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 5. TEXAS FACILITIES COMMISSION

CHAPTER 115. FACILITIES LEASING PROGRAM

Introduction and Background.

The Texas Facilities Commission ("Commission") adopts an amendment to Chapter 115, §115.13, and a new Subchapter B §§115.20 - 115.22. Sections 115.13, 115.20, and 115.21 are adopted without changes. Section 115.22 is adopted with changes. Proposed amendments were published in the May 6, 2016, issue of the *Texas Register* (41 TexReg 3215). The revised rules are adopted pursuant to the Commission's rulemaking authority found in Texas Government Code §2167.0021(b) and §2167.008 (West 2008).

Justification for the Rule.

During its rule review, published in the December 11, 2015, issue of the *Texas Register* (40 TexReg 8915), the Commission reviewed and considered Texas Administrative Code, Title 1, Chapter 115, Facilities Leasing Program, for readoption, revision, or repeal in accordance with Texas Government Code §2001.039 (West 2008). The Commission determined that Chapter 115 was still necessary. Revisions to the rules, however, were necessary to ensure consistency with governing statutes and to provide guidance and clarity to situations where a state lease is cancelled due to lack of funding. Section 115.13 establishes guidelines for determining best value in procurement of leased space. Subsection (b) lists the criteria to be used in the evaluation of qualified sites. Subsection (b)(8) references the "Facilities Master Plan." In order to be consistent with the Commission's governing statutes, Texas Government Code §§2166.101 - 104 (West Supp. 2015), the Commission adopts an amendment to Subsection (b)(8) to reference the "master facilities plan."

In addition to the adopted amendment, the Commission adopts a new Subchapter B concerning the cancellation of a lease due to a lack of funding. Section 115.20 will provide definitions for the subchapter. Section 115.21 sets out the procedure for determining whether a leased facility is an idle facility or has idle capacity. Section 115.22 sets out the procedure for the cancellation of a lease due to a lack of funding. The adopted rules provide a process by which any request to cancel a lease due to a lack of funding is accompanied by a written determination of the facts justifying such a request as well as the approval of the requesting agency's governing body or executive director. Section 115.22 is adopted with changes to address one of the public comments received by the Commission. As discussed below, the Commission is changing the language at the end of Subsection (c) to "whichever is earlier," as opposed to "whichever is later," as suggested in the proposed language.

Public Comments.

At its meeting on April 20, 2016, the commissioners requested that the proposed rules be communicated to state client agencies and current lessors; accordingly, notice of the proposed rules was emailed to 50 state agencies and 605 current lessors and mailed to 12 current lessors.

The 30-day comment period ended on June 5, 2016. During the 30-day comment period, the Commission received one written comment from the Texas Department of Motor Vehicles ("DMV") and two written comments and four phone calls from the general public all of whom were current or prospective lessors. Summary of the written comments and the Commission's response follow:

"The Texas Department of Motor Vehicles (TxDMV) generally concurs with the proposed new rules, but wishes to comment regarding the required minimum 180-day notice for intent to cancel the lease as outlined in §115.22. Specifically, we respectfully request additional information explaining why 180 days was selected for the clause. The proposed change to §115.22(c) states that 'the Commission will serve written notice to the lessor of intent to cancel the lease effective on a date certain at least 180 days prior to the date of the lease cancellation.' It further states that 'Rent shall continue to be paid through the date that the lessee vacates the facilities or through the end of the biennium, whichever is later. . . .' A minimum of 180 days seems like a long time for a 'funding out' to become effective since it is theoretically possible that the Legislature would defund an agency or a part of an agency prior to the end of the biennium."

Commission response: Texas Government Code §2167.101, entitled Certification of Available Money, requires a state agency occupying space leased under this chapter certify to the Commission, at least 60 days before the beginning of each fiscal biennium during the lease term, that money is available to pay for the lease until the end of the next fiscal biennium. Based upon DMV's comment, the Commission changed "whichever is later" to "whichever is earlier" in the adopted language.

The Commission received two written comments and four phone calls from the general public all of whom were current or prospective lessors.

A written comment was received from Mr. Michael Fallek who stated:

"I am very concerned about then new rules changes being proposed, and I urge you to vote against incorporating these new rules provisions into the Code.

Any changes in the Code that adds more uncertainty to the term of leases entered into by the State of Texas will make it harder

for bidders to propose lease space to the State, ultimately resulting in fewer bidders and more expensive lease space for the State. If a bidder cannot count on the State fulfilling its financial commitment made under leases, especially when new buildings are built to house the government agencies, then there will be fewer bidders willing to undertake the risk. It is usually the case that a bidder will have to take on debt, oftentimes with personal guarantees attached, in order to construct facilities to house the government agencies. If the bidder cannot count on getting repaid by way of lease payments over the duration of the expected term of the lease, it makes it a much more difficult decision to take on such risk.

Moreover, banks will be less likely to be willing to extend credit to bidders because of the added uncertainty of repayment. If a bidder cannot get financing for government projects, the projects will languish.

I have bid numerous times for lease facilities, and my companies currently have six state leases in place. These changes would lessen the likelihood that I would bid on any RFPs in which new facilities would either have to be built or in which existing facilities would require significant capital to renovate for the government use. Again, I urge you to reject the proposed rules changes to the Code."

A written comment was received from Mr. George E. Grobowsky, who stated:

"I have been a lessor in two Texas Facilities Commission leases, but under the proposed rules I would not have considered such transactions. Both of my transactions involved "single purpose buildings", which I guess most of yours are. The cancellation before maturity of a lease on a single purpose building would probably cause the lessor to suffer a loss on a property that will be very difficult to re-lease.

If the new rules are adopted, I predict, that you will have difficulty finding interested lessors, and in the long run, you will lose any savings gained by the change to increased rents on new and renewed leases. Investors will certainly want to be paid for the increased risk - and you will be adding a very large risk."

Commission response: In every lease between the private sector, as landlord, and the Commission on behalf of governmental agencies, as tenants, there is a written option to terminate contingent on whether funding for the lease remains available. This flows from the balanced budget, pay-as-you-go, requirements of Article III, Sections 49 and 49a of the Texas Constitution, which was codified in §2167.055(e), Texas Government Code. The lease is contingent upon the continued availability of funds to cover the full term and cost of the lease. If funds that may legally be used to pay for the lease become unavailable, the Commission has the right to terminate the lease, upon written notice to the landlord.

Legally such a provision turns a lease with a multi-year term into a series of one-year leases, which may be an unlikely result as a practical matter, but causes concern during lease procurement. Lenders, upon which landlords almost invariably rely, may discount some of the value otherwise attributed to a lease with a governmental entity that is an otherwise credit-worthy tenant. There is no drafting around this provision, because it is constitutional. The Commission has no authority to enter an agreement barred by the constitution and laws of the State.

The Commission has experienced requests from governmental agencies to cancel a lease based upon lack of funding. These requests typically result from the loss of federal funds due to idle capacity or idle facilities. In these instances, a governmental agency can provide evidence of lack of funding together with a directive from the federal agency. In other instances, governmental agencies have elected to cancel a lease exercising discretion in managing their appropriations. In these instances, there is no requirement that the governmental agency provide the basis for its request.

The proposed rules lay out a process by which any request to cancel a lease due to lack of funding must be accompanied by a written determination of the facts justifying such request and the approval of the agency's commission or executive director as the case may be.

Commission response to telephone calls: The Commission requested that the telephone callers submit their comments in writing in the manner specified in the notice of proposed rule changes published in the May 6, 2016, issue of the *Texas Register* (41 TexReg 3215).

SUBCHAPTER A. STATE LEASED PROPERTY

1 TAC §115.13

Statutory Authority.

The amendment to §115.13 is adopted pursuant to Texas Government Code §2167.0021(b), which directs the Commission to adopt rules establishing guidelines for the determination of best value in a lease contract, and §2167.008, which directs the Commission to adopt rules necessary to administer its duties under Chapter 2167, (West 2008).

Cross Reference to Statute.

The statutory provisions affected by the adoption are those set forth in Chapter 2167 of the Texas 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 13, 2016.

TRD-201604790
Kay Molina
General Counsel
Texas Facilities Commission
Effective date: October 3, 2016
Proposal publication date: May 6, 2016
For further information, please call: (512) 475-2400

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SUBCHAPTER B. CANCELLATION OF LEASE DUE TO LACK OF FUNDING

1 TAC §§115.20 - 115.22

Statutory Authority.

The new rules are adopted pursuant to Texas Government Code §2167.008, which directs the Commission to adopt rules necessary to administer its duties under Chapter 2167, (West 2008).

Cross Reference to Statute.

The statutory provisions affected by the adoption are those set forth in Chapter 2167 of the Texas Government Code.

§115.22. Cancellation of Lease Upon Request by a Governmental Agency Due to Lack of Funding.

(a) Unless a governmental agency has been abolished by the Legislature, a governmental agency that elects to invoke the Funding Out Clause to cancel a lease due to lack of funding shall request the Commission to either cancel the lease or make the leased premises available to another governmental agency.

(b) A request by a governmental agency to cancel a lease due to lack of funding must have the approval of the governing body of the governmental agency making the request. Any agency under the authority of an individual commissioner or executive director, appointed by or directly accountable to the Governor, must provide evidence of notification to the Office of the Governor in order for such a request to be considered for action by the Commission.

(c) Unless the term of the lease is amended by written agreement between a lessor and the Commission, the Commission will serve written notice to the lessor of intent to cancel the lease effective on a date certain at least 180 days prior to the date of the lease cancellation. Notice to the lessor is effective upon receipt if served by electronic mail directed to the lessor's designated contact on the Commission's database. Rent shall continue to be paid through the date that the lessee vacates the facilities or through the end of the biennium, whichever is earlier, for which funds had been certified pursuant to Texas Government Code §2167.101 (West 2008).

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

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PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 370. STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SUBCHAPTER C. ENROLLMENT, RENEWAL, DISENROLLMENT, AND COST SHARING

DIVISION 1. ENROLLMENT AND DISENROLLMENT

1 TAC §370.303

The Texas Health and Human Service Commission (HHSC) adopts amendments to §370.303, concerning Completion of Enrollment, with changes to the proposed text as published in the May 13, 2016, issue of the *Texas Register* (41 TexReg 3389). The text of the rule will be republished.

BACKGROUND AND JUSTIFICATION

HHSC amended this rule to include consideration of a Children's Health Insurance Program (CHIP) child's managed care history in the algorithm used to assign a managed care organization (MCO) when the applicant has not made a selection. The change is intended to improve continuity of care.

HHSC also amended this rule to include requirements for completion of enrollment when a Medicaid member transitions to CHIP after being determined ineligible for Medicaid, including paying any applicable enrollment fees. Effective January 1, 2014, the modified adjusted gross income (MAGI) methodologies established a 12-month certification period for Medicaid. The first six months are designated as continuous eligibility, and the second six-month period is non-continuous eligibility. Children may not be denied eligibility for excess income during the continuous period. However, during the non-continuous period, children may be determined ineligible for Medicaid but eligible for CHIP. When a child on Medicaid moves to CHIP during the non-continuous eligibility period, there may be a gap in the child's medical coverage, even if the child meets all HHSC deadlines. Children in Medicaid transitioning to CHIP may be required to pay an enrollment fee if their income exceeds a certain amount. Under existing rules, children will not receive CHIP coverage until the enrollment fee is paid. The rule change will allow children in these circumstances to be enrolled in CHIP prior to paying any applicable enrollment fees, minimizing gaps in coverage. However, if the enrollment fee is not paid on or before the due date, the child will be disenrolled from CHIP.

In addition to these changes, HHSC amended the rule to clarify that an applicant must pay an enrollment fee, if one is due, to complete CHIP enrollment. Current Medicaid processes require CHIP applicants to pay applicable enrollment fees prior to enrollment, so the addition of this requirement to the rule is only for clarification and consistency. The proposed amendment was further amended prior to adoption to clarify that for a child transitioning to CHIP from Medicaid, the applicant must pay any applicable enrollment fee by the assigned due date, but the transitioning child may be enrolled into CHIP prior to payment of the enrollment fee. Finally, HHSC made minor changes in terminology from "member" to "child" and from "beneficiary" to "child" as appropriate for clarity.

COMMENTS

The 30-day comment period ended June 13, 2016. During this period, HHSC did not receive any comments regarding the amended rule.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and 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.

§370.303. Completion of Enrollment.

(a) To complete CHIP enrollment, an applicant must:

(1) select and indicate on the enrollment form a health care MCO and a dental MCO for all eligible children;

(2) select a PCP and a dental home, and place the names on the enrollment form;

(3) if applicable, indicate if an eligible child has special health care needs based on criteria in the member guide;

(4) sign and return the enrollment form; and

(5) pay any applicable enrollment fee on or before the due date.

(b) If an applicant does not pay an applicable enrollment fee as described in subsection (a) of this section, the child is not enrolled in CHIP.

(c) Notwithstanding subsections (a) and (b) of this section, if an application is for a child enrolled in Medicaid transitioning to CHIP after being determined ineligible for Medicaid before the end of the child's Medicaid certification period, the child may be enrolled in CHIP prior to payment of the enrollment fee. However, if the enrollment fee is not paid on or before the due date, the child is disenrolled.

(d) An applicant may select a PCP, dental home, health care MCO, and dental MCO by mail, telephone, or facsimile. Unless the application is for a perinate receiving expedited enrollment in accordance with §370.401 of this chapter (relating to Perinates), the applicant will have 30 calendar days from the date the enrollment packet is mailed to choose a health care MCO, dental MCO, PCP, and dental home. If the applicant does not choose a health care MCO, dental MCO, PCP, or dental home within the time period established by HHSC, HHSC or its designee will assign one using the default assignment methodologies described in this section.

(e) PCP assignment. If an applicant has not selected a PCP, the health care MCO will assign one using an algorithm that considers:

(1) the child's established history with a PCP, as demonstrated by encounter history with the provider in the preceding year, if available;

(2) the geographic proximity of the child's home address to the PCP;

(3) whether the provider serves as a PCP to other members of the child's household;

(4) limitations on default assignment, such as PCP restrictions on age, gender, and capacity; and

(5) other criteria approved by HHSC.

(f) Dental home assignment. If an applicant has not selected a dental home, the dental MCO will assign one using an algorithm that considers:

(1) the child's established history with a dental home, as demonstrated by encounter history with the provider in the preceding year, if available;

(2) the geographic proximity of the child's home address to the dental home;

(3) whether the provider serves as the dental home to other members of the child's household;

(4) limitations on default assignment, such as dental home restrictions on age and capacity; and

(5) other criteria approved by HHSC.

(g) MCO assignment. If an applicant has not selected a health care MCO or dental MCO, HHSC or its administrative services contractor will assign one using an algorithm that considers the child's history, including PCP or dental home when possible. If this is not possible, HHSC or its administrative services contractor will equitably distribute members among qualified MCOs, using an algorithm that considers one or more of the following factors:

(1) whether the child was previously enrolled in the MCO in Medicaid or CHIP;

(2) whether other members of the child's household are enrolled in the MCO in Medicaid or CHIP;

(3) MCO performance;

(4) the greatest variance between the percentage of elective and default enrollments (with the percentage of default enrollments subtracted from the percentage of elective enrollments);

(5) capitation rates;

(6) market share; and

(7) other criteria determined by HHSC.

(h) Modified default enrollment process. HHSC has the option to implement a modified default enrollment process for MCOs when contracting with a new MCO or implementing managed care in a new service area, or when it has placed an MCO on full or partial enrollment suspension.

(i) Request to change dental home or PCP. There is no limit on the number of times a member can request to change his or her dental home or PCP. A member can request a change in writing or by calling the MCO's toll-free member hotline.

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 424-6900

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TITLE 22. EXAMINING BOARDS

PART 9. TEXAS MEDICAL BOARD

CHAPTER 174. TELEMEDICINE

22 TAC §174.11

The Texas Medical Board (Board) adopts amendments to §174.11, concerning On-Call Services without changes to the proposed text as published in the July 1, 2016, issue of the *Texas Register* (41 TexReg 4761) and will not be republished.

The amendment to §174.11 amends and adds language referring to Chapter 177 (relating to Business Organizations, also adopted for amendment in this issue of the *Texas Register)* and newly adopted Subchapter E titled "Physician Call Coverage Medical Services," which provides physicians guidance and sets forth the minimum requirements relating to on-call services and agreements. The adopted amendment to relocate the substantive requirements related to the topic of "on-call" services to Chapter 177 results from the Board's meetings with stakehold-

ers who expressed the need for more clarity with respect to the application of the rule and whether it applied to all physicians or just those physicians practicing in the area of telemedicine. The removal of the substantive requirements for "on-call" services from Chapter 174 of this title (relating to Telemedicine), and relocation of the call coverage topic to Chapter 177 of this title will alleviate such confusion and provide more clarity as to the rule's applicability.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the authority of the Texas Occupations Code Annotated, §153.001, which provides authority for the Board to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

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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Mari Robinson, J.D.
Executive Director
Texas Medical Board
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CHAPTER 177. BUSINESS ORGANIZATIONS AND AGREEMENTS
SUBCHAPTER C. JOINTLY OWNED ENTITIES

22 TAC §177.16

The Texas Medical Board (Board) adopts amendments to §177.16, concerning Physician Assistants, with nonsubstantive changes to the proposed text as published in the July 1, 2016, issue of the *Texas Register* (41 TexReg 4762). The amended text is republished below.

The Board sought stakeholder input through Stakeholder Groups, which made comments on the suggested changes to the rule at a meeting held on May 2, 2016. The comments were incorporated into the proposed rule.

The amendments eliminate subsection (e) and amend subsection (f) in order to align with a recent 3rd Court of Appeals decision, which invalidated part of the rule relating to the grandfathering clause and business entities solely owned by physician assistants. The rule as written in 2011 was pursuant to HB 2098 (82nd Regular Session) which amended §162.053 and §204.209 of the Texas Occupations Code and stated that "an ownership interest acquired before the effective date of this Act is governed by the law in effect at the time the interest was acquired, and the former law is continued in effect for that purpose." Accordingly, the amendments to this section correct portions of the rule that were invalidated by the 3rd Court of Appeals decision and bring the rule in line with the intent of HB 2098.

The amendment to the title of Chapter 177, Business Organizations, adds the word "Agreements" to the title in order to accurately reflect the topic of new Subchapter E, thereby resulting in a title that reads "Business Organizations and Agreements."

Minor spelling errors were corrected in subsections (a), (b), and (c) of the text after adoption by the board.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the authority of the Texas Occupations Code Annotated, §153.001, which provides authority for the Board to adopt rules and bylaws as necessary to govern its own proceedings, perform its duties, regulate the practice of medicine in this state, enforce this subtitle, and establish rules related to licensure.

§177.16. Physician Assistants.

(a) Corporations.

(1) Pursuant to §22.0561 of the Business Organizations Code, a physician and a physician assistant may form a corporation to perform a professional service that falls within the scope of practice of those practitioners.

(2) A physician assistant may not:

(A) be an officer of the corporation;

(B) contract with or employ a physician to be a supervising physician of the physician assistant or of any physician in the corporation;

(C) direct the activities of a physician in the practice of medicine;

(D) interfere with supervision of physician assistants by a physician owner or supervising physician;

(E) own individually or in combination with other physician assistants more than a minority ownership interest in an entity created under this subsection; or

(F) have an ownership interest that equals or exceeds the ownership interest of any physician owner.

(b) Partnerships.

(1) Pursuant to §152.0551 of the Business Organizations Code, physicians and physician assistants may create a partnership to perform a professional service that falls within the scope of practice of those practitioners.

(2) A physician assistant may not:

(A) be a general partner or participate in the management of the partnership;

(B) contract with or employ a physician to be a supervising physician of the physician assistant or of any physician in the partnership;

(C) direct the activities of a physician in the practice of medicine;

(D) interfere with supervision of physician assistants by a physician owner or supervising physician;

(E) individually or in combination with other physician assistants have more than a minority ownership interest in the partnership; or

(F) have an ownership interest that equals or exceeds the ownership interest of any physician owner.

(3) An organizer of the entity, as defined under §3.004 of the Texas Business Organization Code, must be a physician and ensure that a physician or physicians control and manage the entity.

(c) Professional Associations and Professional Limited Liability Companies.

(1) Pursuant to §301.012 of the Business Organizations Code, physicians and physician assistants may form and own a professional association or professional limited liability company to perform a professional service that falls within the scope of practice of those practitioners.

(2) A physician assistant may not:

(A) be an officer in the professional association or professional limited liability company;

(B) contract with or employ a physician to be a supervising physician of the physician assistant or of any physician in the professional association or professional limited liability company;

(C) direct the activities of a physician in the practice of medicine;

(D) interfere with supervision of physician assistants by a physician owner or supervising physician;

(E) individually or in combination with other physician assistants have more than a minority ownership interest in the professional association or professional limited liability company; or

(F) have an ownership interest that equals or exceeds the ownership interest of any physician owner.

(3) An organizer of the entity, as defined under §3.004 of the Texas Business Organization Code, must be a physician and ensure that a physician or physicians control and manage the entity.

(d) All physicians and physician assistants who jointly own an entity must annually submit a joint form to the Board providing date of formation of the entity, each licensee's ownership interest in the entity, proof of ownership, and proof of date of formation, along with required fees as provided in Chapter 175 of this title (relating to Fees and Penalties).

(e) Restrictions on ownership interests, shall apply only to those entities formed on or after June 17, 2011. An ownership interest acquired before the effective date of this Act is governed by the law in effect at the time the interest was acquired.

(f) This section shall not apply to pain management clinics owned and operated pursuant to Chapter 195 of this title (relating to Pain Management Clinics).

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 19, 2016.

TRD-201604821

Mari Robinson, J.D.
Executive Director
Texas Medical Board
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For further information, please call: (512) 305-7016

SUBCHAPTER E. PHYSICIAN CALL COVERAGE MEDICAL SERVICES

22 TAC §§177.18 - 177.20

The Texas Medical Board (Board) adopts new Subchapter E, Physician Call Coverage Medical Services, §§177.18 - 177.20 without changes to the proposed text as published in the July 1, 2016, issue of the *Texas Register* (41 TexReg 4763). The new rules will not be republished.

The Board sought stakeholder input through Stakeholder Groups, which made comments on the suggested changes to the rules at a meeting held on May 2, 2016. The comments were incorporated into the proposed rules.

Title Change to Chapter 177, Relating to Business Organizations

The amendment to the title of Chapter 177, Business Organizations, adds the word "Agreements" to the title in order to accurately reflect the topic of new Subchapter E, thereby resulting in a title that reads "Business Organizations and Agreements."

Background

The call coverage rule has been located in Chapter 174, relating to telemedicine, for a number of years. However, such location caused undue confusion about call coverage in general, and who could provide such coverage.

General Intent and Purpose

Call coverage has never been limited only to telemedicine and has been and is currently utilized by all types of physicians and practices. The purpose of the newly adopted rules is to:

1. eliminate strict reciprocity and same practice requirements;

2. recognize traditional call coverage arrangements in Texas; and

3. recognize methods of call coverage facilitated by technological advances to allow greater access and flexibility for physicians to procure call coverage services/arrangements for their patients.

Summary of New Rules

New Subchapter E, "Physician Call Coverage Medical Services," is added to Chapter 177, to include three new sections: §§177.18 - 177.20.

New §177.18, concerning Purpose and Scope, sets forth the purpose, scope and applicability of Subchapter E.

New §177.19, concerning Definitions, defines the "Act" and the "Board" as is used throughout Subchapter E.

New §177.20, concerning Call Coverage Minimum Requirements, sets forth specific minimum requirements for physician call coverage agreements generally, and further delineates the parameters and requirements for two call coverage models:

"Non-Reciprocal Call Coverage Model", and "Reciprocal Call Coverage Model."

Summary of Comments

The Board received written comments from Teladoc, Inc., American Well, and Texas E-Health Alliance (TeHA). No one appeared to testify at the public hearing held on August 25, 2016, regarding §§177.18 - 177.20.

Comment No. 1: Texas E-Health Alliance

The commenter expressed support for the new rules, stating:

On behalf of our board of directors, I would like to convey our support for the finalization of this rule so that it can take effect. We have a number of TeHA members that plan to use this new provision to better support their clients and businesses.

I would also like to thank the Board and its staff for meeting with stakeholders throughout the rule development process, and for continuing to take into account the ongoing developments in the use of technology for the delivery of telemedicine.

Comment No. 2: American Well

The commenter expressed support for the new rules, stating:

We would like to convey our formal support for the adoption of this rule. Not only will it clarify and support vital, traditional "on-call" relationships, but it will also create a pathway for innovative technologies and other models of care to open access to much needed specialty clinicians and after hours capacity.

Comment No. 3: Teladoc, Inc.

The commenter opposed the rules on various grounds. The Board believes the commenter is mistaken about the intent and effect of the rules.

Response to Comment

Point No. 1: The commenter states that there presently exists no confusion regarding the applicability of call coverage within the physician community.

Response: Despite the commenter's assertion that there is no confusion in the physician community about the applicability of the call coverage rule, practitioners, including physician stakeholders, have expressed concern to the Board that traditional call coverage was not allowed under the existing rules. The revisions adopted clearly establish that call coverage rules pertain to all physicians, as the rules have been re-located from the chapter pertaining to telemedicine to another chapter of general applicability.

Point No. 2: The commenter maintains that stakeholders are confused as to why the Board did not simply revise the call coverage rule in Chapter 174.

Response: As stated above, there were concerns about the applicability and limitations on call coverage arrangements under the existing rule and the requirements of "reciprocity" and "same specialty." The stakeholders expressed a need for a rule that provided the same clarity to all physicians, not just telemedicine physicians, using call coverage arrangements. The rules provide guidance regarding the parameters for permissible use of such call coverage arrangements relating to all physicians. This need for clarification to facilitate expanded coverage is illustrated in the following comment made by a member of the Board's telemedicine stakeholder group during the May 2, 2016 stakeholder meeting:

"That's how the issue came onto our radar screen, was folks calling us and saying, 'I can't find anybody to do call coverage for me. I would love it if I could use a service or I could contract with someone from another city. But if I don't have any partners to begin with, then I don't have anybody to cover for me. I can't do reciprocal because there's no one to do an exchange with.' So that, to us, was a significant barrier that we submitted as a formal comment during two rounds of rule-making. I think it was the 2015 round of rule-making. So this new model, then, would provide that dermatologist the chance to contract with a dermatologist in another city without necessarily having to take that person's call."

The relocation of the rule from Chapter 174, which is limited to the subject of telemedicine, to Chapter 177, which pertains to business organizations connected to all medicine, clearly establishes that the rule pertaining to "on-call" coverage applies to all physicians, rather than just those physicians utilizing telemedicine in their practice. This clarification is illustrated in the following exchange made during the stakeholder meeting on May 2, 2016 between a stakeholder and Ms. Robinson, the Executive Director for the Board:

DR. PHILLIPS:

"So in that answer, it actually prompted my next question, and that is, this process moved from the telemedicine rules Chapter 174 to a new set of rules, Chapter 177. Again, I don't want to go into a lot of detail, but what was the context for expanding to all coverage rather than focusing on the telemedicine coverage?"

MS. ROBINSON:

"Because we realized that there was a generalized standard and it applied to all medicine."

Point No. 3: The rules limit patient choice and prevent a patient from using an ER, urgent care, or retail clinic.

Response: Such claims are erroneous and demonstrate this commenter's misunderstanding of the new rule's intent and effect. This rule has no effect on a patient's ability to freely select a medical service provider, whether it is an ER, urgent care or retail clinic.

The adopted rule addresses a physician's mechanism and need to provide continued patient care when the physician is absent. This rule does not limit the patient's choice to seek care from any other physician or at an ER, urgent care, or retail clinic.

Call coverage has traditionally been understood to apply to those situations in which one physician asks another physician to cover any potential medical issues during an absence. Again, this rule does not impact a patient's choice to seek care elsewhere during his/her primary care physician's absence.

Point No. 4: The commenter addressed the absence of the phrase "mutual responsibility" in the rule.

Response: The commenter pointed out that the adopted rule lacks the phrase "mutual responsibility," a term included in an earlier version of rules that has since been withdrawn by the board as the result of several comments received in opposition to the phrase.

The new adopted rule provides that the physician providing coverage is responsible for the care provided during the time of coverage. This rule satisfies the prior concerns expressed by TMA and TOMA regarding the phrase "mutual responsibility" by eliminating such language. No comments have been received from

TMA, TOMA, or any other individual in opposition to this most recent change, other than the commenter.

The rule's requirement of having a written agreement in a non-reciprocal arrangement is intended to ensure communication between the physicians who are parties to the call coverage agreement/arrangement.

The rule allows for innovative call coverage models by removal of the "same specialty" and "reciprocity" requirements, while simultaneously ensuring patient safety through the requirement to memorialize, in the patient's record, the care provided during the coverage period. The manner of memorializing the care provided is also flexible. This requirement ensures patient continuity of care and safety.

In the new rule, the written agreement provision simply ensures that both the primary and covering physician agree to provision of call coverage services. Further, upon conclusion of the coverage period, the care provided by the covering physician, if any, is memorialized in the patient's record. The Board certainly understands the problem of fragmented medical records, and the new rule actually reduces such fragmentation by requiring such care to be documented in the patient's record. This memorialization of care allows a patient and/or the primary care physician to access information about the care of a patient, including who to contact about such information or care, in the event of confusion or concerns regarding the care provided during the coverage period.

Point No. 5: The commenter asserts that the rules are vague and confusing, and takes issue that certain terms are not defined in the rules.

Response: The rules contain terms that are clear on their face and are commonly understood within the medical community. No stakeholders, other than the commenter, have expressed confusion regarding any of these terms.

Point No. 6: The commenter makes several unsupported arguments regarding Rule 190.8.

Response: These comments are unrelated in any manner to the adopted call coverage rule. Moreover, the enforcement or amendment of the rule in Chapter 174 has never been enjoined by any court. A large portion of the commenter's remarks focus on pending litigation between the commenter and the Board that is framed entirely in terms of Rule 190.8. The commenter claims that this new rule cannot be passed without empirical evidence. However, such is not the standard and, again, the commenter's focus is misplaced as it refers to Rule 190.8 rather than Chapter 174.

The new rules are adopted under the authority of the Texas Occupations Code Annotated, §153.001, which provides authority for the Board to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

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 19, 2016.

TRD-201604822
Mari Robinson, J.D.
Executive Director
Texas Medical Board
Effective date: October 9, 2016
Proposal publication date: July 1, 2016
For further information, please call: (512) 305-7016

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PART 10. TEXAS FUNERAL SERVICE COMMISSION

CHAPTER 203. LICENSING AND ENFORCEMENT--SPECIFIC SUBSTANTIVE RULES

SUBCHAPTER A. LICENSING

22 TAC §203.5, §203.7

The Texas Funeral Service Commission adopts amendments to 22 TAC §203.5 and §203.7 without changes to the proposed text as published in the July 8, 2016, issue of the *Texas Register* (41 TexReg 4944).

The amendments clarify questions regarding the provisional license program. The amended rules provide clarification on education waivers, the mortuary law exam expiration, and what is required for re-applications for a provisional license.

The amendment to §203.5(a) clarifies the educational waiver provided for in statute is only good for an applicant who has never held a provisional license. The amendment to §203.5(b) clarifies that a person who has completed coursework and "filed for graduation" but has not graduated may continue to hold a provisional license. The amendment to §203.5(n) clarifies the mortuary law exam expiration date is tied to filing an application by requiring an examinee to apply for a provisional license within six months of taking the exam or the exam score is invalid.

The amendment to §203.7 clarifies a new application for a provisional license (even if the person previously had a license) triggers both a new criminal background check and the requirement for a new mortuary law exam.

No comments were received regarding the amendments to §203.5 and §203.7.

These amendments are adopted under Cemetery and Crematory Services, Funeral Directing and Embalming Act, Texas Occupations Code §651.152, which authorizes the Commission to adopt rules considered necessary for carrying out the Commission's work and Texas Occupations Code Subchapter G (§§651.301 - 651.306), which authorizes the Commission to issue provisional licenses.

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 16, 2016.

TRD-201604815

Janice McCoy
Executive Director
Texas Funeral Service Commission
Effective date: October 6, 2016
Proposal publication date: July 8, 2016
For further information, please call: (512) 936-2469

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22 TAC §203.9

The Texas Funeral Service Commission adopts an amendment to 22 TAC §203.9 without changes to the proposed text as published in the July 8, 2016, issue of the *Texas Register* (41 TexReg 4945). The amendment provides that change of ownership affidavits may require the new owner to submit a fee along with the affidavit. With the amendment, the Commission could but would not be required to adopt a fee to accompany the ownership affidavit.

No comments were received regarding the amendment to §203.9(c).

This amendment is adopted under Cemetery and Crematory Services, Funeral Directing and Embalming Act, Texas Occupations Code §651.152, which authorizes the Commission to adopt rules considered necessary for carrying out the Commission's work and Texas Occupations Code §651.154 which authorizes the Commission to adopt fees.

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 16, 2016.

TRD-201604816
Janice McCoy
Executive Director
Texas Funeral Service Commission
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For further information, please call: (512) 936-2469

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 97. LICENSING STANDARDS FOR HOME AND COMMUNITY SUPPORT SERVICES AGENCIES

The Texas Health and Human Services Commission (HHSC) adopts, on behalf of the Department of Aging and Disability Services (DADS), amendments to §97.2 and §97.527, in Chapter 97, Licensing Standards for Home and Community Support Services Agencies. The amendments to §97.2 and §97.527 are adopted with changes to the proposed text as published in the July 8, 2016, issue of the *Texas Register* (41 TexReg 5025).

The purpose of the adoption is to make terminology used in Chapter 97 consistent with terminology used in Title 42, Code of Federal Regulations, Part 488, Subparts I and J. Specifically, the adoption replaces the term "informal review of deficiencies" (IRoD) with the term "informal dispute resolution" (IDR). Currently, IRoD is available for all violations and deficiencies, but the adoption provides that IDR is available for violations and only for deficiencies that rise to the condition level, which are deficiencies that substantially limit the capacity of a home and community support services agency to furnish adequate care or that adversely affect the health or safety of patients. Additional amendments provide that DADS does not grant an agency's request for IDR if DADS cited the violation or deficiency at the agency's immediately preceding survey and DADS has cited the violation or deficiency again, with no new findings.

DADS received no comments regarding adoption of the amendments.

The agency made changes to §97.2 to reflect the previous adoption of the section as published in the August 26, 2016, issue of the *Texas Register* (41 TexReg 6501).

SUBCHAPTER A. GENERAL PROVISIONS

40 TAC §97.2

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS, and Texas Health and Safety Code, §142.0011 which authorizes the HHSC executive commissioner to adopt rules relating to the licensing and regulation of home and community support services agencies.

§97.2. Definitions.

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

(1) Accessible and flexible services--Services that are delivered in the least intrusive manner possible and are provided in all settings where individuals live, work, and recreate.

(2) Administration of medication--The direct application of any medication by injection, inhalation, ingestion, or any other means to the body of a client. The preparation of medication is part of the administration of medication and is the act or process of making ready a medication for administration, including the calculation of a client's medication dosage; altering the form of the medication by crushing, dissolving, or any other method; reconstitution of an injectable medication; drawing an injectable medication into a syringe; preparing an intravenous admixture; or any other act required to render the medication ready for administration.

(3) Administrative support site--A facility or site where an agency performs administrative and other support functions but does not provide direct home health, hospice, or personal assistance services. This site does not require an agency license.

(4) Administrator--The person who is responsible for implementing and supervising the administrative polices and operations of a home and community support services agency and for administratively supervising the provision of all services to agency clients on a day-to-day basis.

(5) ADS--Alternate delivery site. A facility or site, including a residential unit or an inpatient unit:

(A) that is owned or operated by an agency providing hospice services;

(B) that is not the hospice's principal place of business, which for the purposes of this definition, means it is not the parent agency;

(C) that is located in the geographical area served by the hospice; and

(D) from which the hospice provides hospice services.

(6) Advanced practice nurse--An advanced practice registered nurse.

(7) Advanced practice registered nurse--A person licensed by the Texas Board of Nursing as an advanced practice registered nurse. The term is synonymous with "advanced practice nurse."

(8) Advisory committee--A committee, board, commission, council, conference, panel, task force, or other similar group, or any subcommittee or other subgroup, established for the purpose of obtaining advice or recommendations on issues or policies that are within the scope of a person's responsibility.

(9) Affiliate--With respect to an applicant or license holder that is:

(A) a corporation--means each officer, director, and stockholder with direct ownership of at least 5.0 percent, subsidiary, and parent company;

(B) a limited liability company--means each officer, member, and parent company;

(C) an individual--means:

(i) the individual's spouse;

(ii) each partnership and each partner thereof of which the individual or any affiliate of the individual is a partner; and

(iii) each corporation in which the individual is an officer, director, or stockholder with a direct ownership or disclosable interest of at least 5.0 percent.

(D) a partnership--means each partner and any parent company; and

(E) a group of co-owners under any other business arrangement--means each officer, director, or the equivalent under the specific business arrangement and each parent company.

(10) Agency--A home and community support services agency.

(11) Applicant--The owner of an agency that is applying for a license under the statute. This is the person in whose name the license will be issued.

(12) Assistance with self-administration of medication--Any needed ancillary aid provided to a client in the client's self-administered medication or treatment regimen, such as reminding a client to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storage area, and assisting in reordering medications from a pharmacy. Such ancillary aid includes administration of any medication when the client has the cognitive ability to direct the administration of their medication and would self-administer if not for a functional limitation.

(13) Association--A partnership, limited liability company, or other business entity that is not a corporation.

(14) Audiologist--A person who is currently licensed under the Texas Occupations Code, Chapter 401, as an audiologist.

(15) Bereavement--The process by which a survivor of a deceased person mourns and experiences grief.

(16) Bereavement services--Support services offered to a family during bereavement. Services may be provided to persons other than family members, including residents of a skilled nursing facility, nursing facility, or intermediate care facility for individuals with an intellectual disability or related conditions, when appropriate and identified in a bereavement plan of care.

(17) Biologicals--A medicinal preparation made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

(18) Boarding home facility--An establishment defined in Texas Health and Safety Code §260.001(2).

(19) Branch office--A facility or site in the service area of a parent agency from which home health or personal assistance services are delivered or where active client records are maintained. This does not include inactive records that are stored at an unlicensed site.

(20) Care plan--

(A) a written plan prepared by the appropriate health care professional for a client of the home and community support services agency; or

(B) for home dialysis designation, a written plan developed by the physician, registered nurse, dietitian, and qualified social worker to personalize the care for the client and enable long- and short-term goals to be met.

(21) Case conference--A conference among personnel furnishing services to the client to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care or care plan.

(22) Certified agency--A home and community support services agency, or portion of the agency, that:

(A) provides a home health service; and

(B) is certified by an official of the Department of Health and Human Services as in compliance with conditions of participation in Social Security Act, Title XVIII (42 United States Code (USC) §1395 et seq.).

(23) Certified home health services--Home health services that are provided by a certified agency.

(24) CFR--Code of Federal Regulations. The regulations and rules promulgated by agencies of the Federal government that address a broad range of subjects, including hospice care and home health services.

(25) CHAP--Community Health Accreditation Program, Inc. An independent, nonprofit accrediting body that publicly certifies that an organization has voluntarily met certain standards for home and community-based health care.

(26) Chief financial officer--An individual who is responsible for supervising and managing all financial activities for a home and community support services agency.

(27) Client--An individual receiving home health, hospice, or personal assistance services from a licensed home and community support services agency. This term includes each member of the primary client's family if the member is receiving ongoing services. This term does not include the spouse, significant other, or other family

member living with the client who receives a one-time service (for example, vaccination) if the spouse, significant other, or other family member receives the service in connection with the care of a client.

(28) Clinical note--A dated and signed written notation by agency personnel of a contact with a client containing a description of signs and symptoms; treatment and medication given; the client's reaction; other health services provided; and any changes in physical and emotional condition.

(29) CMS--Centers for Medicare and Medicaid Services. The federal agency that administers the Medicare program and works in partnership with the states to administer Medicaid.

(30) Complaint--An allegation against an agency regulated by DADS or against an employee of an agency regulated by DADS that involves a violation of this chapter or the statute.

(31) Community disaster resources--A local, statewide, or nationwide emergency system that provides information and resources during a disaster, including weather information, transportation, evacuation, and shelter information, disaster assistance and recovery efforts, evacuee and disaster victim resources, and resources for locating evacuated friends and relatives.

(32) Controlling person--A person with the ability, acting alone or with others, to directly or indirectly influence, direct, or cause the direction of the management, expenditure of money, or policies of an agency or other person.

(A) A controlling person includes:

(i) a management company or other business entity that operates or contracts with others for the operation of an agency;

(ii) a person who is a controlling person of a management company or other business entity that operates an agency or that contracts with another person for the operation of an agency; and

(iii) any other individual who, because of a personal, familial, or other relationship with the owner, manager, or provider of an agency, is in a position of actual control or authority with respect to the agency, without regard to whether the individual is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the agency.

(B) A controlling person, as described by subparagraph (A)(iii) of this paragraph, does not include an employee, lender, secured creditor, or other person who does not exercise formal or actual influence or control over the operation of an agency.

(33) Conviction--An adjudication of guilt based on a finding of guilt, a plea of guilty, or a plea of nolo contendere.

(34) Counselor--An individual qualified under Medicare standards to provide counseling services, including bereavement, dietary, spiritual, and other counseling services to both the client and the family.

(35) DADS--Department of Aging and Disability Services.

(36) Day--Any reference to a day means a calendar day, unless otherwise specified in the text. A calendar day includes weekends and holidays.

(37) Deficiency--A finding of noncompliance with federal requirements resulting from a survey.

(38) Designated survey office--A DADS Home and Community Support Services Agencies Program office located in an agency's geographic region.

(39) Dialysis treatment record--For home dialysis designation, a dated and signed written notation by the person providing dialysis treatment which contains a description of signs and symptoms, machine parameters and pressure settings, type of dialyzer and dialysate, actual pre- and post-treatment weight, medications administered as part of the treatment, and the client's response to treatment.

(40) Dietitian--A person who is currently licensed under the laws of the State of Texas to use the title of licensed dietitian or provisional licensed dietitian, or who is a registered dietitian.

(41) Disaster--The occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or man-made cause, such as fire, flood, earthquake, wind, storm, wave action, oil spill or other water contamination, epidemic, air contamination, infestation, explosion, riot, hostile military or paramilitary action, or energy emergency. In a hospice inpatient unit, a disaster also includes failure of the heating or cooling system, power outage, explosion, and bomb threat.

(42) ESRD--End stage renal disease. For home dialysis designation, the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

(43) Functional need--Needs of the individual that require services without regard to diagnosis or label.

(44) Habilitation--Habilitation services, as defined by Texas Government Code §534.001, provided by an agency licensed under this chapter.

(45) Health assessment--A determination of a client's physical and mental status through inventory of systems.

(46) Home and community support services agency--A person who provides home health, hospice, or personal assistance services for pay or other consideration in a client's residence, an independent living environment, or another appropriate location.

(47) Home health aide--An individual working for an agency who meets at least one of the requirements for home health aides as defined in §97.701 of this chapter (relating to Home Health Aides).

(48) Home health medication aide--An unlicensed person issued a permit by DADS to administer medication to a client under the Texas Health and Safety Code, Chapter 142, Subchapter B.

(49) Home health service--The provision of one or more of the following health services required by an individual in a residence or independent living environment:

(A) nursing, including blood pressure monitoring and diabetes treatment;

(B) physical, occupational, speech, or respiratory therapy;

(C) medical social service;

(D) intravenous therapy;

(E) dialysis;

(F) service provided by unlicensed personnel under the delegation or supervision of a licensed health professional;

(G) the furnishing of medical equipment and supplies, excluding drugs and medicines; or

(H) nutritional counseling.

(50) Hospice--A person licensed under this chapter to provide hospice services, including a person who owns or operates a residential unit or an inpatient unit.

(51) Hospice aide--A person working for an agency licensed to provide hospice services who meets the qualifications for a hospice aide as described in §97.843 of this chapter (relating to Hospice Aide Qualifications).

(52) Hospice homemaker--A person working for an agency licensed to provide hospice services who meets the qualifications described in §97.845 of this chapter (relating to Hospice Homemaker Qualifications).

(53) Hospice services--Services, including services provided by unlicensed personnel under the delegation of a registered nurse or physical therapist, provided to a client or a client's family as part of a coordinated program consistent with the standards and rules adopted under this chapter. These services include palliative care for terminally ill clients and support services for clients and their families that:

(A) are available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement;

(B) are provided by a medically directed interdisciplinary team; and

(C) may be provided in a home, nursing facility, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client. For the purposes of this definition, the word "home" includes a person's "residence" as defined in this section.

(54) IDR--Informal dispute resolution. An informal process that allows an agency to refute a violation or condition-level deficiency cited during a survey.

(55) Independent living environment--A client's residence, which may include a group home, foster home, or boarding home facility, or other settings where a client participates in activities, including school, work, or church.

(56) Individual and family choice and control--Individuals and families who express preferences and make choices about how their support service needs are met.

(57) Individualized service plan--A written plan prepared by the appropriate health care personnel for a client of a home and community support services agency licensed to provide personal assistance services.

(58) Inpatient unit--A facility, also referred to as a hospice freestanding inpatient facility, that provides a continuum of medical or nursing care and other hospice services to clients admitted into the unit and that is in compliance with:

(A) the conditions of participation for inpatient units adopted under Social Security Act, Title XVIII (42 United States Code §1395 et seq.); and

(B) standards adopted under this chapter.

(59) JCAHO--Joint Commission on Accreditation of Healthcare Organizations. An independent, nonprofit organization for standard-setting and accrediting in-home care and other areas of health care.

(60) Joint training--Training provided by DADS at least semi-annually for home and community support services agencies and DADS surveyors on subjects that address the 10 most commonly cited violations of federal or state law by home and community support services agencies as published in DADS annual reports.

(61) LAR--Legally authorized representative. A person authorized by law to act on behalf of a client with regard to a matter described in this chapter, and may include a parent of a minor, guardian of an adult or minor, managing conservator of a minor, agent under a medical power of attorney, or surrogate decision-maker under Texas Health and Safety Code, §313.004.

(62) Licensed vocational nurse--A person who is currently licensed under Texas Occupations Code, Chapter 301, as a licensed vocational nurse.

(63) Life Safety Code (also referred to as NFPA 101)--The Code for Safety to Life from Fire in Buildings and Structures, Standard 101, of the National Fire Protection Association (NFPA).

(64) Local emergency management agencies--The local emergency management coordinator, fire, police, and emergency medical services.

(65) Local emergency management coordinator-- The person identified as the emergency management coordinator by the mayor or county judge in an agency's service area.

(66) Manager--An employee or independent contractor responsible for providing management services to a home and community support services agency for the overall operation of a home and community support services agency including administration, staffing, or delivery of services. Examples of contracts for services that will not be considered contracts for management services include contracts solely for maintenance, laundry, or food services.

(67) Medication administration record--A record used to document the administration of a client's medications.

(68) Medication list--A list that includes all prescription and over-the-counter medication that a client is currently taking, including the dosage, the frequency, and the method of administration.

(69) Mitigation--An action taken to eliminate or reduce the probability of a disaster, or reduce a disaster's severity or consequences.

(70) Multiple location--A Medicare-approved alternate delivery site that meets the definition in 42 CFR §418.3.

(71) Notarized copy--A sworn affidavit stating that attached copies are true and correct copies of the original documents.

(72) Nursing facility--An institution licensed as a nursing home under the Texas Health and Safety Code, Chapter 242.

(73) Nutritional counseling--Advising and assisting individuals or families on appropriate nutritional intake by integrating information from the nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status, with the goal being health promotion, disease prevention, and nutrition education. Nutritional counseling may include the following:

(A) dialogue with the client to discuss current eating habits, exercise habits, food budget, and problems with food preparation;

(B) discussion of dietary needs to help the client understand why certain foods should be included or excluded from the client's diet and to help with adjustment to the new or revised or existing diet plan;

(C) a personalized written diet plan as ordered by the client's physician or practitioner, to include instructions for implementation;

(D) providing the client with motivation to help the client understand and appreciate the importance of the diet plan in getting and staying healthy; or

(E) working with the client or the client's family members by recommending ideas for meal planning, food budget planning, and appropriate food gifts.

(74) Occupational therapist--A person who is currently licensed under the Occupational Therapy Practice Act, Texas Occupations Code, Chapter 454, as an occupational therapist.

(75) Operating hours--The days of the week and the hours of day an agency's place of business is open as identified in an agency's written policy as required by §97.210 of this chapter (relating to Agency Operating Hours).

(76) Original active client record--A record composed first-hand for a client currently receiving services.

(77) Palliative care--Intervention services that focus primarily on the reduction or abatement of physical, psychosocial, and spiritual symptoms of a terminal illness. It is client and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating client autonomy, access to information, and choice.

(78) Parent agency--An agency that develops and maintains administrative controls and provides supervision of branch offices and alternate delivery sites.

(79) Parent company--A person, other than an individual, who has a direct 100 percent ownership interest in the owner of an agency.

(80) Person--An individual, corporation, or association.

(81) Person with a disclosable interest--Any person who owns at least a 5.0 percent interest in any corporation, partnership, or other business entity that is required to be licensed under Texas Health and Safety Code, Chapter 142. A person with a disclosable interest does not include a bank, savings and loan, savings bank, trust company, building and loan association, credit union, individual loan and thrift company, investment banking firm, or insurance company, unless these entities participate in the management of the agency.

(82) Personal assistance services--Routine ongoing care or services required by an individual in a residence or independent living environment that enable the individual to engage in the activities of daily living or to perform the physical functions required for independent living, including respite services. The term includes:

(A) personal care;

(B) health-related services performed under circumstances that are defined as not constituting the practice of professional nursing by the Texas Board of Nursing through a memorandum of understanding with DADS in accordance with Texas Health and Safety Code, §142.016; and

(C) health-related tasks provided by unlicensed personnel under the delegation of a registered nurse or that a registered nurse determines do not require delegation.

(83) Personal care--The provision of one or more of the following services required by an individual in a residence or independent living environment:

(A) bathing;

(B) dressing;

(C) grooming;

(D) feeding;

(E) exercising;

(F) toileting;

(G) positioning;

(H) assisting with self-administered medications;

(I) routine hair and skin care; and

(J) transfer or ambulation.

(84) Pharmacist--A person who is licensed to practice pharmacy under the Texas Pharmacy Act, Texas Occupations Code, Chapter 558.

(85) Pharmacy--A facility defined in the Texas Occupations Code, §551.003(31), at which a prescription drug or medication order is received, processed, or dispensed.

(86) Physical therapist--A person who is currently licensed under Texas Occupations Code, Chapter 453, as a physical therapist.

(87) Physician--This term includes a person who is:

(A) licensed in Texas to practice medicine or osteopathy in accordance with Texas Occupations Code, Chapter 155;

(B) licensed in Arkansas, Louisiana, New Mexico, or Oklahoma to practice medicine, who is the treating physician of a client and orders home health or hospice services for the client, in accordance with the Texas Occupations Code, §151.056(b)(4); or

(C) a commissioned or contract physician or surgeon who serves in the United States uniformed services or Public Health Service if the person is not engaged in private practice, in accordance with the Texas Occupations Code, §151.052(a)(8).

(88) Physician assistant--A person who is licensed under the Physician Assistant Licensing Act, Texas Occupations Code, Chapter 204, as a physician assistant.

(89) Physician-delegated task--A task performed in accordance with the Texas Occupations Code, Chapter 157, including orders signed by a physician that specify the delegated task, the individual to whom the task is delegated, and the client's name.

(90) Place of business--An office of a home and community support services agency that maintains client records or directs home health, hospice, or personal assistance services. This term includes a parent agency, a branch office, and an alternate delivery site. The term does not include an administrative support site.

(91) Plan of care--The written orders of a practitioner for a client who requires skilled services.

(92) Practitioner--A person who is currently licensed in a state in which the person practices as a physician, dentist, podiatrist, or a physician assistant, or a person who is a registered nurse registered with the Texas Board of Nursing as an advanced practice nurse.

(93) Preparedness--Actions taken in anticipation of a disaster.

(94) Presurvey conference--A conference held with DADS staff and the applicant or the applicant's representatives to review licensure standards and survey documents, and to provide consultation before the survey.

(95) Progress note--A dated and signed written notation by agency personnel summarizing facts about care and the client's response during a given period of time.

(96) Psychoactive treatment--The provision of a skilled nursing visit to a client with a psychiatric diagnosis under the direction of a physician that includes one or more of the following:

(A) assessment of alterations in mental status or evidence of suicide ideation or tendencies;

(B) teaching coping mechanisms or skills;

(C) counseling activities; or

(D) evaluation of the plan of care.

(97) Recovery--Activities implemented during and after a disaster response designed to return an agency to its normal operations as quickly as possible.

(98) Registered nurse delegation--Delegation by a registered nurse in accordance with:

(A) 22 TAC Chapter 224 (concerning Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); and

(B) 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).

(99) Residence--A place where a person resides, including a home, a nursing facility, a convalescent home, or a residential unit.

(100) Residential unit--A facility that provides living quarters and hospice services to clients admitted into the unit and that is in compliance with standards adopted under the Texas Health and Safety Code, Chapter 142.

(101) Respiratory therapist--A person who is currently licensed under Texas Occupations Code, Chapter 604, as a respiratory care practitioner.

(102) Respite services--Support options that are provided temporarily for the purpose of relief for a primary caregiver in providing care to individuals of all ages with disabilities or at risk of abuse or neglect.

(103) Response--Actions taken immediately before an impending disaster or during and after a disaster to address the immediate and short-term effects of the disaster.

(104) Restraint--A restraint is:

(A) a manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client in a hospice inpatient unit to move his or her arms, legs, body, or head freely, but does not include a device, such as an orthopedically prescribed device, a surgical dressing or bandage, a protective helmet, or other method that involves the physical holding of the client for the purpose of:

(i) conducting a routine physical examination or test;

(ii) protecting the client from falling out of bed; or

(iii) permitting the client to participate in activities without the risk of physical harm, not including a physical escort; or

(B) a drug or medication when used as a restriction to manage a client's behavior or restrict the client's freedom of movement in a hospice inpatient unit, but not as a standard treatment or medication dosage for the client's condition.

(105) RN--Registered nurse. A person who is currently licensed under the Nursing Practice Act, Texas Occupations Code, Chapter 301, as a registered nurse.

(106) Seclusion--The involuntary confinement of a client alone in a room or an area in a hospice inpatient unit from which the client is physically prevented from leaving.

(107) Section--A reference to a specific rule in this chapter.

(108) Service area--A geographic area established by an agency in which all or some of the agency's services are available.

(109) Skilled services--Services in accordance with a plan of care that require the skills of:

(A) a registered nurse;

(B) a licensed vocational nurse;

(C) a physical therapist;

(D) an occupational therapist;

(E) a respiratory therapist;

(F) a speech-language pathologist;

(G) an audiologist;

(H) a social worker; or

(I) a dietitian.

(110) Social worker--A person who is currently licensed as a social worker under Texas Occupations Code, Chapter 505.

(111) Speech-language pathologist--A person who is currently licensed as a speech-language pathologist under Texas Occupations Code, Chapter 401.

(112) Statute--The Texas Health and Safety Code, Chapter 142.

(113) Substantial compliance--A finding in which an agency receives no recommendation for enforcement action after a survey.

(114) Supervised practical training--Hospice aide training that is conducted in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual. The training is supervised by a registered nurse or by a licensed vocational nurse who works under the direction of a registered nurse.

(115) Supervising nurse--The person responsible for supervising skilled services provided by an agency and who has the qualifications described in §97.244(c) of this chapter (relating to Administrator Qualifications and Conditions and Supervising Nurse Qualifications). This person may also be known as the director of nursing or similar title.

(116) Supervision--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity.

(117) Support services--Social, spiritual, and emotional care provided to a client and a client's family by a hospice.

(118) Survey--An on-site inspection or complaint investigation conducted by a DADS representative to determine if an agency is in compliance with the statute and this chapter or in compliance with applicable federal requirements or both.

(119) Terminal illness--An illness for which there is a limited prognosis if the illness runs its usual course.

(120) Unlicensed person--A person not licensed as a health care provider. The term includes home health aides, hospice aides, hospice homemakers, medication aides permitted by DADS, and other unlicensed individuals providing personal care or assistance in health services.

(121) Unsatisfied judgments--A failure to fully carry out the terms or meet the obligation of a court's final disposition on the matters before it in a suit regarding the operation of an agency.

(122) Violation--A finding of noncompliance with this chapter or the statute resulting from a survey.

(123) Volunteer--An individual who provides assistance to a home and community support services agency without compensation other than reimbursement for actual expenses.

(124) Working day--Any day except Saturday, Sunday, a state holiday, or a federal holiday.

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

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SUBCHAPTER E. LICENSURE SURVEYS
DIVISION 2. THE SURVEY PROCESS

40 TAC §97.527

The amendment is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS, and Texas Health and Safety Code, §142.0011 which authorizes the HHSC executive commissioner to adopt rules relating to the licensing and regulation of home and community support services agencies.

§97.527. Post-Survey Procedures.

(a) After a survey is completed, the surveyor holds an exit conference with the administrator or alternate administrator to inform the agency of the preliminary findings.

(b) An agency may make an audio recording of the exit conference only if the agency:

(1) records two tapes simultaneously;

(2) allows the surveyor to review the tapes; and

(3) gives the surveyor the tape of the surveyor's choice before leaving the agency.

(c) An agency may make a video recording of the exit conference only if the surveyor agrees to allow it and if the agency:

(1) records two tapes simultaneously;

(2) allows the surveyor to review the tapes; and

(3) gives the surveyor the tape of the surveyor's choice before leaving the agency.

(d) An agency may submit additional written documentation and facts after the exit conference only if the agency describes the additional documentation and facts to the surveyor during the exit conference.

(1) The agency must submit the additional written documentation and facts to the designated survey office within two working days after the end of the exit conference.

(2) If an agency properly submits additional written documentation, the surveyor may add the documentation to the record of the survey.

(e) If DADS identifies additional violations or deficiencies after the exit conference, DADS holds an additional face-to-face exit conference with the agency regarding the additional violations or deficiencies.

(f) DADS provides official written notification of the survey findings to the agency within 10 working days after the exit conference.

(g) The official written notification of the survey findings includes a statement of violations, condition-level deficiencies, or both, cited by DADS against the agency as a result of the survey, and instructions for submitting an acceptable plan of correction, and for requesting IDR.

(1) If the official written notification of the survey findings declares that an agency is in violation of the statute or this chapter, an agency must follow DADS instructions included with the statement of violations for submitting an acceptable plan of correction.

(2) An acceptable plan of correction includes the corrective measures and time frame with which the agency must comply to ensure correction of a violation. If an agency fails to correct each violation by the date on the plan of correction, DADS may take enforcement action against the agency. An agency must correct a violation in accordance with the following time frames:

(A) A Severity Level B violation that results in serious harm to or death of a client or constitutes a serious threat to the health or safety of a client must be addressed upon receipt of the official written notice of the violations and corrected within two days.

(B) A Severity Level B violation that substantially limits the agency's capacity to provide care must be corrected within seven days after receipt of the official written notice of the violations.

(C) A Severity Level A violation that has or had minor or no health or safety significance must be corrected within 20 days after receipt of the official written notice of the violations.

(D) A violation that is not designated as Severity Level A or Severity Level B must be corrected within 60 days after the date the violation was cited.

(3) An agency must submit an acceptable plan of correction for each violation or deficiency no later than 10 days after its receipt of the official written notification of the survey findings.

(4) If DADS finds the plan of correction unacceptable, DADS gives the agency written notice and provides the agency one additional opportunity to submit an acceptable plan of correction. An agency must submit a revised plan of correction no later than 30 days after the agency's receipt of DADS written notice of an unacceptable plan of correction.

(h) An acceptable plan of correction does not preclude DADS from taking enforcement action against an agency.

(i) An agency must submit a plan of correction in response to an official written notification of survey findings that declares a violation or deficiency even if the agency disagrees with the survey findings.

(j) If an agency disagrees with the survey findings citing a violation or condition-level deficiency, the agency may request IDR to refute the violation or deficiency.

(1) DADS does not grant an agency's request for IDR if:

(A) DADS cited the violation or deficiency at the agency's immediately preceding survey; and

(B) DADS cited the violation or deficiency again, with no new findings.

(2) To request IDR, an agency must:

(A) mail or fax a complete and accurate IDR request form to the address or fax number listed on the form, which must be postmarked or faxed within 10 days after the date of receipt of the official written notification of the survey findings;

(B) mail or fax a rebuttal letter and supporting documentation to the address or fax number listed on the IDR request form and ensure receipt by the DADS Survey and Certification Enforcement Unit within seven days after the postmark or fax date of the IDR request form; and

(C) mail or fax a copy of the IDR request form, rebuttal letter, and supporting documentation to the designated survey office within the same time frames each is submitted to the DADS Survey and Certification Enforcement Unit.

(3) An agency may not submit information after the deadlines established in paragraph (2)(A) and (B) of this subsection unless DADS requests additional information. The agency's response to DADS request for information must be received within three working days after the request is made.

(4) An agency waives its right to IDR if the agency fails to submit the required information to the DADS Survey and Certification Enforcement Unit within the required time frames.

(5) An agency must present sufficient information to the DADS Survey and Certification Enforcement Unit to support the agency's desired IDR outcome.

(6) The rebuttal letter and supporting documentation must include:

(A) identification of the disputed deficiencies or violations;

(B) the reason the deficiencies or violations are disputed;

(C) the desired outcome for each disputed deficiency or violation; and

(D) copies of client records, policies and procedures, and other documentation and information that directly demonstrate that the condition-level deficiency or violation should not have been cited.

(7) The written decision issued by DADS after the completion of its review is the final decision from IDR.

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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