relevant MCO adjustment factor.

(VI) Sum the amounts in item (-c-) of this subclause and subclause (V) of this clause for each hospital.

(VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.

(iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.

(E) Add-on status verification.

(i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file at the time of realignment, Medicaid days, and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare teaching hospital designation for children's hospitals as applicable, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to hospital associations to disseminate to their member hospitals.

(ii) Rate realignment. HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of its eligibility for a different teaching medical education add-on or teaching hospital designation;

(II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA; or

(III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iii) Annual SDA calculation. HHSC will calculate a hospital's final SDA annually using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of a new teaching program or new teaching hospital designation; or

(II) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iv) Failure to notify. If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(4) Final children's hospital SDA calculations. HHSC calculates a children's hospital's final SDA as follows.

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.

(B) For labor and delivery services provided to adults age 18 or older in a children's hospital, the final SDA is equal to the base SDA for urban hospitals without add-ons, calculated as described in subsection (d)(4)(E)(i) of this section plus the urban hospital geographic wage add-on for an urban hospital located in the same CBSA as the children's hospital providing the service.

(C) For new children's hospitals that are not teaching hospitals, for which HHSC has no base year claim data, the final SDA is the base SDA plus the hospital's geographic wage add-on. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(D) For new children's hospitals that qualify for the teaching medical education add-on, as defined in subsection (b) of this section, for which HHSC has no base year claim data, the final SDA is calculated based on one of the following options until realignment is performed with base year claim data for the hospital. A new children's hospital must notify the HHSC Provider Finance Department of its selected option within 60 days from the date the hospital is notified of its provider activation by HHSC's fiscal intermediary. If the HHSC Provider Finance Department does not receive timely notice of the option, HHSC will assign the hospital the SDA calculated as described in clause (i) of this subparagraph. The SDA calculated based on the selected option will be effective retroactive to the first day of the provider's enrollment.

(i) Children's hospital base SDA plus the applicable geographic wage add-on and the minimum teaching add-on for existing children's hospitals. No settlement of costs is required for services reimbursed under this option. The SDA will be in effect until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(ii) Children's base SDA plus the applicable geographic wage add-on and the maximum teaching add-on for existing children's hospitals. A cost settlement is required for services reimbursed under this option. The SDA will be in effect for the hospital until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(d) Base urban hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the average statewide base SDA and the final SDA for each urban hospital.

(1) HHSC calculates the average base year cost per claim (the universal mean) as follows.

(A) To calculate the total inpatient base year cost per urban hospital:

(i) sum the allowable inpatient charges by hospital for the base year claims; and

(ii) multiply clause (i) of this subparagraph by the hospital's inpatient RCC and the inflation update factors to inflate the base year cost to the current year.

(B) Sum the amount for all hospitals' base year costs from subparagraph (A) of this paragraph.

(C) To derive the average base year cost per claim, divide the result from subparagraph (B) of this paragraph by the total number of base year claims.

(2) HHSC calculates the base urban SDA as follows.

(A) From the amount determined in paragraph (1)(B) of this subsection for urban hospitals, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

(B) The amount remaining from paragraph (1)(B) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the total number of base year claims to derive the base SDA.

(3) An urban hospital may receive increases to the base SDA for any of the following.

(A) Add-on amounts, which will be determined or adjusted based on the following.

(i) Impact files.

(I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and

(II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.

(ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.

(iii) Medical education add-on during fiscal year. If an existing hospital has a change in its medical education operating adjustment factor under Medicare, the hospital will become eligible for the adjustment to its medical education add-on upon the next realignment.

(iv) New medical education add-on. If a hospital becomes eligible for the medical education add-on after the most recent realignment:

(I) the hospital will receive a medical education add-on, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year; and

(II) HHSC will calculate the add-on using the impact file in effect at the time the hospital initially claims eligibility for the medical education add-on; and

(III) this amount will remain fixed until the next realignment.

(B) Geographic wage add-on.

(i) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.

(ii) Wage index. To determine an urban geographic wage add-on, HHSC first calculates a wage index for Texas as follows.

(I) HHSC identifies the Medicare wage index factor for each CBSA in Texas;

(II) HHSC identifies the lowest Medicare wage index factor in Texas;

(III) HHSC divides the Medicare wage index factor identified in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.

(iii) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (F) of this paragraph.

(iv) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.

(v) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (d)(2)(B) of this section, the wage index calculated in clause (ii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (iv) of this subparagraph.

(C) Medical education add-on.

(i) Eligibility. If an urban hospital meets the definition of a teaching hospital, as defined in subsection (b) of this section, it is eligible for the medical education add-on. Each hospital is required to confirm, under the process described in subparagraph (F) of this paragraph, that HHSC's determination of the hospital's eligibility and medical education operating adjustment factor under Medicare for the add-on is correct.

(ii) Add-on amount. HHSC multiplies the base SDA calculated in subsection (d)(2)(B) of this section by the hospital's Medicare education adjustment factor to determine the hospital's medical education add-on amount.

(D) Trauma add-on.

(i) Eligibility.

(I) If an urban hospital meets the definition of a trauma hospital, as defined in subsection (b) of this section, it is eligible for a trauma add-on.

(II) HHSC initially uses the trauma level designation associated with the physical address of a hospital's TPI. A hospital may request that HHSC, under the process described in subparagraph (F) of this paragraph use a higher trauma level designation associated with a physical address other than the hospital's TPI address.

(ii) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:

(I) by 28.3 percent for hospitals with Level 1 trauma designation;

(II) by 18.1 percent for hospitals with Level 2 trauma designation;

(III) by 3.1 percent for hospitals with Level 3 trauma designation; or

(IV) by 2.0 percent for hospitals with Level 4 trauma designation.

(iii) Reconciliation with other reimbursement for uncompensated trauma care. Subject to General Appropriations Act and other applicable law:

(I) if a hospital's allocation from the trauma facilities and emergency medical services account administered under Texas Health and Safety Code Chapter 780, is greater than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the Department of State Health Services will pay the hospital the difference between the two amounts at

the time funds are disbursed from that account to eligible trauma hospitals; and

(II) if a hospital's allocation from the trauma facilities and emergency medical services account is less than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the hospital will not receive a payment from the trauma facilities and emergency medical services account.

(E) Safety-Net add-on.

(i) Eligibility. If an urban hospital meets the definition of a safety-net hospital as defined in subsection (b) of this section, it is eligible for a safety-net add-on.

(ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.

(I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:

(-a-) total allowable Medicaid inpatient days for fee-for-service claims;

(-b-) total allowable Medicaid inpatient days for managed care encounters;

(-c-) total relative weights for fee-for-service claims; and

(-d-) total relative weights for managed care encounters.

(II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of this subclause.

(III) Determine the hospital's percentage of total allowable days to the total in subclause (II) of this clause.

(IV) Determine the hospital's portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.

(V) For each hospital, multiply item (-d-) of this subclause by the relevant MCO adjustment factor.

(VI) Sum the amounts in item (-c-) of this subclause and subclause (V) of this clause for each hospital.

(VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.

(iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.

(F) Add-on status verification.

(i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file available at the time of realignment or at the time of eligibility for a new medical education add-on as described in subparagraph (A)(iv) of this paragraph; the Texas Department of State Health Services' list of trauma-designated hospitals; and Medicaid days and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare education adjustment factor assigned to the hospital for urban hospitals, the trauma level designation assigned to the hospital, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.

(ii) During realignment, HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, the HHSC Provider Finance Department receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of its eligibility for a different medical education add-on or teaching hospital designation;

(II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA;

(III) the hospital provides documentation of its eligibility for a different trauma designation; or

(IV) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iii) Annually, HHSC will calculate a hospital's final SDA using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital (in a format determined by HHSC) that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of a new teaching program or new teaching hospital designation; or

(II) the hospital provides documentation of its eligibility for a different trauma designation; or

(III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iv) If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(4) Urban hospital final SDA calculations. HHSC calculates an urban hospital's final SDA as follows.

(A) Add all add-on amounts for which the hospital is eligible to the base SDA. These are the fully funded final SDAs.

(B) Multiply the final SDA determined in subparagraph (A) of this paragraph by each urban hospital's total relative weight of the base year claims.

(C) Sum the amount calculated in subparagraph (B) of this paragraph for all urban hospitals.

(D) Divide the total funds appropriated for reimbursing inpatient urban hospital services under this section by the amount determined in subparagraph (C) of this paragraph.

(E) To determine the budget-neutral final SDA:

(i) multiply the base SDA in paragraph (2) of this subsection by the percentage determined in subparagraph (D) of this paragraph;

(ii) multiply each of the add-ons described in paragraph (3)(B) - (E) by the percentage determined in subparagraph (D) of this paragraph; and

(iii) sum the results of clauses (i) and (ii) of this subparagraph.

(F) For new urban hospitals for which HHSC has no base year claim data, the final SDA is a base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in subparagraph (D) of this paragraph.

(e) Rural hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the final SDA for each rural hospital.

(1) HHSC calculates the rural final SDA as follows.

(A) Base year cost. Calculate the total inpatient base year cost per rural hospital.

(i) Total the inpatient charges by hospital for the rural base year stays.

(ii) Multiply clause (i) by the hospital's inpatient RCC and the inflation update factors to inflate the rural base year stays to the current year of the realignment.

(B) Full-cost SDA. Calculate a hospital-specific full-cost SDA by dividing each hospital's base year cost, calculated as described in subparagraph (A) of this paragraph, by the sum of the relative weights for the rural base year stays.

(C) Calculating the SDA floor and ceiling.

(i) Calculate the average adjusted hospital-specific SDA from subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.

(ii) Calculate the standard deviation of the hospital-specific SDAs identified in subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.

(iii) Calculate an SDA floor as clause (i) minus clause (ii) multiplied by a factor, determined by HHSC to maintain budget neutrality.

(iv) Calculate an SDA ceiling as clause (i) plus clause (ii) multiplied by a factor, determined by HHSC to maintain budget neutrality.

(D) Assigning a final hospital-specific SDA.

(i) If the adjusted hospital-specific SDA from subparagraph (B) is less than the SDA floor in subparagraph (C)(iii) of this paragraph, the hospital is assigned the SDA floor amount as the final SDA.

(ii) If the adjusted hospital-specific SDA from subparagraph (B) is more than the SDA ceiling in subparagraph (C)(iv), the hospital is assigned the SDA ceiling amount as the final SDA.

(iii) Assign the adjusted hospital-specific SDA as the final SDA to each hospital not described in clauses (i) and (ii) of this subparagraph.

(2) Alternate SDA for labor and delivery. For labor and delivery services provided by rural hospitals on or after September 1, 2019, the final SDA is the alternate SDA for labor and delivery stays, which is equal to the final SDA determined in paragraph (1)(D) of this subsection plus an SDA add-on sufficient to increase paid claims by no less than $500.

(3) HHSC calculates a new rural hospital's final SDA as follows.

(A) For new rural hospitals for which HHSC has no base year claim data, the final SDA is the mean rural SDA in paragraph (1)(C)(i) of this subsection.

(B) The mean rural SDA assigned in subparagraph (A) of this paragraph remains in effect until the next realignment.

(4) Minimum Fee Schedule. Effective March 1, 2021, MCOs are required to reimburse rural hospitals based on a minimum fee schedule. The minimum fee schedule is the rate schedule as described above.

(5) Biennial review of rural rates. Every two years, HHSC will calculate new rural SDAs using the methodology in this subsection to the extent allowed by federal law and subject to limitations on appropriations.

(f) Final SDA for military and out-of-state. The final SDA for military and out-of-state hospitals is the urban hospital base SDA multiplied by the percentage determined in subsection (d)(4)(D) of this section.

(g) DRG statistical calculations. HHSC rebases the relative weights, MLOS, and day outlier threshold whenever the base SDAs for urban hospitals are recalculated. The relative weights, MLOS, and day outlier thresholds are calculated using data from urban hospitals and apply to all hospitals. The relative weights that were implemented for urban hospitals on September 1, 2012, apply to all hospitals until the next realignment.

(1) Recalibration of relative weights. HHSC calculates a relative weight for each DRG as follows.

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the base year costs per DRG as determined in subsection (d) of this section;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG; and

(iii) divides the result in clause (ii) of this subparagraph by the universal mean, resulting in the relative weight for the DRG.

(2) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims; and

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

(3) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.

(A) Calculate for all claims the standard deviations from the MLOS in paragraph (2) of this subsection.

(B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.

(E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph.

(F) Multiply the result in subparagraph (E) of this paragraph by two and add that to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.

(4) If a DRG has fewer than five base year claims, HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.

(5) Adjust the MLOS, day outlier, and relative weights to increase or decrease with SOI to coincide with the National Claim Statistics.

(h) DRG grouper logic changes. Beginning September 1, 2021, HHSC may adjust DRG statistical calculations to align with annual grouper logic changes. The changes will remain budget neutral unless rates are rebased, and additional funding is appropriated by the legislature. The adjusted relative weights, MLOS, and day outlier threshold apply to all hospitals until the next adjustment or rebasing described in subsection (g) of this section.

(1) Base year claim data and rural base year stays are regrouped, using the latest grouping software version to determine DRG assignment changes by comparing the newly assigned DRG to the DRG assignment from the previous grouper version.

(2) For DRGs impacted by the grouping logic changes, relative weights must be adjusted. HHSC adjusts a relative weight for each impacted DRG as follows.

(A) Divide the total cost for all claims in the base year by the number of claims in the base year.

(B) Base year claims and rural base year stays are grouped by DRG, and for each DRG, HHSC:

(i) sums the base year costs for all claims in each DRG;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in each DRG; and

(iii) divides the result in clause (ii) of this subparagraph by the amount determined in subparagraph (A) of this paragraph, resulting in the relative weight for the DRG.

(3) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.

(A) Base year claims and rural base year stays are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims; and

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

(4) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.

(A) Calculate for all claims the standard deviations from the MLOS in paragraph (3) of this subsection.

(B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.

(E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph and multiply by two.

(F) Add the result of subparagraph (E) of this paragraph to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.

(5) If a DRG has fewer than five base year claims, HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.

(6) Adjust the MLOS, day outliers, and relative weights to increase or decrease with SOI to coincide with the National Claim Statistics.

(i) Reimbursements.

(1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's final SDA as calculated in subsections (c) - (f) of this section as applicable, by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital.

(2) Full payment. The prospective payment as described in paragraph (1) of this subsection is considered full payment for covered inpatient hospital services. A hospital's request for payment in an amount higher than the prospective payment will be denied.

(3) Day and cost outlier adjustments. HHSC pays a day outlier or a cost outlier for medically necessary inpatient services provided to clients under age 21 in all Medicaid participating hospitals that are reimbursed under the prospective payment system. If a patient age 20 is admitted to and remains in a hospital past his or her 21st birthday, inpatient days and hospital charges after the patient reaches age 21 are included in calculating the amount of any day outlier or cost outlier payment adjustment.

(A) Day outlier payment adjustment. HHSC calculates a day outlier payment adjustment for each claim as follows.

(i) Determine whether the number of medically necessary days allowed for a claim exceeds:

(I) the MLOS by more than two days; and

(II) the DRG day outlier threshold as calculated in subsection (g)(3) of this section.

(ii) If clause (i) of this subparagraph is true, subtract the DRG day outlier threshold from the number of medically necessary days allowed for the claim.

(iii) Multiply the DRG relative weight by the final SDA.

(iv) Divide the result in clause (iii) of this subparagraph by the DRG MLOS described in subsections (g)(2) or (h)(3) of this section to arrive at the DRG per diem amount.

(v) Multiply the number of days in clause (ii) of this subparagraph by the result in clause (iv) of this subparagraph.

(vi) Multiply the result in clause (v) of this subparagraph by 60 percent.

(vii) Multiply the allowed charges by the current interim rate to determine the cost.

(viii) Subtract the DRG payment amount calculated in clause (iii) of this subparagraph from the cost calculated in clause (vii) of this subparagraph.

(ix) The day outlier amount is the lesser of the amount in clause (vi) of this subparagraph or the amount in clause (viii) of this subparagraph.

(x) For urban and rural hospitals, multiply the amount in clause (ix) of this subparagraph by 90 percent to determine the final day outlier amount. For children's hospitals the amount in clause (ix) of this subparagraph is the final day outlier amount.

(B) Cost outlier payment adjustment. HHSC makes a cost outlier payment adjustment for an extraordinarily high-cost claim as follows.

(i) To establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims and rural base year stays multiplied by 11.14 or the hospital's final SDA multiplied by 11.14.

(ii) Multiply the full DRG prospective payment by 1.5.

(iii) The cost outlier threshold is the greater of clause (i) or (ii) of this subparagraph.

(iv) Subtract the cost outlier threshold from the amount of reimbursement for the claim established under cost reimbursement principles described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(v) Multiply the result in clause (iv) of this subparagraph by 60 percent to determine the amount of the cost outlier payment.

(vi) For urban and rural hospitals, multiply the amount in clause (v) of this subparagraph by 90 percent to determine the final cost outlier amount. For children's hospitals the amount in clause (v) of this subparagraph is the final cost outlier amount.

(C) Final outlier determination.

(i) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero, HHSC pays the higher of the two amounts.

(ii) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is less than or equal to zero, HHSC pays the day outlier amount.

(iii) If the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero and the amount calculated in subparagraph (A)(ix) of this paragraph is less than or equal to zero, HHSC pays the cost outlier amount.

(iv) If the amount calculated in subparagraph (A)(ix) of this paragraph and the amount calculated in subparagraph (B)(vi) of this paragraph are both less than or equal to zero HHSC will not pay an outlier for the admission.

(D) If the hospital claim resulted in a downgrade of the DRG related to reimbursement denials or reductions for preventable adverse events, the outlier payment will be determined by the lesser of the calculated outlier payment for the non-downgraded DRG or the downgraded DRG.

(4) Interim bill. A hospital may submit a claim to HHSC before a patient is discharged, but only the first claim for that patient will be reimbursed the prospective payment described in paragraph (1) of this subsection. Subsequent claims for that stay are paid zero dollars. When the patient is discharged, and the hospital submits a final claim to ensure accurate calculation for potential outlier payments for clients younger than age 21, HHSC recoups the first prospective payment and issues a final payment in accordance with paragraphs (1) and (3) of this subsection.

(5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in subparagraphs (A) - (D) of this paragraph. HHSC manually reviews transfers for medical necessity and payment.

(A) If the patient is transferred from a hospital to a nursing facility, HHSC pays the transferring hospital the total payment amount of the patient's DRG.

(B) If the patient is transferred from one hospital (transferring hospital) to another hospital (discharging hospital), HHSC pays the discharging hospital the total payment amount of the patient's DRG. HHSC calculates a DRG per diem and a payment amount for the transferring hospital as follows.

(i) Multiply the DRG relative weight by the final SDA.

(ii) Divide the result in clause (i) of this subparagraph by the DRG MLOS described in subsections (g)(2) or (h)(3) of this section, to arrive at the DRG per diem amount.

(iii) To arrive at the transferring hospital's payment amount:

(I) for a patient age 21 or older, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS, the transferring hospital's number of medically necessary days allowed for the claim, or 30 days; or

(II) for a patient under age 21, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS or the transferring hospital's number of medically necessary days allowed for the claim.

(C) HHSC makes payments to multiple hospitals transferring the same patient by applying the per diem formula in subparagraph (B) of this paragraph to all the transferring hospitals and the total DRG payment amount to the discharging hospital.

(D) HHSC performs a post-payment review to determine if the hospital that provided the most significant amount of care

received the total DRG payment. If the review reveals that the hospital that provided the most significant amount of care did not receive the total DRG payment, an adjustment is initiated to reverse the payment amounts. The transferring hospital is paid the total DRG payment amount and the discharging hospital is paid the DRG per diem.

(j) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.

(1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC within 30 days after the hospital's receipt of the cost report. Failure to submit copies or respond to inquiries on the status of the Medicare cost report will result in provider vendor hold.

(2) HHSC uses data from these reports when realigning or rebasing to calculate base SDAs, DRG statistics, and interim rates and to complete cost settlements.

(k) Cost Settlement.

(1) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) for children's and state-owned teaching hospitals.

(2) Notwithstanding the process described in paragraph (1) of this subsection, HHSC uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for a hospital.

(3) HHSC may select a new base year period for calculating the TEFRA target cap at least every three years.

(4) HHSC increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the hospital's target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(5) For a new children's hospital, the base year for calculating the TEFRA target cap is the hospital's first full 12-month cost reporting period occurring after the date the hospital is designated by Medicare as a children's hospital. For each cost reporting period after the hospital's base year, an increase in the TEFRA target cap will be applied as described in paragraph (4) of this subsection, until the TEFRA target cap is recalculated as described in paragraph (3) of this subsection.

(6) After a Medicaid participating hospital is designated by Medicare as a children's hospital, the hospital must submit written notification to HHSC's provider enrollment contact, including documents verifying its status as a Medicare children's hospital. Upon receipt of the written notification from the hospital, HHSC will convert the hospital to the reimbursement methodology described in this subsection retroactive to the effective date of designation by Medicare.

(l) Out-of-state children's hospitals. HHSC calculates the prospective payment rate for an out-of-state children's hospital as follows:

(1) HHSC determines the overall average cost per discharge for all in-state children's hospitals by:

(A) summing the Medicaid allowed cost from tentative or final cost report settlements for the base year; and

(B) dividing the result in subparagraph (A) of this paragraph by the number of in-state children's hospitals' base year claims.

(2) HHSC determines the average relative weight for all in-state children's hospitals' base year claims by:

(A) assigning a relative weight to each claim pursuant to subsections (g)(1)(B)(iii) or (h)(2)(B)(iii) of this section;

(B) summing the relative weights for all claims; and

(C) dividing by the number of claims.

(3) The result in paragraph (1) of this subsection is divided by the result in paragraph (2) of this subsection to arrive at the adjusted cost per discharge.

(4) The adjusted cost per discharge in paragraph (3) of this subsection is the payment rate used for payment of claims.

(5) HHSC reimburses each out-of-state children's hospital a prospective payment for covered inpatient hospital services. The payment amount is determined by multiplying the result in paragraph (4) of this subsection by the relative weight for the DRG assigned to the adjudicated claim.

(m) Merged hospitals.

(1) When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare.

(2) The merged entity receives the final SDA of the hospital associated with the surviving TPI. HHSC will reprocess all claims for the merged entity back to the effective date of the merger or the first day of the fiscal year, whichever is later.

(3) HHSC will not recalculate the final SDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the final SDA assigned before the acquisition or buyout.

(4) When Medicare requires a merged hospital to maintain two Medicare provider numbers because they are in different CBSAs, HHSC assigns one base TPI with a separate suffix for each facility. Both suffixes receive the SDA of the primary hospital TPI which remains active.

(n) Adjustments. HHSC may adjust a hospital's final SDA in accordance with §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid).

(o) Additional data. HHSC may require a hospital to provide additional data in a format and at a time specified by HHSC. Failure to submit additional data as specified by HHSC may result in a provider vendor hold until the requested information is provided.

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 31, 2021.

TRD-202103429
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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Proposal publication date: June 25, 2021
For further information, please call: (512) 839-9493

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TITLE 10. COMMUNITY DEVELOPMENT

PART 1. TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

CHAPTER 1. ADMINISTRATION

SUBCHAPTER A. GENERAL POLICIES AND PROCEDURES

10 TAC §1.8

The Texas Department of Housing and Community Affairs (the Department or TDHCA) adopts new 10 TAC Subchapter A, Administration, §1.8, Plan Requirements, Process and Approval Criteria for Properties Designated for Camping Political Subdivisions for Homeless Individuals, with changes to the proposed text as published in the July 23, 2021, issue of the *Texas Register* (46 TexReg 4421). The rule will be republished. The purpose of the rule is to implement new requirements established by the 87th Regular Texas Legislature that establishes in Chapter 2306, Texas Government Code, new Subchapter PP. Subchapter PP provides that a political subdivision may not designate a property to be used by homeless individuals to camp unless the Department has approved a plan as further described by Subchapter PP. The rule provides clear objective guidance for political subdivisions on how they can submit such plans, the content of the plans, how plans will be reviewed, and the criteria by which such plans will be approved.

The Department has analyzed this rulemaking action and the analysis is described below for each category of analysis performed.

Tex. Gov't Code §2001.0045(b) does not apply to the rule. §2001.0045(c)(9) provides that the requirements of the section do not apply to a rule that is "necessary to implement legislation, unless the legislature specifically states this section applies to the rule."

a. GOVERNMENT GROWTH IMPACT STATEMENT REQUIRED BY TEX. GOV'T CODE §2001.0221.

1. Mr. Bobby Wilkinson, Executive Director, has determined that, for the first five years the rule will be in effect, the rule does not create or eliminate a government program, but only provides the process and framework for how a political subdivision may submit a plan to designate a property to be used by homeless individuals to camp, what must be included in the plan, and provides how the Department will review and approve such plans.

2. The enacted law does create additional work associated with the review and processing of such plans, however the rule only formalizes the process created by statute. Therefore, the rule does not require a change in work that will require the creation of new employee positions, nor will the rule reduce work load to a degree that any existing employee positions are eliminated.

3. The rule does not require additional future legislative appropriations.

4. The rule does not result in an increase in fees paid to the Department, nor in a decrease in fees paid to the Department.

5. The rule is creating a new regulation; the regulation is applicable only to those political subdivisions seeking to obtain plan approval to designate a property to be used by homeless individuals to camp.

6. The action will not repeal any rule.

7. The rule will increase the number of individuals subject to the rule's applicability as the rule currently does not exist. When adopted, those political subdivisions seeking such plan approvals will become subject to the rule's applicability.

8. The rule will not negatively or positively affect this state's economy.

b. ADVERSE ECONOMIC IMPACT ON SMALL OR MICRO-BUSINESSES OR RURAL COMMUNITIES AND REGULATORY FLEXIBILITY REQUIRED BY TEX. GOV'T CODE §2006.002.

The Department has evaluated this rule and determined that the rule will not create an economic effect on small or micro-businesses or rural communities.

c. TAKINGS IMPACT ASSESSMENT REQUIRED BY TEX. GOV'T CODE §2007.043. The rule does not contemplate or authorize a taking by the Department, therefore no Takings Impact Assessment is required.

d. LOCAL EMPLOYMENT IMPACT STATEMENTS REQUIRED BY TEX. GOV'T CODE §2001.024(a)(6).

The Department has evaluated the rule as to its possible effects on local economies and has determined that for the first five years the rule will be in effect there will be no economic effect on local employment; therefore no local employment impact statement is required to be prepared for the rule.

e. PUBLIC BENEFIT/COST NOTE REQUIRED BY TEX. GOV'T CODE §2001.024(a)(5). Mr. Wilkinson has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of the rule would be the provision of a clear policy for how a political subdivision may designate a property to be used by homeless individuals to camp through submission of a plan to the Department. The rule provides clear guidance for political subdivisions on how they can submit such plans, what must be included in the plan, how plans will be reviewed, and the criteria by which such plans will be approved. There will not be economic costs to individuals required to comply with the rule.

f. FISCAL NOTE REQUIRED BY TEX. GOV'T CODE §2001.024(a)(4). Mr. Wilkinson also has determined that for each year of the first five years the rule is in effect, enforcing or administering the rule has minimal implications related to costs or revenues of the state or local governments. There may be negligible costs associated with the time required of a political subdivision to prepare and submit the plan, and respond to questions from the Department, but these processes and costs are necessary to ensure implementation of the newly enacted law. All costs are borne by the political subdivision.

SUMMARY OF PUBLIC COMMENT. Public comment was received from July 23, 2021, to August 23, 2021. Comment received is summarized herein and a reasoned response provided. Comment was received from the ten commenters listed: Commenter 1, Dianna Grey, City of Austin Homeless Strategy Officer; Commenter 2, Steve & Amy Bresnen, Bresnen Associates; Commenter 3, Michael Nichols, President and CEO, Coalition for the Homeless; Commenter 4, Tanya Lavelle, Policy Specialist, Disability Rights Texas (DRTx); Commenter 5, Matthew Mollica, Executive Director, Ending Community Homelessness Coalition (ECHO); Commenter 6, Daniel Buckley, Deputy City Manager, City of Galveston; Commenter 7, Kate Goodrich, Jack-

son Walker LLP; Commenter 8, Matthew Lovitt, Policy Fellow, National Alliance on Mental Illness (NAMI); Commenter 9, Eric Samuels, President & CEO, Texas Homeless Network (THN); and Commenter 10, Mary Wilbanks.

General Comments

Commenter 2 felt that the rule may be unnecessarily restrictive in some areas which may drive up expenses. Those comments are provided in greater detail under specific sections below.

Staff Response: The specific comments and examples provided by Commenter 2 are addressed in the following responses.

Commenter 2 stated that because Chapter 2306, Texas Government Code, does not define what 'designate' means when it comes to a property being designated by a municipality for the purpose of camping by homeless individuals, the City of Austin effectively 'designated' much of the city for homeless camping when it repealed its ordinance prohibiting such camping. While Government Code provides the Texas Attorney General and Texas Comptroller of Public Accounts with authority to take actions against a political subdivision, HB 1925 did not provide the Department with enforcement authority; therefore, the commenter felt that a municipality could elect to take no affirmative action to designate any properties for camping and simply ignore the requirement to submit a plan, and thereby avoid negative consequences. They felt that to make sure there is a clear sharing of information between TDHCA and the agencies with enforcement authority under the statute, the rule should include language as follows: "When the Department receives information that a political subdivision is allowing camping by homeless people in a public place that is not the subject of a plan approved under this section, the Department will refer the information to the Attorney General's Office for possible action under Chapter 364, Local Government Code, or other law."

Staff Response: Staff concurs. Responsive language is added in the rule in new subsection (g).

Commenter 2 suggests that throughout the rule any reference to calendar days should be replaced with business days.

Staff Response: Calendar days are less subject to interpretation; no edits are proposed in response to this comment.

Commenter 4 notes that their comments do not address the legality of the enabling legislation, nor the plan, and the implications related to the Americans with Disabilities Act as Amended by the Amendments Act of 2008 (ADA) and Section 504 of the Rehabilitation Act of 1973. They state that they reserve the right to address any issues of legality at a later time.

Staff Response: The public comment period on a proposed rule is to allow interested persons a reasonable opportunity to submit their views and argument regarding the substance of a proposed rule, and to allow the agency to consider the submissions about the proposed rule. This comment, regarding reservations as to the legality of the enabling statute of the proposed rule, is not a comment on the rule, itself. Accordingly, no edits are proposed in response to this comment.

Commenter 4 provided data from the 2020 HUD Point in Time count to document that Texas has a homelessness problem and provided some of the attributes of those counted as homeless. They noted that the typical HUD Point in Time count is widely accepted as undercounting homeless individuals and also noted that there are many homeless who have a disability.

Staff Response: Staff appreciates the information provided as context for the comments submitted. No edits are proposed in response to this comment.

Commenters 3 and 9, both commenting from the perspective of the Continuums of Care, noted that the plan has no requirements relating to the political subdivision needing to work with the local Continuum of Care (CoC) or the CoC-designated lead for that geographic area. Both commenters felt that the CoC should be a required part of the planning and decision-making as a municipality develops its proposal for a property. Commenter 5 also indicated their support throughout the rule for required coordination with the local CoC.

Staff Response: While the Department hopes that political subdivisions take the thoughtful planning steps of consulting with their local CoC, the Department does not support adding CoC coordination as a minimum requirement that may be burdensome for a jurisdiction or would prevent an otherwise acceptable plan from being approved. No edits are proposed in response to this comment. The specific comments and examples provided by Commenters 3 and 9 are addressed in the following sections.

Commenter 4 suggests that many of their concerns with the plan (rule) would be mitigated by a requirement that political subdivisions work with their own ADA coordinators before submitting a plan to TDHCA for a site; they noted that public entities with over 50 employees are required to employ an ADA coordinator.

Staff Response: While staff appreciates the perspective in which this comment was made, the Department is concerned that adding such a requirement will add delay and challenges for local political subdivisions. No edits are proposed in response to this comment.

Commenter 4 noted that the rule did not provide for how a public entity or individual could request a modification under the ADA and the Rehabilitation Act.

Staff Response: The Department does have a rule addressing how a reasonable accommodation request can be made to the Department. Staff agrees that the proposed rule did not clearly refer to the applicability of that rule in the plan process. §1.8(d)(2)(D) has been revised to add a provision addressing this.

Commenter 4 states that the plan does not address the increased housing instability resulting from the COVID-19 pandemic. They noted: "If political subdivisions must turn to campsites to provide a modicum of shelter and stability to people facing homelessness, including people with disabilities, TDHCA should do everything in its power to create a plan [rule] that will allow political subdivisions to support every person who is unsheltered as easily and fairly as possible."

Staff Response: While true that the rule does not explicitly mention the pandemic, the rule is drafted intentionally with flexibility for political subdivisions to be able to address their local homelessness needs through camping, including their homelessness needs derived from the pandemic. The rule in no way limits to what extent a political subdivision may use camping as a solution to homelessness in their community. No edits are proposed in response to this comment.

Commenter 5 provides a contextual comment, expressing a belief that government-sanctioned encampments do not reduce and end homelessness and could make it more difficult for communities to focus on lasting solutions. They note that solutions in one community do not work in another community.

Staff Response: Staff appreciates the context provided. No edits are proposed in response to this comment

Commenter 6, as a small city, feels the requirements of HB 1925 create an unfunded mandate. The commenter noted several instances of this relating to the roles public safety will be required to fulfill, custody and storage of property, and documentation of the belongings of homeless individuals.

Staff Response: TDHCA is only tasked with implementing one of the components of HB 1925, which is approving plans for properties designated for camping. TDHCA has no oversight or authority as it relates to the issues raised by Commenter 6 and is not in a position to provide answers on components of the legislation for which the Department is not involved. No edits are proposed in response to this comment.

Section 1.8(b). Applicability.

Commenter 6 points out that HB 1925 provides that camping in relation to an emergency shelter during a disaster is allowable with consent given by the political subdivision, however the rule does not address whether such emergency shelter must be contemplated in a plan submitted to TDHCA. They suggest that the rule should explicitly clarify the plan requirements that do not apply to camping for households displaced after a natural disaster.

Staff Response: There are four situations noted in HB 1925 in which a political subdivision can allow camping without it being a violation of the camping prohibition: recreational purposes, purposes for which a plan has been approved by TDHCA, camping in compliance with a beach access plan, and in cases relating to emergency shelter during a disaster. Because these factors are listed separately from the reference to camping plans approved by TDHCA, staff does not believe that the other three situations listed require reference or inclusion in the camping plans. Staff has added a clarification in the rule regarding those excluded situations.

Section 1.8(c). Definitions.

Commenters 3 and 9 suggest adding a definition relating to the CoC.

Staff Response: While the Department hopes that political subdivisions take the thoughtful planning steps of consulting with their local CoC, the Department does not support adding CoC coordination as a minimum requirement, therefore no definition needs to be added.

Commenter 6 notes that the rule does not define 'homeless' which is needed to differentiate between persons who are homeless and persons who are displaced due to a natural disaster. They also note that the rule references 'camp' as defined by Section 48.05 of the Penal Code, a citation not found in the Penal Code.

Staff Response: TDHCA does not feel that the term 'homeless' needs a definition for purposes of this rule. The plan requirements focus primarily on an eligible use of a public space, not on explicitly who may, or may not, be able to use the approved site. TDHCA feels that to define the term 'homeless' may inadvertently limit political jurisdiction's ability to flexibly use their approved sites. As it relates to the comment that the term 'camp' is not defined in Penal Code, that is incorrect. HB 1925 amended the Penal Code to include this definition; while not reflected in the posted Texas Statutes online at this time because the enacted laws have not yet been included in the published Penal Code, the definition has been enacted and the citation is correct. No revisions are made to the rule in response to this comment.

Section 1.8(d)(2). Review Process.

Commenter 10 does not feel five calendar days to address deficiencies is sufficient, particularly if those days fall on a weekend.

Staff Response: While staff appreciates this comment, the Department is required by statute to approve plans within 30 days of receipt. Without a fairly prompt deficiency period, that is not achievable. It should be noted that plans can be resubmitted as often as possible, so if a political subdivision is unable to respond to a deficiency, they can withdraw their plan and resubmit with the required information when they have it ready. No edits are proposed in response to this comment.

Section 1.8(e). Threshold Plan Requirements Overall.

Commenter 1 notes that mobile clinics are an eligible source of health service provision in the draft rule, but that mobile indigent service providers are not listed as eligible. They request that mobile providers be specifically included in this category. While the commenter submitted this under subsection (f), the portion of the rule that addresses this is in subsection (e).

Staff Response: Staff concurs that mobile service providers should also be allowable for indigent services. The revision to include this is now reflected in the rule at §1.8(e)(4)(B)(i).

Commenters 3 and 9 both suggest requiring as a threshold plan requirement that the political subdivision include a letter in the plan from their local CoC verifying that the political subdivision collaborated with the CoC in the development of the plan and selection of the proposed site.

Staff Response: While the Department hopes that political subdivisions take the thoughtful planning steps of consulting with their local CoC, the Department does not support adding CoC coordination, or requiring a letter from the CoC, as a minimum requirement that may be burdensome for a jurisdiction or would prevent an otherwise acceptable plan from being approved.

Commenter 8 noted that the required submission information in subsection (e) provided a high degree of uniformity in the information requested and they appreciated the depth and degree of information the rule requires of a political subdivisions. However they are concerned with disparities in the information requested regarding the fourth factor, law enforcement. They note that this section of the rule requests a comparative analysis on the resources provided for the area, is required to address added resources specifically to address the site, and to explain any lower than typical law enforcement coverage in the area. They feel that this is a higher standard for the law enforcement component of the rule which may create an oversubscription of law enforcement in the services provide to campsite residents; by the plans requiring this higher level of attention it may lead to unnecessary criminal justice involvement for campsite residents and greater rates of incarceration. "Once involved with criminal justice system, individuals living with mental illness, homeless or otherwise, often experience worsened mental health outcomes and higher rates of recidivism." They felt this could be addressed by applying the same level of rigor from the other factors to the law enforcement item; however, commenter prefers that the comparative analysis suggested for law enforcement relative to other areas of the community be applied to the other four factors by comparing other potential sites.

Staff Response: While staff appreciates the value of comparative analysis and would hope that political subdivisions apply a strong level of comparative scrutiny in their selection of sites, staff does not recommend that this heightened level of scrutiny be provided in the plan submission for all factors. To apply a comparative analysis requirement for all factors may be unnecessarily burdensome. No revisions are made to the proposed rule in response to this comment.

Section 1.8(e)(3). Estimated Number of Campers.

Commenters 3 and 9 suggest that the estimated number of campers to be located at the proposed site needs to have been agreed upon by the local CoC or CoC-designated lead.

Staff Response: While the Department hopes that political subdivisions take the thoughtful planning steps of consulting with their local CoC and coordinate on accurate estimates on the number of campers for a proposed site, the Department does not support adding CoC coordination as a minimum requirement that may be burdensome for a jurisdiction or would prevent an otherwise acceptable plan from being approved. No revisions are made to the proposed rule in response to this comment.

Section 1.8(e)(4)(A) and (E). Health Care and Mental Health Services.

Commenter 4 states that the rule intrinsically inter-links and targets people with disabilities because it specifies a need for health services and coordination with Local Mental Health Authorities that applies only to persons with disabilities.

Staff Response: The wording of the statute requires coordination with the Local Mental Health Authority. No revisions are made to the proposed rule in response to this comment.

Commenter 7 noted that this section requires that communication have taken place with the Texas Department of Health and Human Services (HHS) to ascertain availability of access to Medicaid services; commenter asked whether HHS has already established a process for the communication and what both the Political Subdivision and/or HHS need to include to meet this requirement.

Staff Response: TDHCA does not believe that the rule requires HHS to establish a process for this issue. This section was intentionally written to allow a summary of a conversation with HHS to satisfy the requirement. A formal process or written communication is not required. Staff recommends no changes in response to this comment to retain flexibility for both Political Subdivisions and HHS.

Section 1.8(e)(4)(B). Indigent Services.

Commenters 3 and 9 suggest requiring that the description of indigent services to be provided at the property be written in collaboration with the local CoC or CoC-designated lead.

Staff Response: While the Department hopes that political subdivisions take the thoughtful planning steps of consulting with their local CoC on indigent services, the Department does not support adding CoC coordination as a minimum requirement that may be burdensome for a jurisdiction or would prevent an otherwise acceptable plan from being approved.

Commenter 5 suggests that any services provided at a sanctioned site be consistent with a Housing First model to connect people with low-barrier housing.

Staff Response: While staff appreciates this comment, staff does not support requiring restrictions on the type of service delivery provided, as some communities may elect not to adhere to a Housing First model and should not have an otherwise acceptable Plan denied.

Commenter 7 suggested that because indigent services are not defined, all organizations in the city providing services to people experiencing homelessness would meet the standard for this section and be considered indigent services.

Staff Response: The Department uses the term 'indigent services' in this section because that terminology is used in the statute. The Department has intentionally not defined 'indigent services' so as to not limit what could possibly be included in this category. While staff agrees with the commenter that any organizations in a city providing homeless services would be considered a provider of indigent services, those organizations may not be the only indigent service providers in a community. There may be other organizations that would be considered indigent service providers that are not providing homeless services (such as community action agencies, food banks, health clinics, etc.). No edits are proposed in response to this comment.

Section 1.8(e)(4)(C)(i) and (iii). Transportation.

Commenter 2 noted that the sentence in §1.8(e)(4)(C)(i), "Transportation provided by a homeless service provider is not considered public transportation" may be too restrictive. If a homeless service provider is a municipality or working under contract with a municipality, it would be unnecessarily limiting to exclude their provision of transportation services. "It would make sense to allow them to obtain such services via paid contracts or services donated to the political subdivision, such as by a church or other nonprofit."

Staff Response: Staff concurs that this may limit creative solutions to transportation. The sentence has been deleted from the rule.

Commenter 2 also suggested removing the clause in §1.8(e)(4)(C)(iii) that required that the description of the closest public transportation spot or station have "a sidewalk for pedestrians". Commenter 2 felt this may eliminate sites that would allow safe passage for pedestrians but do not have sidewalks. They thought the Department should not be put in the position of having to enforce such details. Alternatively, Commenter 4 felt that the rule does not require the plan to include anything about accessibility or the ADA requirements for transportation. They suggest that to serve persons with disabilities, political subdivisions be required to coordinate with local transportation authorities to provide fully accessible transportation options, as well as to ensure that ADA modification requests can by entertained for transportation services.

Staff Response: Staff has revised the language in the rule to include "or an alternative pathway identified by the Political Subdivision" to increase potential eligible sites. Nothing in this rule alters, reduces, or supplants a Political Subdivision's obligations under the ADA.

Section 1.8(e)(4)(D). Law Enforcement.

Commenter 5 suggests that people experiencing homelessness have a mistrust of law enforcement and law enforcement agencies are not trained to respond to crises using best practices in trauma-informed care and can thus escalate situations. The commenter suggests removing the clause that references "any added resources" and replacing it with "a written plan limiting the presence of law enforcement at the site and detailing how trauma-informed responders, such as social workers or rapid cri-

sis response teams, will be engaged as primary responders to crises involving people living at the site".

Staff Response: While staff appreciates this comment, staff does not support requiring restrictions on the approaches to law enforcement that some communities may elect, as not all jurisdictions will agree with the limitation of law enforcement at the site, and should not have an otherwise acceptable Plan denied. No revisions have been made to the rule in response to this comment.

Section 1.8(f). Evaluation Criteria.

Commenter 1 felt that the way the criteria for each of the five evaluative factors were detailed would make it unlikely for local governments to be able to submit a compliant plan. Commenter 1 also suggested adding more specificity about plan requirements (which were then detailed further and are described elsewhere in comment summary).

Staff Response: The specific comments and examples provided by Commenter 1 are addressed in the following specific summaries.

Commenter 1 felt that the criteria for Local Health Care, Indigent Services and Mental Health were very similar (example given was that county indigent healthcare programs are listed as acceptable health care provider) and it was suggested that these might become mutually exclusive. Commenter suggested that adding language addressing similarities and overlapping services between the providers for Health Care and Indigent Services would provide greater clarity.

Staff Response: While staff appreciates this perspective, in practice there are overlaps among providers and between health and non-health indigent services. To restrict these sections to be mutually exclusive may limit a political subdivisions ability to meet multiple criteria. Staff believes the rule as drafted provides sufficient detail while allowing creative, and/or overlapping service provision among categories. No revisions are proposed in response to this comment.

Commenter 1 also asked that greater detail and specificity be added for the 'proof' of the criteria. They felt it was unclear what level of specificity would be required and whether the Department would want short simple statements or complex explanations, particularly given the limits on the length of the plan.

Staff Response: While staff appreciates this perspective, the risk of adding too much specificity in the rule is that it will become overly complicated and require political subdivisions to meet burdensome requirements. The page limit is intended to be a guide to how extensive the responsive content needs to be. Staff believes the rule as drafted provides sufficient detail to let political subdivisions know what is required while allowing flexibility in their Plans. No revisions are proposed in response to this comment.

Commenter 2 felt that in categories (A,)(B) and (C), the rule's 90% threshold of eligibility is too restrictive and will lead to plan rejections when there is substantial need for designated camping sites. They also note that it will be difficult, if not impossible, to determine that these requirements are met. There may be limited data available on the proposed camper population and a municipality will take on unnecessary administrative expense to try to measure and meet the requirement. Commenter 2 suggested that if there must be a threshold, no more than 50% be used; however they prefer that a blanket description which echoes the statutory terms be used to leave the Department with discretion to evaluate each plan on an individual basis.

Staff Response: Staff agrees that having excessive standards or standards that are unmeasurable create programmatic inefficiencies. To address that the 90% is excessive, the percentage for each of these three factors has been revised to 50% in the rule. Additionally, to make it clear that this is not expected to be a monitored deliverable, but instead is an important goal and focus for the site, the language has been clarified to reflect that the Political Jurisdiction needs to commit to a goal of 50%.

Commenter 5 notes that the rule in both paragraphs (A) and (B) of this section are too restrictive. The provisions regarding proximity to services drastically limit options for sites. They note that limiting locations to only a few eligible areas restricts the options a homeless individual will have in choosing where to go. They specifically suggest that an option be added to these two categories that the services can be provided onsite to take advantage of mobile service options that providers may already have.

Staff Response: Staff concurs that an on-site offer of services should also be allowable. Revisions as noted are made in sections (A) and (B). It should be noted that Commenter 5's proposed language (not the comment) did indicate that indigent services provided on-site include housing assessments. Staff did not include that revision, as housing assessments may be one offered type of indigent services, but the Department does not want to add further restrictions or requirements on what services must be provided.

Commenter 10 notes that sites that would meet all of the evaluative criteria are likely to be located where the neighboring residents are likely to oppose the use of a property for this purpose.

Staff Response: While staff agrees that sites proximate to services and transportation may prompt opposition, the Department does not believe that this means the standards should be lowered; the provision and proximity of services is critical to fulfilling the statutory requirements and assisting persons addressed by the statutorily-required plan.

Section 1.8(f)(1)(A). Criteria relating to Local Health Care.

Commenters 1 and 10 noted that requiring that health care services and mental health services be available at little or no cost for at least 90% of Proposed News campers would place the burden of health care expenses on local governments because the availability of Medicaid is a state function, is not within the control of a local government, and has stringent eligibility requirements and barriers that result in a relatively small portion of those experiencing homelessness receiving Medicaid-funded services. Commenter 10 also pointed out that the provision of Medicaid services assumes that the person has a valid ID and has been approved for Medicaid.

Staff Response: As noted in the comment above that suggested that a lower threshold be used, staff has revised this from a requirement to a goal and reduced the goal from 90% to 50% which both address this comment as well.

Commenter 1 also noted that the Evaluative Criteria for this item alludes to 'little cost' for the Medicaid managed care insurance coverage and/or other providers that may require a copay. Commenter recommends defining what constitutes 'little' cost.

Staff Response: Staff has revised to instead reference little "or low" cost, but is not electing to provide any more specific of a

standard that may only create burdensome administrative challenges for the Political Jurisdiction.

Section 1.8(f)(1)(B). Criteria relating to Indigent Services.

Commenter 1 notes that mobile clinics are an eligible source of service provision for health providers in the draft rule, but are not included in the list of possible indigent service providers. They request that mobile providers be specifically included in this category for approval. Commenter 1 also specifically requests that the ability to rely on mobile services is noted in the plan submission requirements, but it is not actually stated in the evaluation criteria in subsection (f) that the mobile services are acceptable to meet the criteria.

Staff Response: Staff concurs that mobile service providers should also be allowable for indigent services. Staff concurs that the requirements need to reflect the acceptability of mobile clinics within the requirements in subsection (f). To address this comment, responsive edits have been made to subsections (e)(4)(B)(i), (f)(1)(A) and (f)(1)(B) to tie together what is requested in the plan with the approval criteria.

Commenter 2 requests that the criteria for indigent services include access to sanitation, including restrooms and showers. They noted: "homeless people who are camping often do not have access to restrooms and showers, which often leads to urinating and defecating in public." While not stated in the statute, they felt the Legislature did not desire to see plans approved that do not have such basic services as sanitation available to the indigent households.

Staff Response: Staff concurs that this is a basic necessity for any site and is a logical outgrowth of indigent services. This has been added, not as a component of indigent services, but as a requirement for the site in new subsection (e)(7), as demonstrated by information from the Political Jurisdiction.

Section 1.8(f)(1)(C). Criteria relating to Transportation.

Commenter 10 felt that the transportation requirement of running six days per week was too stringent and that many cities have limited weekend public transportation.

Staff Response: Staff appreciates the comment, but feels access to transportation is critical and does not recommend revisions to this standard.

Section 1.8(f)(1)(D). Criteria relating to Local Law Enforcement Resources.

Commenters 1 and 4 felt that the rule's allusion to demographics in the law enforcement section 'requires a local government to make a determination about law enforcement based on the encampment demographics'. Commenter 4 notes that the rule places unnecessary emphasis in the plan on the availability of additional law enforcement resources that may be needed; in doing so the rule stigmatizes homelessness as a criminal act and perpetuates a stereotype of those who are homeless as criminals.

Staff Response: The reference in the rule regarding demographics in the law enforcement section does not reference the demographics of the encampment, but to the demographics of the law enforcement beat/area in which the encampment would reside. The rule states that the law enforcement resources for the law enforcement beat/area containing the site be similar to law enforcement resources for other beats/areas of similar demographics. This is comparing two beats with similar demographics within the whole municipality and stating that the law enforcement resources be similar. Nowhere in the rule is reference to the demographics of the camp residents mentioned. No revisions are proposed in response to these comments; although, more flexibility has been provided to Political Subdivisions as a result of another commenter.

Commenter 2 noted that the rule requires that law enforcement resources be on par with other areas within the political subdivision. They suggest adding language such as "unless the political subdivision provides a specific plan for security in and around the property that reasonably meets the need for law enforcement services in that area". This will allow political subdivisions to tailor security needs.

Staff Response: Staff concurs that flexibility is needed for political subdivisions. Responsive language has been added to this section.

Commenter 6 notes that availability of law enforcement personnel in the aftermath of a disaster may be severely limited and requiring that camping by those displaced have a similar level of law enforcement presence may be challenging. The commenter requested an exception in the case of displaced persons camping due to emergency response.

Staff Response: As noted earlier in the section on Applicability, camping approved by a political subdivision in response to a natural disaster is excluded from the plan requirements. This has been revised in the rule in subsection (b).

Section 1.8(f)(2). Plan Approval.

Commenters 3 and 9 suggest that the CoC needs to be an integral part in the determination of whether a political subdivision has met the correct number of required factors. They suggest adding that the plan be approved when their local CoC or CoC-designated lead agrees in writing.

Staff Response: While the Department encourages political subdivisions to submit plans that the local CoC finds satisfy all of the evaluation factors, the Department does not support adding this level of CoC approval to the process, nor did the statute contemplate CoC being a required component in the plan approval process. No revisions are made in response to this comment.

General Comments regarding Civil Rights Laws.

Commenter 1 and 4 raise concerns that the proposed rule makes assumptions about the individuals experiencing homelessness that will utilize the site. They felt this was particularly true with the rule's focus on law enforcement needs, primary care, and behavioral health resources.

Commenter 1 also is concerned that the proposed rule could create a scenario where compliance with the rule will conflict with the State's and a municipality's obligation to comply with the Fair Housing Act by fundamentally limiting where people can live based on their health and/or disability status.

Commenters 1 and 4 felt that the rule's allusion to demographics in the law enforcement section 'requires a local government to make a determination about law enforcement based on the encampment demographics'. Commenter 4 notes that the rule places unnecessary emphasis in the plan on the availability of additional law enforcement resources that may be needed; in doing so the rule stigmatizes homelessness as a criminal act and perpetuates a stereotype of those who are homeless as criminals. Commenter 4 notes that "...because there is no way for persons with disabilities who are experiencing homelessness to request modifications to this plan, a law enforcement-heavy ap-

proach rather than a civil approach through an ADA coordinator or other civil public entity department or office will result in persons with disabilities being incarcerated or institutionalized rates through no fault of their own other than they are homeless due to their disabilities." The commenter suggests that TDHCA place more emphasis on civil and social services aimed at limiting interactions with law enforcement, including working with an ADA Coordinator.

Commenter 4 notes that "...because there is no way for persons with disabilities who are experiencing homelessness to request modifications to this plan, a law enforcement-heavy approach rather than a civil approach through an ADA coordinator or other civil public entity department or office will result in persons with disabilities being incarcerated or institutionalized rates through no fault of their own other than they are homeless due to their disabilities." The commenter suggests that TDHCA place more emphasis on civil and social services aimed at limiting interactions with law enforcement, including working with an ADA Coordinator.

Commenter 1 felt that requiring siting to be proximate to health care 'means the government is assuming that the individuals who will reside at the site are disabled.' They also felt that because clinics that accept Medicaid or provide health/mental health services at no cost are typically located in low-income areas, encampments could be concentrated in underprivileged areas.

Staff Response: The rule is implementing HB 1925, enacted by the 87th Texas Legislature (Regular Session), which provides the five evaluative criteria to be considered in a plan. It does not supplant any civil rights law or any other laws that political subdivisions must follow, including but not limited to requests for reasonable accommodations and modifications. No revisions to this rule have been made in response to these comments.

STATUTORY AUTHORITY. The rule is adopted pursuant to Tex. Gov't Code §2306.053, which authorizes the Department to adopt rules and Tex. Gov't Code §§2306.1121 - 1124, which establish Subchapter PP requiring the plan process covered by the rule. Except as described herein the rule affect no other code, article, or statute.

§1.8. Plan Requirements, Process and Approval Criteria for Properties Designated for Camping by Political Subdivisions for Homeless Individuals.

(a) Purpose. Subchapter PP of Chapter 2306, Texas Government Code, Property Designated by Political Subdivision for Camping by Homeless Individuals, was enacted in September 2021. §2306.1122 provides that a Political Subdivision may not designate a property to be used by homeless individuals to Camp unless the Department has approved a Plan as further described by Subchapter PP. This rule provides the Department's policies for such Plans, including the process for Plan submission, Plan requirements, the review process, and the criteria by which a Plan will be reviewed by the Department.

(b) Applicability.

(1) This rule applies only to the designation and use of a property designated for camping by homeless individuals that first begins that use on or after September 1, 2021, except that the rule and requirements of Subchapter PP, Chapter 2306, Texas Government Code, do not apply to a Proposed Property to be located on/in a Public Park. Public Parks are ineligible to be used as a Camp by homeless individuals per Subchapter PP, Chapter 2306, Texas Government Code.

(2) The designation and use of a Proposed Property described by Subchapter PP, Chapter 2306, Government Code that first began before September 1, 2021, is governed by the law in effect when the designation and use first began, and the former law is continued in effect for that purpose.

(3) A Political Subdivision that designated a property to be used by homeless individuals to Camp before September 1, 2021, may apply on or after that date for approval of a Plan pursuant to this section.

(4) A Political Subdivision that authorizes camping under the authority of §48.05(d)(1), (3) or (4), Texas Penal Code, are not required to submit a Plan for those instances.

(c) Definitions.

(1) Camp--Has the meaning assigned by Section 48.05 of the Texas Penal Code.

(2) Department--The Texas Department of Housing and Community Affairs.

(3) Plan--Specifically an application drafted by a Political Subdivision, submitted to the Department by the Political Subdivision, with the intention of meeting the requirements provided for in subsection (e) of this section (relating to Threshold Plan Requirements).

(4) Plan Determination Notice--The notification provided by the Department to the Political Subdivision stating a Plan's Approval or Denial.

(5) Political Subdivision--A local government as defined in Chapter 2306, Texas Government Code.

(6) Proposed New Campers--Homeless individuals that the Political Subdivision intends to allow to Camp at the Proposed Property for which a Plan is submitted.

(7) Proposed Property--That property proposed for use for Proposed New Campers and submitted in the Plan, owned, controlled, leased, or managed by the Political Subdivision.

(8) Public Park--Any parcel of land dedicated and used as parkland, or land owned by a political subdivision that is used for a park or recreational purpose that is under the control of the political subdivision, which is designated by the political subdivision.

(d) Plan Process.

(1) Submission.

(A) Plans may be submitted at any time. Plan resubmissions may also be submitted at any time.

(B) All Plans must be submitted electronically to campingplans@tdhca.state.tx.us.

(C) At least one designated email address must be provided by the Political Subdivision; all communications from the Department to the Political Subdivision regarding the Plan will be sent to that email address. No communication will be sent by traditional postal delivery methods. Up to two email contacts may be provided.

(2) Review Process.

(A) Upon receipt, Department staff will send a confirmation email receipt to the designated email address and initiate review of the Plan. The Plan will be reviewed first to determine that all information specified in subsection (e) of this section (relating to Threshold Plan Requirements) have been included and that sufficient information has been provided by which to evaluate the Plan against the Plan Criteria provided for in subsection (f) of this section (relating to Plan Criteria).

(B) If a Plan as submitted does not sufficiently meet the requirements of §2306.1123, Texas Government Code, and subsection (e) of this section, or does not provide sufficient explanation by which to assess the Plan Criteria provided for in subsection (f) of this section, staff will issue the Political Subdivision a notice of deficiency. The Political Subdivision will have five calendar days to fully respond to all items requested in the deficiency notice.

(i) For a Political Subdivision that satisfies all requested deficiencies by the end of the five calendar day period, the review will proceed.

(ii) For a Political Subdivisions that does not satisfy all requested deficiencies by the end of the five calendar day period, no further review will occur. A Plan Determination Notice will be issued notifying the Political Subdivision that its Plan has been denied and stating the reason for the denial. The Political Subdivision may resubmit a Plan at any time after receiving a Plan Determination Notice.

(C) Plan Determination Notice.

(i) Upon completion of the review by staff, the Political Subdivision will be notified that its Plan has been Approved or Denied in a Plan Determination Notice.

(ii) Not later than the 30th day after the date the Department receives a plan or resubmitted Plan, the Department will make a final determination regarding approval of the Plan and send a Plan Determination Notice to the Political Subdivision. For a Political Subdivision that had a deficiency notice issued, and that satisfied all requested deficiencies by the end of the five calendar day period, the Department will strive to still issue a final determination notice by the 30th day from the date the Plan was originally received, however the date of issuance of the Plan Determination Notice may extend past the 30th day by the number of days taken by the Political Subdivision to resolve the deficiencies.

(iii) A Political Subdivision may appeal the decision in the Plan Determination Notice using the appeal process outlined in §1.7 of this Chapter (relating to Appeals Process).

(D) Reasonable Accommodations may be requested from the Department as reflected in §1.1 of this subchapter (relating to Reasonable Accommodation Requests to the Department).

(e) Threshold Plan Requirements. A Plan submitted for approval to the Department must include all of the items described in paragraphs (1) - (8) of this subsection for the property for which the Plan is being submitted:

(1) pertinent contact information for the Political Subdivision as specified by the Department in its Plan template;

(2) the physical address or if there is no physical address the legal description of the property;

(3) the estimated number of Proposed New Campers to be located at the Proposed Property;

(4) a description with respect to the property of the five evaluative factors that addresses all of the requirements described in subparagraphs (A) - (E) of this paragraph:

(A) Local Health Care. Provide:

(i) A description of the availability of local health care for Proposed New Campers, including access to Medicaid services and mental health services;

(ii) A description of the specific providers of the local health care and mental health services available to Proposed New Campers. Local health/mental health care service providers do not include hospitals or other emergency medical assistance, but contemplate access to ongoing and routine health and mental health care. Providers of such services can include, but are not limited to: local health clinics, local mental health authorities, mobile clinics that have the location in their service area, and county indigent healthcare programs;

(iii) A description or copy of a communication from the Texas Department of Health and Human Services specific to the Political Subdivision and specific to the population of homeless individuals must be provided to establish the availability of access to Medicaid services;

(iv) A map or clear written description of the geographic proximity (in miles) of each of those providers to the Proposed Property;

(v) The cost of such care and services, whether those costs will be borne by the Proposed New Campers or an alternative source, and if an alternative source, then what that source is; and

(vi) A description of any limitations on eligibility that each or any of the providers may have in place that could preclude Proposed New Campers from receiving such care and services from the specific providers.

(B) Indigent Services. Provide:

(i) A description of the availability of indigent services for Proposed New Campers. For purposes of this factor, indigent services are any services that assist individuals or households in poverty with their access to basic human needs and supports. Indigent service providers include, but are not limited to: community action agencies, area agencies on aging, mobile indigent service providers that have the location in their service area; and local nonprofit or faith-based organizations providing such indigent services;

(ii) A description of the specific providers of the services and what services they provide;

(iii) A map or clear written description of the geographic proximity (in miles) of each of those providers to the Proposed Property; and

(iv) A description of any limitations on eligibility that each or any the providers may have in place that could preclude Proposed New Campers from receiving such services from the specific providers.

(C) Public Transportation. Provide:

(i) A description of the availability of reasonably affordable public transportation for Proposed New Campers. Reasonably affordable for the purposes of this Section means the rate for public transportation for the majority of users of that public transportation; if for instance the standard bus fare in an area is $2 per ride, then that rate is considered the reasonable affordable rate for the Proposed Property; Proposed New Campers should not have to pay a rate higher than that standard fare;

(ii) A description of the specific providers of the public transportation services and their prices;

(iii) A description of the closest proximity of the property to a specified entrance to a public transportation stop or station, with a sidewalk or an alternative pathway identified by the Political Subdivision for pedestrians, including a map of the closest stop and public transportation route shown in relation to the Proposed Property;

(iv) A description of the route schedule of the closest proximate public transportation route; and

(v) If public transportation is available upon demand at the property location, identification of any limitations on eligibility that each or any of the providers may have in place that could preclude Proposed New Campers from receiving such transportation services from that specific on-demand provider.

(D) Law Enforcement Resources. Provide:

(i) A description of the local law enforcement resources in the area;

(ii) The description should include a brief explanation of which local law enforcement patrol beat covers the Proposed Property;

(iii) A description of local law enforcement resources and local coverage in several other census tracts or law enforcement beats/areas with similar demographics to that of the beat/area of the Proposed Property to provide a comparative picture;

(iv) a description of any added resources for the area or proposed specifically for the property, and how proximate those resources are; and

(v) any explanation of reduced (or lower than typical of similar demographic areas) local law enforcement coverage in the area.

(E) Coordination with Local Mental Health Authority. Provide:

(i) a description of the steps the Political Subdivision has taken to coordinate with the Local Mental Health Authority to provide services for any Proposed New Campers; and

(ii) a description must include documentation of meetings or conversations, dates when they occurred, any coordination steps resulting from the conversations, and whether any ongoing coordination is intended for the Proposed Property.

(5) The Political Subdivision must provide evidence that establishes that the property is not a Public Park. Evidence must include documentation addressing the definition of a Public Park as defined in subsection (c)(8) of this section.

(6) Plans should be limited in length. Plans in excess of 15 pages of text, not including documentation and attachments, will not be reviewed.

(7) The Political Subdivision must include documentation that the site will include basic human sanitation services including toilets, sinks, and showers. Such facilities may be temporary fixtures such as portable or mobile toilets, sinks and showers.

(8) Any Plan that is a resubmission of a denied Plan, submitted again for the same Proposed Property, must include a short summary at the front of the Plan explaining what has been changed in the resubmitted Plan from the original denied Plan.

(f) Plan Criteria

(1) Approval. In no case will a Plan be approved if the Department has determined that the Proposed Property referenced in a Plan is a Public Park as defined in subsection (c)(6) of this section. Plans for other properties will be approved if the five factors are satisfied as described in subparagraphs (A) - (E) of this paragraph:

(A) Local health care, including access to Medicaid services (or other comparable health services) and mental health services, are within one mile of the Proposed Property, are accessible via public transportation, can be provided on-site by qualified providers, or transportation is provided (which includes mobile clinics that have the location in their service area), and the Political Jurisdiction commits to a goal that such services are available at little, low or no cost for at least 50% Proposed New Campers (some limited exceptions from providers as may be described in accordance with subsection (d)(5)(A)(v) of this section will not preclude approval for this factor);

(B) There are indigent services providers that have locations within one mile of the Proposed Property, are accessible via public transportation, can provide services on-site, or transportation is provided (which includes mobile indigent service providers that have the location in their service area), and the Political Subdivision commits to a goal that such services are available for at least 50% of Proposed New Campers are expected to be eligible;

(C) The property is within 1/2 mile or less from a public transportation stop or station that has scheduled service at least several times per day for at least six days per week, or there is on demand public transportation available, and the Political Subdivision commits to a goal that at least 50% of the Proposed New Campers are eligible for that on-demand public transportation;

(D) The local law enforcement resources for the patrol zone or precinct that includes the Proposed Property are not materially less than those available in other zones or precincts of the local law enforcement entity, unless the Political Subdivision provides a specific plan for security in and around the property that the Political Subdivision has determined is appropriate for law enforcement services in that area; and

(E) the Political Subdivision has had at least one meeting to discuss initial steps and coordination with the Local Mental Health Authority, specific to this particular Proposed Property and the volume/service needs of Proposed New Campers.

(2) A Plan that meets at least four of the five factors in paragraph (1) of this subsection, may be approved if significant and sufficient mitigation is provided that delivers similarly comprehensive resources as required, to justify how the remaining factor not met will still be sufficiently addressed through some other means.

(3) Denial. An Application that does not meet all of the requirements in paragraph (1) of this subsection, or that does not meet the requirements of paragraph (2) of this subsection will be issued a Plan Determination Notice within 30 days of Plan application (which may be extended by the amount of calendar days the Political Subdivision took to respond to deficiencies) reflecting denial.

(g) Information Sharing. When the Department receives a complaint under §1.2 of this subchapter (relating to Department Complaint System to the Department) or information that a Political Subdivision is allowing camping by homeless individuals on a property that is not the subject of a Plan approved under this section, the Department will refer such information to the Office of the Attorney General, for possible action under Chapter 364, Local Government Code, or other law.

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 September 2, 2021.

TRD-202103484

Bobby Wilkinson
Executive Director
Texas Department of Housing and Community Affairs
Effective date: September 22, 2021
Proposal publication date: July 23, 2021
For further information, please call: (512) 475-1762

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TITLE 22. EXAMINING BOARDS

PART 21. TEXAS STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS

CHAPTER 463. APPLICATIONS AND EXAMINATIONS

SUBCHAPTER B. LICENSING REQUIREMENTS

22 TAC §463.9

The Texas Behavioral Health Executive Council adopts amendments to §463.9, relating to Licensed Specialist in School Psychology. Section 463.9 is adopted without changes to the proposed text as published in the June 18, 2021, issue of the *Texas Register* (46 TexReg 3671). The rule will not be republished.

Reasoned Justification.

Trainee status for LSSPs is now obsolete since applicants are no longer preapproved to take the jurisprudence examination. Since applicants must pass the examination prior to application, future trainee status for LSSP applicants will no longer be issued; therefore §463.9 is amended to reflect this change.

If a rule will pertain to the qualifications necessary to obtain a license; the scope of practice, standards of care, or ethical practice for a profession; continuing education requirements; or a schedule of sanctions then the rule must first be proposed to the Executive Council by the applicable board for the profession before the Executive Council may propose or adopt such a rule, see §507.153 of the Tex. Occ. Code. The amended rule pertains to the qualifications necessary to obtain a license to practice psychology; therefore, this rule is covered by §507.153 of the Tex. Occ. Code.

The Texas State Board of Examiners of Psychologists, in accordance with §501.1515 of the Tex. Occ. Code, previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 501 and 507 of the Tex. Occ. Code and may adopt this rule.

List of interested groups or associations against the rule.

None.

Summary of comments against the rule.

None.

List of interested groups or associations for the rule.

None.

Summary of comments for the rule.

None.

Agency Response.

None.

Statutory Authority.

The rule is adopted under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council adopts this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

In accordance with §501.1515 of the Tex. Occ. Code the Board previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. The rule is specifically authorized by §501.1515 of the Tex. Occ. Code which states the Board shall propose to the Executive Council rules regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice; continuing education requirements for license holders; and a schedule of sanctions for violations of this chapter or rules adopted under this chapter.

The Executive Council also adopts this rule in compliance with §507.153 of the Tex. Occ. Code. The Executive Council may not propose and adopt a rule regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice for a profession; continuing education requirements; or a schedule of sanctions unless the rule has been proposed by the applicable board for the profession. In this instance, the underlying board has proposed the rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 501 and 507 of the Texas Occupations Code and may adopt this rule.

Lastly, the Executive Council adopts this rule under the authority found in §2001.004 of the Tex. Gov't Code 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 30, 2021.

TRD-202103417
Darrel D. Spinks
Executive Director
Texas State Board of Examiners of Psychologists
Effective date: September 19, 2021
Proposal publication date: June 18, 2021
For further information, please call: (512) 305-7706

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CHAPTER 465. RULES OF PRACTICE

22 TAC §465.2

The Texas Behavioral Health Executive Council adopts amended §465.2, relating to Supervision. Section 465.2 is adopted without changes to the proposed text as published in

the June 18, 2021, issue of the *Texas Register* (46 TexReg 3674). The rule will not be republished.

Reasoned Justification.

Trainee status for LSSPs is now obsolete since applicants are no longer preapproved to take the jurisprudence examination. Since applicants must pass the examination prior to application, future trainee status for LSSP applicants will no longer be issued; therefore §465.2 is amended to reflect this change.

If a rule will pertain to the qualifications necessary to obtain a license; the scope of practice, standards of care, or ethical practice for a profession; continuing education requirements; or a schedule of sanctions then the rule must first be proposed to the Executive Council by the applicable board for the profession before the Executive Council may propose or adopt such a rule, see §507.153 of the Tex. Occ. Code. The amended rule pertains to the scope of practice, standards of care, or ethical practice for the profession of psychology; therefore, this rule is covered by §507.153 of the Tex. Occ. Code.

The Texas State Board of Examiners of Psychologists, in accordance with §501.2015 of the Tex. Occ. Code, previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 501 and 507 of the Tex. Occ. Code and may adopt this rule.

List of interested groups or associations against the rule.

None.

Summary of comments against the rule.

None.

List of interested groups or associations for the rule.

None.

Summary of comments for the rule.

None.

Agency Response.

None.

Statutory Authority.

The rule is adopted under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council adopts this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

In accordance with §501.2015 of the Tex. Occ. Code the Board previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. The rule is specifically authorized by §501.2015 of the Tex. Occ. Code which states the Board shall propose to the Executive Council rules regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice; continuing education requirements for license holders; and a schedule of sanctions for violations of this chapter or rules adopted under this chapter.

The Executive Council also adopts this rule in compliance with §507.153 of the Tex. Occ. Code. The Executive Council may not propose and adopt a rule regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice for a profession; continuing education requirements; or a schedule of sanctions unless the rule has been proposed by the applicable board for the profession. In this instance, the underlying board has proposed the rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 501 and 507 of the Texas Occupations Code and may adopt this rule.

Lastly, the Executive Council adopts this rule under the authority found in §2001.004 of the Tex. Gov't Code 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 30, 2021.

TRD-202103418
Darrel D. Spinks
Executive Director
Texas State Board of Examiners of Psychologists
Effective date: September 19, 2021
Proposal publication date: June 18, 2021
For further information, please call: (512) 305-7706

22 TAC §465.38

The Texas Behavioral Health Executive Council adopts amendments to §465.38, relating to Psychological Services for Schools. Section 465.38 is adopted without changes to the proposed text as published in the June 18, 2021, issue of the *Texas Register* (46 TexReg 3677). The rule will not be republished.

Reasoned Justification.

Sections 463.10, 463.11, and 465.12 have been amended, so the references to these rules in subsection (e) of this rule are amended to reflect these changes.

If a rule will pertain to the qualifications necessary to obtain a license; the scope of practice, standards of care, or ethical practice for a profession; continuing education requirements; or a schedule of sanctions then the rule must first be proposed to the Executive Council by the applicable board for the profession before the Executive Council may propose or adopt such a rule, see §507.153 of the Tex. Occ. Code. The amended rule pertains to the scope of practice, standards of care, or ethical practice for the profession of psychology; therefore, this rule is covered by §507.153 of the Tex. Occ. Code.

The Texas State Board of Examiners of Psychologists, in accordance with §501.1515 of the Tex. Occ. Code, previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 501 and 507 of the Tex. Occ. Code and may adopt this rule.

List of interested groups or associations against the rule.

The Texas Association of Psychological Associates

Summary of comments against the rule.

The commenter requests that individuals seeking to fulfill licensing requirements for a Licensed Psychological Associate be included in the list of individuals authorized to provide psychological services in a public school.

List of interested groups or associations for the rule.

None.

Summary of comments for the rule.

None.

Agency Response.

The Executive Council declines to amend the rule as requested by the commenter. School psychological services is a highly specialized practice, in order to provide such services in a public school a license as a specialist in school psychology is required. The exemption from this licensure requirement found in §465.38(e)(1) is intended to cover individuals enrolled in a psychology doctoral degree program, such as interns and practicum students, and those individuals conducting their post-doctoral supervised experience required for licensure as a psychologist. Currently under §463.9(h)(1)(B), but changing to §463.9(g)(1)(B), an unlicensed individual may provide psychological services under supervision in a public school if the individual is enrolled in an internship, practicum or other site based training in a psychology program in a regionally accredited institution of higher education. This rule includes interns and practicum students in graduate degree programs focused towards achieving an LPA or an LSSP. Therefore the exemption previously found in §465.38(e)(1)(C) is already in another rule, §463.9, so a duplicative provision does not need to be retained.

Statutory Authority.

The rule is adopted under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council adopts this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

In accordance with §501.1515 of the Tex. Occ. Code the Board previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. The rule is specifically authorized by §501.1515 of the Tex. Occ. Code which states the Board shall propose to the Executive Council rules regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice; continuing education requirements for license holders; and a schedule of sanctions for violations of this chapter or rules adopted under this chapter.

The Executive Council also adopts this rule in compliance with §507.153 of the Tex. Occ. Code. The Executive Council may not propose and adopt a rule regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice for a profession; continuing education requirements; or a schedule of sanctions unless the rule has been proposed by the applicable board for the profession. In this instance, the underlying board has proposed the rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 501 and 507 of the Texas Occupations Code and may adopt this rule.

Lastly, the Executive Council adopts this rule under the authority found in §2001.004 of the Tex. Gov't Code 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.

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Darrel D. Spinks
Executive Director
Texas State Board of Examiners of Psychologists
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For further information, please call: (512) 305-7706

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PART 35. TEXAS STATE BOARD OF EXAMINERS OF MARRIAGE AND FAMILY THERAPISTS

CHAPTER 801. LICENSURE AND REGULATION OF MARRIAGE AND FAMILY THERAPISTS

SUBCHAPTER C. APPLICATIONS AND LICENSING

22 TAC §801.205

The Texas Behavioral Health Executive Council adopts new §801.205, relating to Remedy for Incomplete License Requirements. Section 801.205 is adopted without changes to the proposed text as published in the June 18, 2021, issue of the *Texas Register* (46 TexReg 3694). The rule will not be republished.

Reasoned Justification.

The new rule is necessary to allow the Texas State Board of Examiners of Marriage and Family Therapists to make exceptions for applicants that have difficulty fulfilling certain licensing requirements due to a declared disaster. For example, some LMFT Associates have expressed difficulty in meeting the required in-person supervised experience hours because, due to the COVID-19 pandemic, some supervisors or employers are only allowing telehealth services. The new rule grants the Board flexibility in approving these future applications for the full LMFT license.

If a rule will pertain to the qualifications necessary to obtain a license; the scope of practice, standards of care, or ethical practice for a profession; continuing education requirements; or a schedule of sanctions then the rule must first be proposed to the Executive Council by the applicable board for the profession before the Executive Council may propose or adopt such a rule;

see §507.153 of the Tex. Occ. Code. The new rule pertains to the qualifications necessary to obtain a license; therefore, this rule is covered by §507.153 of the Tex. Occ. Code.

The Board, in accordance with §502.1515 of the Tex. Occ. Code, previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 502 and 507 of the Tex. Occ. Code and may adopt this rule.

List of interested groups or associations against the rule.

None.

Summary of comments against the rule.

Commenters voiced opposition to the 500 hour maximum of technology assisted services that can be counted towards the required 3,000 hours of supervised clinical practiced needed for full licensure as a marriage and family therapist. Another commenter voice confusion regarding the application of this rule, whether it would apply to just the 500 hour maximum for technology assisted services or possibly other licensing requirements as well. Commenters opined that they want the 500 hour maximum of technology assisted services addressed, and not the proposed new rule. Many believe the use of technology assisted services are beneficial to clients as well as the supervisor and supervisee relationship, as it promotes greater access and less exposure to health risks, and that the level of services and supervision are the same if not better.

List of interested groups or associations for the rule.

None.

Summary of comments for the rule.

Several commenters support the adoption of this new rule. Some commenters voiced support for this new rule because they believe associates should not be penalized for something out of their control, such as the COVID-19 pandemic. If more than the 500 hour maximum of telehealth hours are not allowed to be counted towards licensure this will slow the process of individuals becoming fully licensed, it will likely negatively impact associates financially, it could cause potential health risks to clients and providers by requiring in-person services during a pandemic, and it could limit community access to mental health services.

Agency Response.

The Executive Council declines to make any changes to the adopted new rule. The requirement that no more than 500 hours of technology assisted services can be counted towards licensure as a marriage and family therapist is found in §801.142. There are no proposed changes published in the *Texas Register* to §801.142, therefore, no changes can be made regarding this requirement. New §801.205, which was published in the *Texas Register* for comment, will allow applicants to petition the Board to waive or modify some licensure requirements that include, but are not limited to, this 500 hour technology assisted limit. The limits to what an applicant can petition the Board to waive or modify is limited by what is required by state or federal law. For example, Texas statutes requires certain degrees to be obtained or certain examinations passed before a license can be issued, therefore, those requirements cannot be waived or modified. But certain licensing requirements found exclusively in Board rules can be waived or modified by the Board, in response to a declared disaster, with the passage of this new rule.

Statutory Authority.

The rule is adopted under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council adopts this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

In accordance with §502.1515 of the Tex. Occ. Code the Board previously voted and, by a majority, approved to propose the adoption of this rule to the Executive Council. The rule is specifically authorized by §502.1515 of the Tex. Occ. Code which states the Board shall propose to the Executive Council rules regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice; continuing education requirements for license holders; and a schedule of sanctions for violations of this chapter or rules adopted under this chapter.

The Executive Council also adopts this rule in compliance with §507.153 of the Tex. Occ. Code. The Executive Council may not propose and adopt a rule regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice for a profession; continuing education requirements; or a schedule of sanctions unless the rule has been proposed by the applicable board for the profession. In this instance, the underlying board has proposed this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 502 and 507 of the Texas Occupations Code and may adopt this rule.

Lastly, the Executive Council also adopts this rule under the authority found in §2001.004 of the Tex. Gov't Code 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.

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Darrel D. Spinks
Executive Director
Texas State Board of Examiners of Marriage and Family Therapists
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PART 41. TEXAS BEHAVIORAL HEALTH EXECUTIVE COUNCIL

CHAPTER 881. GENERAL PROVISIONS

SUBCHAPTER B. RULEMAKING

22 TAC §881.21

The Texas Behavioral Health Executive Council adopts amendment to §881.21, relating to Petition for Rulemaking. In response to public comment, §881.21 is adopted with changes to the proposed text as published in the June 18, 2021, issue of the *Texas Register* (46 TexReg 3696). The rule will be republished.

Reasoned Justification.

The amended rule corrects a typographical error. Subsection (f) of this rule referenced §201.021(d) of the Tex. Gov't Code, but the correct citation is §2001.021(d). Therefore, this amended rule is necessary to correct this statutory reference.

List of interested groups or associations against the rule.

None.

Summary of comments against the rule.

None.

List of interested groups or associations for the rule.

None.

Summary of comments for the rule.

A commenter voiced her support for the amendment to this rule. Additionally, the commenter opined that the rule contained repetitious requirements regarding interested persons and the commenter requested the redundant parts of the rule be removed.

Agency Response.

The Executive Council appreciates the commenter's support. The Executive Council agrees that repetition in the rule is unnecessary and adopts this amended rule with changes. Subsection (b) of this rule lists what a person must do to qualify as an interested person, and the last two sentences of Subsection (f) reiterates these same requirements. The Executive Council agrees the last two sentences in Subsection (f) should be deleted since they are duplicative, and the Council adopts this rule with changes in response to the public comment.

Statutory Authority.

The rule is adopted under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council adopts this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council also adopts this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

Lastly, the Executive Council adopts this rule under the authority found in §2001.021 of the Tex. Gov't Code which requires state agencies to prescribe by rule the form for a petition for adoption of rules by interested persons and the procedure for its submission, consideration, and disposition.

§881.21. Petition for Rulemaking.

(a) Any interested person may petition for rulemaking in accordance with §2001.021 of the Government Code by submitting to the Council a written request for the adoption of a rule or rule change. The written request must contain a return mailing address for the agency's response.

(b) The written request must, at a minimum, set forth or identify the rule the petitioner wants the Council to adopt or change, reasons why the petitioner believes the requested rulemaking is necessary, and include a copy of the proposed rule or any proposed changes with deletions crossed through and additions underlined. Additionally, the written request must affirmatively show that the requestor qualifies as an interested person under this rule. Requests which do not affirmatively show that the requestor qualifies as an interested person under this rule may be denied.

(c) The written request should also address the economic cost to persons required to comply with the rule, the effects of the rule on small or micro-businesses or rural communities, and the impact the rule would have on local employment or economics, if such information can be derived from available sources without undue cost or burden.

(d) A petition for rulemaking which involves any of those matters set forth in §507.153(a) of the Occupations Code will be submitted by agency staff to the appropriate member board for initial review and consideration.

(e) The Council will respond to a written request for adoption of a rule from an interested person in accordance with §2001.021 of the Government Code.

(f) The term "interested person" as used in this rule, shall have the same meaning as that assigned by §2001.021(d) of the Government 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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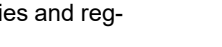

CHAPTER 882. APPLICATIONS AND LICENSING

SUBCHAPTER A. LICENSE APPLICATIONS

22 TAC §882.11

The Texas Behavioral Health Executive Council adopts amendment to §882.11, relating to Applicants with Foreign Degrees. Section 882.11 is adopted without changes to the proposed text as published in the June 18, 2021, issue of the *Texas Register* (46 TexReg 3697). The rule will not be republished.

Reasoned Justification.

The amended rule expands the number of acceptable foreign degree evaluation services who conduct foreign degree evaluations to include members of the Association of International Credential Evaluators, Inc. This change is based, in part, upon the suggestion of the Registrar's Office at the University of Texas at Austin.

List of interested groups or associations against the rule.

None.

Summary of comments against the rule.

None.

List of interested groups or associations for the rule.

None.

Summary of comments for the rule.

A commenter voiced her support for the amendment to this rule.

Agency Response.

The Executive Council appreciates the commenter's support.

Statutory Authority.

The rule is adopted under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council adopts this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council also adopts this rule under the authority found in §2001.004 of the Tex. Gov't Code 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.

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CHAPTER 885. FEES

22 TAC §885.1

The Texas Behavioral Health Executive Council adopts amendments to §885.1, relating to Fees. Section 885.1 is adopted without changes to the proposed text as published in the June 18, 2021, issue of the *Texas Register* (46 TexReg 3700). The rule will not be republished.

Reasoned Justification.

The amended rule clarifies that late fees are not applicable to licenses on inactive status, which is currently stated in §882.21.

Additionally, the amended rule clarifies that when a person's license has been expired for certain periods of time, it is referring to delinquent license status as stated in §882.21.

List of interested groups or associations against the rule.

None.

Summary of comments against the rule.

None.

List of interested groups or associations for the rule.

None.

Summary of comments for the rule.

A commenter voiced her support for the amendment to this rule.

Agency Response.

The Executive Council appreciates the commenter's support.

Statutory Authority.

The rule is adopted under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council adopts this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council adopts this rule pursuant to the authority found in §507.154 of the Tex. Occ. Code which authorizes the Executive Council to set fees necessary to cover the costs of administering Chapters 501, 502, 503, 505, and 507 of the Tex. Occ. Code.

The Executive Council also adopts this rule under the authority found in §2001.004 of the Tex. Gov't Code 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.

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