(1) the date on which the student ceases to be enrolled at least half-time at an eligible institution, for borrowers enrolled in credential programs measured in semester credit hours; or

(2) the anticipated graduation date certified by the institution of higher education on the loan application, for borrowers enrolled in programs that are not measured in semester credit hours.

(c) Monthly repayment amount. The method for calculating the monthly repayment amount for loans through this Program shall be determined annually by the Commissioner, and shall be calculated annually based on:

(1) the borrower's income, as demonstrated through federal income tax returns or other documentation determined to be acceptable by Board staff;

(2) the borrower's monthly accrued interest on loans through the Program; and

(3) the borrower's cumulative outstanding student loan principal balance.

(d) Income threshold. Borrowers may be automatically placed in forbearance when the demonstrated income is below a threshold established by Board staff in consultation with the Texas Workforce Commission.

§22.187. Deceased or Disabled Borrowers and Cosigners.

(a) Upon final verification of the death or determination of permanent and total disability of a borrower, all loans through the Program shall be discharged unless there is a judgment against the borrower and the Commissioner determines that a release of the borrower's liability is not in the best interest of the Program.

(b) Verification of death and determination of permanent and total disability of a borrower or cosigner through the Program shall be made in accordance with the governing provisions of the Federal Direct Loan Program.

(c) The final verification of death and determination of permanent and total disability of a borrower or cosigner shall be made by Board Staff.

(d) Upon final verification of the death or determination of permanent and total disability of a borrower, the liability of the cosigner for that borrower shall be discharged.

(e) Upon final verification of the death or determination of permanent and total disability of a cosigner, Board Staff shall determine if the release of the liability of the cosigner is in the best interest of the loan program and, if so, shall authorize a release of the cosigner's liability, whether or not there is a judgment against the cosigner.

§22.188. Enforcement of Collection.

When any borrower or cosigner fails or refuses to make as many as five monthly payments due in accordance with an executed note through the Program, the full amount of remaining principal, accrued interest, and other charges shall become due and payable immediately. When as many as six payments have been missed, the loan will be considered in default, and the Office of the Attorney General may file suit for the outstanding balance.

§22.189. Delegation.

The board delegates to the Commissioner the powers, duties, and functions authorized by the Act, necessary to carry out this subchapter, except those relating to the sale of bonds and the letting of contracts for insurance.

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 December 12, 2022.

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General Counsel
Texas Higher Education Coordinating Board
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Proposal publication date: October 7, 2022
For further information, please call: (512) 427-6365

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 133. HOSPITAL LICENSING
SUBCHAPTER K. HOSPITAL LEVEL OF CARE DESIGNATIONS FOR MATERNAL CARE

25 TAC §§133.201 - 133.211

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), adopts amendments to §133.201, concerning Purpose; §133.202, concerning Definitions; §133.203, concerning General Requirements; §133.204, concerning the Designation Process; §133.205, concerning Program Requirements; §133.206, concerning Maternal Designation Level I; §133.207, concerning Maternal Designation Level II; §133.208, concerning Maternal Designation Level III; §133.209, concerning Maternal Designation Level IV; §133.210, concerning the Survey Team; and new §133.211 concerning the Perinatal Care Regions.

The amendments to §§133.202 - 133.210 are adopted with changes to the proposed text as published in the July 8, 2022, issue of the *Texas Register* (47 TexReg 3888) and the sections will be republished. Sections 133.201 and 133.211 are adopted without changes and will not be republished.

BACKGROUND AND JUSTIFICATION

The adoption updates the content and processes with the advances and practices since the rules were adopted in 2018. Senate Bill (S.B.) 749, 86thLegislature, Regular Session, 2019, amended Texas Health and Safety Code, Chapter 241. S.B. 749 requires language specific to waiver agreements, a three-person appeal panel for designation reviews, and language specific to telemedicine and telehealth be integrated into the maternal rules.

House Bill (H.B.) 1164, 87th Legislature, Regular Session, 2021, amended Texas Health and Safety Code, Chapter 241. H.B. 1164 added statutes concerning patient safety practices for placenta accreta spectrum disorder (PASD) in hospitals with maternal levels of care designation. As part of the standards for designation, hospitals must implement patient safety practices for screening, evaluation, diagnosis, treatment, management, and reporting of PASD for all maternal patients and integrate these

measures into their maternal Quality Assessment and Performance Improvement (QAPI) Plan.

DSHS worked in collaboration with the Perinatal Advisory Council's (PAC) subcommittee assigned to address the PASD patient safety practices. The PAC used data collected by DSHS in its analysis and recommendations. The PAC considered recommendations and publications of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, including the publication "Guidelines for Perinatal Care." The PAC reviewed guidelines by the Society of Maternal-Fetal Medicine, the geographic and varied needs of citizens of this state, and the patient safety practices adopted under Texas Health and Safety Code §241.1837. The PAC and DSHS solicited comments from physicians who practice in the evaluation, diagnosis, treatment, and management of placenta accreta spectrum disorder; other health professionals who practice in the evaluation, diagnosis, treatment, and management of placenta accreta spectrum disorder; health researchers with expertise in placenta accreta spectrum disorder; representatives of patient advocacy organizations; and other interested persons during the rule development.

A similar PAC subcommittee addressed the rule language specific to integrating the telehealth and telemedicine into the maternal rules.

The PAC formed a workgroup to collaborate with DSHS staff to review the comments received and determine the most appropriate language to ensure the health and safety of pregnant patients and prevent any unnecessary burden on the facilities providing maternal care.

COMMENTS

During the 31-day comment period, DSHS received comments from seventeen commenters, including the Texas Hospital Association (THA); Teaching Hospitals of Texas (THOT) representing sixteen hospitals; University of Texas Medical Branch at Galveston (UTMB); Baylor Scott & White Health (BSWH); Covenant Children's Hospital; Texas Health Resources; Texas EMS, Trauma and Acute Care Foundation (TETAF)/Texas Perinatal Services; Steward Family Hospitals; Texas Medical Association (TMA) representing four additional physician organizations; Sage Family Medicine Associates; Texas Association of Obstetricians and Gynecologists District XI; Children's Hospital of San Antonio; Women's Hospital at Renaissance; and four individuals. The Texas Association of Obstetrician and Gynecologists District XI submitted separate comments in addition to the TMA letter. A summary of comments relating to the rules and DSHS's responses follows.

Comment: Five commenters requested DSHS to evaluate and consider changing the use of "shall" versus "must" in the amended rule language.

Response: DSHS acknowledges the comments. DSHS followed rule writing guidelines and there is no change to the rules in response to this comment.

Comment: Three commenters requested DSHS consider a state-wide database for perinatal information and patient outcomes.

Response: DSHS acknowledges the comments and declines to revise the rule language. DSHS does not have the legislative authority to develop and maintain a state-wide registry or database for perinatal care.

Comment: Four commenters recommended allowing the Regional Advisory Council (RAC)-PCR Alliance to develop and define maternal QAPI review "triggers" with the rules to serve as guidelines for our maternal facilities.

Response: DSHS disagrees and declines to revise the rules. The triggers will be defined by DSHS in collaboration with the PAC and stakeholders.

Comment: Five commenters recommended adding language that defines the required staff to address the additional screening for PASD, QAPI plan activities, and the compiling of data requirements.

Response: DSHS disagrees and declines to revise the rule. There are no staffing standards or recommendations at the national level to define the staff required for these requirements.

Comment: Five commenters recommended DSHS provide written notification to facilities of their requirements not met during the survey process and provide an opportunity for correction.

Response: DSHS disagrees and declines to revise the rules. DSHS meets with the facility to discuss requirements not met and develops a corrective action plan with the facility.

Comment: One commenter recommended facilities be designated as "accreta centers," separate from Level IV Maternal Designation.

Response: DSHS disagrees and declines to revise the rules. Legislation does not authorize designation for accreta centers in Texas.

Comment: One commenter requested DSHS allow a designated Level IV maternal facility to transfer maternal patients for highly specialized services unavailable at their facility to a facility with appropriate services, but not a designated maternal center and for children's hospitals providing maternal services to have exceptions on transfer requirements.

Response: DSHS disagrees and declines to revise the rules at this time. This will be evaluated for future rule amendments.

Comment: §133.202(5): Four commenters recommended adding "medical" to the definition for "board-eligible."

Response: DSHS agrees and modifies the language to include "medical" in the definition.

Comment: §§133.202(6), 133.202(19), 133.203(d), 133.203(e), and 133.205(b)(3)(F): Two commenters recommended replacing the word "compliance" with "met" or "meeting."

Response: DSHS agrees and modifies the language.

Comment: §133.202(13): Two commenters recommended the definition for "immediately" include available, as in "immediately available. "

Response: DSHS disagrees and declines to revise the rule language in response to this comment, as "available" is defined in the rules.

Comment: §133.202(13): Four commenters recommended the definition for "immediately" be "able to respond without delay as in STAT."

Response: DSHS agrees and modifies the language.

Comment: §133.202(13): Four commenters recommended removing "or near, as in location" from the definition for "immediately."

Response: DSHS agrees and revises the language.

Comment: §§133.202(19), 133.205(b)(1), 133.205(b)(3)(C), 133.205(b)(3)(F), and 133.205(b)(3)(G): Forty commenters stated the definition of "Maternal Oversight Committee" is burdensome and excessively prescriptive and requested it be deleted or revised.

Response: DSHS accepts the recommendation, and the language is revised to "Maternal Program Oversight" for this subchapter. This change allows for program flexibility.

Comment: §133.202(21) and §133.202(22): Two commenters recommended a space between Medical and Director, and between Program and Manager.

Response: DSHS disagrees and declines to revise the rule language because the space is present in the published proposed rule language.

Comment: §133.202(25): One commenter recommended adding "or near" to the "on-site" definition to avoid unnecessarily excluding physicians located nearby the facility who are still able to meet the time frame for urgent requests.

Response: DSHS disagrees and declines to revise the rule language. Section 133.202(39) defines "urgent" as capable of arriving within 30 minutes. Section 133.202(13) is being revised to define "immediately" as able to respond without delay, commonly referred to as STAT.

Comment: §133.202(25): Two commenters recommended deleting "rapidly" to the definition for "on-site."

Response: DSHS agrees and modifies the language.

Comment: §133.202(25): One commenter requested additional clarification of the definition "on-site."

Response: DSHS acknowledges this comment but declines to revise the rule in response to this comment.

Comment: §133.202(32): Two commenters stated the language provides good definitions for QAPI.

Response: DSHS appreciates the comments, and no change is necessary.

Comments: §133.203(f)(2)(A): Two commenters stated the language had words spelled incorrectly.

Response: DSHS declines to revise the rule as the words were spelled correctly in the published proposed rule language.

Comments: §§133.203(f)(3)(G) and (f)(4)(I), 133.208(a)(7), and 133.209(a)(9): Fifteen commenters stated the proposed language limits the outreach education to only findings in the QAPI Plan and process.

Response: DSHS agrees and revises the language to provide additional opportunities for outreach education.

Comment: §133.203(f)(4)(F) and §133.209(a)(6): Three commenters requested clarification on privileges for the Level IV PASD multidisciplinary care team members to clarify screening and to add "including postpartum care."

Response: DSHS agrees and revises the language to remove privileges and add "risk factor" screening and "including postpartum care" to the requirement.

Comment: §133.203(g)(5): One commenter recommended revising the language to allow DSHS to determine if requirements were met in the event a facility may fail to provide access to records it may not be aware of and to avoid unintentional consequences.

Response: DSHS agrees and revises the language.

Comment: §133.203(g)(5): One commenter recommended removing the provision for access by DSHS and surveyors to maternal patient records.

Response: DSHS disagrees and declines to revise the rule in response to this comment. The medical record is written evidence of the care provided to maternal patients.

Comment: §133.203(g)(5) and §133.204(v): Seven commenters identified concerns regarding access to peer review information by DSHS and survey organizations due to statutory confidentiality.

Response: DSHS agrees and removes the language from §133.203(g)(5) and §133.204(v).

Comment: §133.203(h): Two commenters thanked DSHS for a clear and reasonable conflict of interest criteria for surveyors.

Response: DSHS appreciates the comments, and no change is necessary.

Comment: §133.204(a)(1)(B): One commenter recommended instituting a site survey requirement for Level I maternal facilities.

Response: DSHS declines to revise the language, which would impose an additional burden on the small, rural hospitals providing perinatal services. Level I facilities currently perform a self-survey and attestation for designation.

Comment: §133.204(a)(1)(C): Two commenters recommended replacing the word "call" with "contact."

Response: DSHS agrees and revises the rule as recommended.

Comment: §133.204(a)(1)(C): Two commenters recommended allowing 10 business days for a facility to call DSHS to discuss a plan of correction if the facility has three or more DSHS-approved designation requirements that are defined as not met.

Response: DSHS agrees and revises the language to 10 business days.

Comment: §133.204(a)(1)(D)(vi): Three commenters recommended to add language specifically to extend the 90 days for a facility to demonstrate improvement in the Plan of Correction (POC).

Response: DSHS appreciates the comments and declines to revise the rule. The rule language was revised before the proposed rule was published in the July 8, 2022, issue of the *Texas Register.* The published language is "documented evidence that the POC was implemented within 90 days of the designation survey" replacing demonstrated improvement.

Comment: §133.204(c): Three commenters recommended deleting the language related to a change of ownership or change in physical location requirement.

Response: DSHS disagrees and declines to revise the rule. Re-designating ensures the commitment and the requirements for designation continue to be met.

Comment: §133.204(e): Two commenters recommended revising "being approved for" to "a final decision is rendered regarding."

Response: DSHS agrees and revises the language to state, "The facility has the right to withdraw its application for maternal designation any time before a designation approval."

Comments: §133.204(k)(1): Three commenters suggested allowing facilities to post the maternal designation status on their facility website and not posting it in a public area in the hospital.

Response: DSHS disagrees and declines to revise the rule. A certificate posted in the facility allows staff, patients, and visitors to view the document. Facility designation may be posted on the facility website, in addition to posting in the facility.

Comment: §133.204(o): Two commenters recommended adding language from S.B. 749 that DSHS provide written explanation regarding the specific reasons that prevented the hospital from receiving a higher level of care designation.

Response: DSHS disagrees to revise the language to include the specific reasons that prevented a hospital from receiving the higher level of designation. DSHS makes a change to clarify the language to "provide written notification" instead of "will notify the facility" of the designation requirements in §133.204(o) and (p).

Comment: §133.204(p): Two commenters recommended the word "guide" be removed and the language be revised for a Corrective Action Plan.

Response: DSHS agrees and revises the language.

Comment: §133.204(q) Two commenters recommended adding "designation" to the requirement for clarification.

Response: DSHS agrees and revises the language to include "designation."

Comment: §133.204(q): One commenter recommended allowing the new process for rule waiver and appeals be available for current designated facilities outside of the 30-day window and not be required to wait a 3-year period to file an appeal.

Response: DSHS acknowledges the comment and declines to revise the rule. An appeal process is currently in place. DSHS currently works with facilities to address requirements not met.

Comment: §133.204(q): Two commenters stated the appeal process seems to be well-structured, clear and fair.

Response: DSHS appreciates the comments, and no change is necessary.

Comments: §133.204(r)(2)(C): Four commenters shared concerns that the waiver language is not reflective of the S.B. 749 language making the rules more restrictive. It is recommended to use statute language in the rule.

Response: DSHS agrees and revises the rule language to reflect the S.B. 749 language.

Comment: §133.204(w) and §133.210(e): Two commenters recommended survey organizations be included in the language regarding complying with all relevant law related to the confidentiality of all facility information reviewed.

Response: DSHS agrees and revises the language.

Comment: §133.205(b)(1): Two commenters recommended the facility's governing body must review and approve the Maternal Program Plan.

Response: DSHS agrees and revises the rule.

Comment: §133.205(b)(2)(E) and §133.205(b)(2)(E)(ii): Sixteen commenters stated facilities may interpret the requirement as mandating telehealth and telemedicine services.

Response: DSHS agrees and modifies the language to include "if utilized."

Comment: §133.205(b)(2)(E)(i): Two commenters requested DSHS clarify that consultation is for inpatient care only.

Response: DSHS agrees and modifies the language to include "inpatient."

Comment: §133.205(b)(2)(E)(i): Two commenters requested DSHS clarify that the telehealth and telemedicine language does not include physician-to-physician discussions.

Response: DSHS disagrees and declines to amend the rule because the definitions in §133.202(36) and (37) are sufficient to address the concern. The telehealth and telemedicine definitions in Texas Occupations Code Chapter 111, reflect it is a healthcare service delivered by a physician or healthcare professional to a patient in a different physical location.

Comment: §133.205(b)(2)(G): Three commenters requested the evaluation of a facility's disaster preparedness and evacuation plan be extended to every three years instead of annually.

Response: DSHS disagrees and declines to revise the rule since many internal operations and individuals may change in three years.

Comment: §133.205(b)(2)(G): Two commenters stated the requirement is much clearer now in the rule language.

Response: DSHS appreciates the comments, and no change is necessary.

Comment: §133.205(b)(3)(A): Three commenters recommended removing the requirement for the Chief Executive Officer, Chief Medical Officer, and Chief Nursing Officer to implement a culture of safety and to ensure adequate resources to support the QAPI Plan, stating it is unnecessary.

Response: DSHS disagrees and declines to revise language. The commitment of facility administration is required for the success of a designation program and patient safety.

Comment: §133.205(b)(3)(A): Two commenters requested the addition of "are allocated" and "maternal" for clarification.

Response: DSHS agrees and modifies the language and also removes the words "are available."

Comment: §133.205(b)(3)(F): Two commenters recommended the word "compliance" be revised to "met" or "meeting."

Response: DSHS agrees and revises the language.

Comment: §133.205(b)(3)(F): Five commenters recommended removing "standards of care," which may be confusing for facilities. The commenters recommended additional language to clarify that telemedicine and telehealth services are not mandatory.

Response: DSHS agrees to revise the language.

Comment: §133.205(b)(3)(F): Three commenters recommended that the telemedicine and telehealth requirement need a distinction between medical and behavioral health encounters for tracking and summary reports.

Response: DSHS disagrees and declines to revise the rule. Both encounters for maternal patients managed in the hospital need to be tracked and reported.

Comment: §133.205(d): One commenter recommended adding language that allows the identified Maternal Medical Director to delegate responsibilities to a qualified individual or committee.

Response: DSHS disagrees and declines to revise the rule. The facility Maternal Medical Director responsibilities cannot be delegated.

Comment: §133.205(d)(7) and §133.205(e)(5): Two commenters requested to remove the Maternal Medical Director's requirement to co-chair the Maternal Oversight Committee.

Response: DSHS agrees and removes co-chairing in §133.205(d)(7). The language for the Maternal Oversight Committee definition is revised. The language is modified to Maternal Program Oversight in §133.205(d)(7) and §133.205(e)(5).

Comment: §133.205(d)(7) and §133.205(e)(5): Four commenters recommended removing the Maternal Medical Director's requirement to co-chair the Maternal Oversight Committee and change it to "providing leadership and input to."

Response: DSHS agrees and revises the language to frequently leading and participating for the Maternal Medical Director and Maternal Program Manager in addition to the revision regarding Maternal Oversight Committee.

Comment: §133.206(c)(3): Six commenters recommended clarifying that the Level I Obstetrics and Gynecology (OB/Gyn) physician be available at all times for consultation.

Response: DSHS agrees and revises the language.

Comment: §133.206(c)(6) and §133.207(c)(3): Three commenters recommended the inclusion of family medicine physicians in the Level I and Level II requirements.

Response: DSHS agrees and revises the language.

Comment: §§133.206(c)(11)(C), 133.207(c)(14)(C), 133.208(d)(20)(C), and 133.209(d)(19)(C): Five commenters recommended the obstetrical support services, such as anesthesia and blood bank personnel, be present at the patient's bedside at the outset of a trial of labor after cesarean and allow the managing physician to arrive rapidly to any request instead of "on-site" only.

Response: DSHS disagrees and declines to revise the rules. Blood bank and anesthesia personnel need to be on-site to respond to an emergent condition, but do not need to remain at the patient bedside during the procedure.

Comment: §§133.206(c)(14)(C), 133.207(c)(17)(C), 133.208(d)(23)(C), and 133.209(d)(22)(C): Twenty commenters recommended clarification for "risk factor assessment" to include "evaluation to identify individuals at risk for placenta accreta spectrum disorder."

Response: DSHS agrees and revises the language to "risk factor screening" for clarification.

Comment: §§133.206(c)(14)(C), 133.207(c)(17)(C), 133.208(d)(23)(C), and 133.209(d)(22)(C): Five commenters recommended including language from H.B. 1164 regarding the fostering of telemedicine medical services and including postpartum care.

Response: DSHS agrees and revises the rules.

Comment: §133.207(c)(1)(B): Two commenters stated concerns that including "must" in the rule will "bind them to transferring patients out of their facility" to a higher-level maternal designated facility.

Response: DSHS disagrees; however, DSHS revises the language to clarify it is the managing physician's decision to transfer patients.

Comment: §133.207(c)(3): Two commenters recommended adding language from S.B. 749 noting that facilities utilizing family medicine physicians must have a written plan for responding to obstetrical emergencies requiring services or procedures outside the scope of privileges granted to the family medicine physician and regularly monitoring outcomes in their QAPI.

Response: DSHS agrees and revises the language to add §133.207(c)(4) with the recommended language. The remaining paragraphs in this subsection are renumbered.

Comment: §§133.207(c)(5), 133.208(d)(5) and (15)(C), 133.209(d)(3) and (14)(C): Seven commenters supported the addition of board-eligible physicians in the rules.

Response: DSHS appreciates the comments, and no change is necessary.

Comment: §133.207(c)(12)(C)(i): Two commenters agreed with the removal of platelets for the required blood products.

Response: DSHS appreciates the comments, and no change is necessary.

Comments: §133.208(a)(7) and §133.209(a)(9): Ten commenters stated the proposed language limits the outreach education to only findings in the QAPI Plan and process. The intent was to ensure additional education, not to limit outreach education.

Response: DSHS agrees and revises the language to expand the opportunities for outreach education.

Comment: §133.208(d)(5): Two commenters recommended clarification regarding consultation with the addition of inpatient.

Response: DSHS agrees and revises the language to inpatient consultation.

Comment: §133.208(d)(5): One commenter requested clarification that telemedicine for Maternal Fetal Medicine (MFM) services does not substitute for in-person consultation on complex and critically ill patients. The commenter stated the language imposes a new and undefined standard for the hospitals.

Response: DSHS disagrees and declines to revise the rule. The language allows flexibility for telemedicine utilization while ensuring complex and critically ill maternal patients receive the services and care needed in-person for the best outcomes.

Comment: §133.208(d)(5): One commenter recommended changes to the Level III requirement for the MFM physician to be available at all times and arrive within 30 minutes of an urgent request to co-manage patients. The commenter stated the MFM physician is a consultant and not a proceduralist and does not need to be available at a specific facility and that this requirement would limit hospitals from obtaining a Level III designation.

Response: DSHS disagrees and declines to revise the rule. Section 133.208(d)(5)(A) allows the MFM physician to consult on maternal inpatient care by telemedicine as appropriate for the patient's condition. However, telemedicine cannot be utilized if

the managing physician requests an in-person consultation for a complex or critically ill maternal patient.

Comment: §133.208(d)(5)(A)(iii): Two commenters recommended adding "as needed" to the requirement language.

Response: DSHS agrees and revises the language.

Comment: §133.208(d)(9): Three commenters recommended Level III and Level IV facilities have the option to utilize telemedicine and telehealth to meet the in-person visit requirements for behavioral health services and in-person psychiatrist visits at a Level IV.

Response: DSHS agrees and modifies the language for the Level III facilities to include telemedicine.

Comment: §133.209(d)(1)(B): Two commenters shared concerns regarding language not included to allow the transfer of maternal patients to a non-designated system hospital in close proximity for medical or surgical specialty care not provided in the Level IV maternal designated facility. The hospitals stated they would have to duplicate all advanced services in both hospital system locations, which would be extremely costly, overly burdensome, and inefficient.

Response: DSHS disagrees and declines to revise the rule. The Level IV designated facility must have an adult Intensive Care Unit and critical care capabilities for highly complex and critically ill or unstable maternal patients.

Comment: §133.209(d)(8): Three commenters recommended deleting "to assume responsibility for" from the Level IV PASD team requirement.

Response: DSHS agrees and revises the language as recommended.

Comment: §133.209(d)(8)(A)(iii): Five commenters recommended the surgeon or surgeons with expertise in pelvic, urologic, and gastroenterological surgery be moved to the secondary team of the PASD multidisciplinary team.

Response: DSHS disagrees and declines to revise the rule. The subject matter expert physicians from the PAC workgroup agree that the obstetrics and gynecology physician could have expertise in the pelvic, urologic, and gastroenterological surgery to meet this requirement. A physician with surgical expertise is necessary for patient safety and outcomes.

Comment: §133.209(d)(8)(C)(ii): Two commenters recommended removing "on-site" from the requirement.

Response: DSHS agrees and revises the rule as requested.

Comment: §133.209(d)(8)(D): Two commenters stated the intent of this rule was to have representatives of each component of the PASD team, as opposed to representatives of the primary and secondary PASD response teams to participate. Language was proposed to add representatives "of each component" to the rule.

Response: DSHS agrees and revises the rule.

Comment: §133.209(d)(8)(E): Three commenters requested clarification for "expertise" and "lead" regarding the PASD team requirement.

Response: DSHS acknowledges these comments but declines to revise the rule. The standard dictionary definitions are sufficient.

Comment: §133.209(d)(8)(F) and §133.209(d)(8)(H): One commenter recommended revising the language to correct grammar.

Response: DSHS agrees and revises the language.

Comment: §133.209(d)(9): Three commenters recommended allowing Level III and Level IV facilities to utilize telemedicine and telehealth to meet the in-person visit requirements for behavioral health services and in-person psychiatrist visits at a Level IV.

Response: DSHS disagrees with the Level IV recommendation and declines to revise the language. The requirement that a behavioral health professional be on-site, at all times, for in-person visits, may be met by social services personnel. The language of "available for in-person visits when requested" for the psychiatrist allows the hospital flexibility in meeting the requirement yet ensures the maternal patient with a condition identified by the managing physician as requiring an in-person visit, receives the appropriate management and care.

Comment: §133.210(b): One commenter recommended the language that surveyors cannot be from the same Perinatal Care Region or Trauma Service Area or a contiguous region of the facility's location be removed. The concern is that the requirement will have a negative impact on the Texas hospitals and state-based survey organizations.

Response: DSHS disagrees and declines to revise the rule. DSHS is establishing requirements to limit surveyor conflicts of interest with the hospital undergoing the survey.

DSHS adds §133.202(34) to define "screening" for the new PASD requirements as agreed upon by the PAC workgroup and DSHS. The numbering for definitions is revised to reflect the addition.

DSHS revises §133.203(c) to state that the department "approves" the designation level for each location instead of "determines."

DSHS revises §133.203(d) to ensure that facilities meet the requirements for level designation.

DSHS revises the language in §133.203(g)(5) to state "must provide the survey team access to records and documentation regarding the QAPI Plan and process related to maternal patients."

DSHS revises the language in §133.204(m) to state "The department will approve designation of a facility that demonstrates the requirements are met" for consistency in §133.204.

DSHS revises the language in §133.204(q) to replace the word "determined" with "awarded." The words "recommends" and "will recommend" were added to §133.204(q)(2) and (3). The word "decision" was replaced with "recommendation" in §133.204(q)(2) and (4).

DSHS revises language in §133.205(e)(5) due to the changes in §133.205(d)(7) deleting the Maternal Program Manager from co-chairing the Maternal Oversight Committee (which was changed to Maternal Program Oversight in this adoption).

DSHS adds the word "inpatient" to replace "on-site" consultation and management in §133.209(d)(8)(C)(i). The PAC workgroup and DSHS agrees to change wording to limit the representative's response to inpatients only. The word "on-site" may have been interpreted to include outpatient services also.

DSHS adds "or this subchapter" in §133.210(e) to ensure all information and materials required in the maternal designation

rules, for review by DSHS or a survey organization, are considered confidential under applicable laws.

DSHS revises the word "Confidentially" in Texas Health and Safety Code, §241.184, to "Confidentiality; Privilege" in §133.210(e) to reflect the name of the statute.

STATUTORY AUTHORITY

The amendments and new rule are authorized by Texas Health and Safety Code, Chapter 241, which provides DSHS with authority to recommend rules establishing the levels of care for maternal care, establish a process for assignment or amendment of the levels of care to hospitals, divide the state into perinatal care regions, and facilitate transfer agreements through regional coordination; and by Texas Government Code §531.0055 and Texas Health and Safety Code §1001.075, which authorize the Executive Commissioner of HHSC to adopt rules and policies necessary for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code, Chapter 1001.

§133.202. Definitions.

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

(1) ACLS--Advanced Cardiovascular Life Support. A resuscitation course that was developed and is administered by the American Heart Association.

(2) Antepartum--The period beginning on the date of conception and ending on delivery.

(3) Attestation--A written statement, signed by the chief executive officer of the facility, verifying the results of a self-survey represent a complete and accurate assessment of the facility's capabilities required in this subchapter.

(4) Available--Relating to staff who can be contacted for consultation at all times without delay.

(5) Board-eligible--A physician who has completed a residency or fellowship and is eligible for board certification according to the applicable medical board.

(6) CAP--Corrective Action Plan. A plan for the facility developed by the department that describes the actions required of the facility to correct identified deficiencies to ensure the applicable designation requirements are met.

(7) Department--The Texas Department of State Health Services.

(8) Designation--A formal recognition by the department of a facility's maternal care capabilities and commitment for a period of three years.

(9) EMS--Emergency medical services. Services used to respond to an individual's perceived need for immediate medical care.

(10) Focused Survey--A department-defined modified facility survey by a department-approved survey organization or the department. The specific goal of this survey is to review designation requirements identified as not met to resolve a contingent designation or requirement deficiencies.

(11) Gestational age--The age of a fetus or embryo determined by the amount of time that has elapsed since the first day of the maternal patient's last menstrual period or the corresponding age of the gestation as estimated by a physician through a more accurate method.

(12) High-risk infant--A newborn that has a greater chance of complications because of conditions that occur during fetal development, pregnancy conditions of the mother, or problems that may occur during labor or birth.

(13) Immediately--Able to respond without delay, commonly referred to as STAT.

(14) Infant--A child from birth to one year of age.

(15) Intrapartum--During labor and delivery or childbirth.

(16) Inter-facility transport--Transfer of a patient from one healthcare facility to another healthcare facility.

(17) Lactation consultant--A health care professional who specializes in the clinical management of breastfeeding.

(18) Maternal--Pertaining to the mother.

(19) Maternal Program Oversight--A multidisciplinary process responsible for the administrative oversight of the maternal program and having the authority for approving the defined maternal program's policies, procedures, and guidelines for all phases of maternal care provided by the facility, to include defining the necessary staff competencies, monitoring to ensure maternal designation requirements are met, and the aggregate review of the maternal QAPI initiatives and outcomes. Maternal Program Oversight may be performed through the maternal program's performance improvement committee, multidisciplinary oversight committee, or other structured means.

(20) MFM--Maternal Fetal Medicine.

(21) MMD--Maternal Medical Director.

(22) MPM--Maternal Program Manager.

(23) Neonate--An infant from birth through 28 completed days after.

(24) Obstetrics--Related to pregnancy, childbirth, and the postpartum period.

(25) On-site--At the facility and able to arrive at the patient bedside for urgent requests.

(26) PCR--Perinatal Care Region. The PCRs are established for descriptive and regional planning purposes. The PCRs are geographically divided by counties and are integrated into the existing 22 Trauma Service Areas (TSAs) and the applicable Regional Advisory Council (RAC) of the TSA provided in §157.122 of this title (relating to Trauma Services Areas) and §157.123 of this title (relating to Regional Emergency Medical Services/Trauma Systems).

(27) Perinatal--Of, relating to, or being the period around childbirth, especially the five months before and one month after birth.

(28) PASD--Placenta Accreta Spectrum Disorder. A disorder that includes placenta accreta, placenta increta, and placenta percreta.

(29) POC--Plan of Correction. A report submitted to the department by the facility detailing how the facility will correct any deficiencies cited in the maternal designation site survey summary or documented in the self-attestation.

(30) Premature/prematurity--Birth at less than 37 weeks of gestation.

(31) Postpartum--The six-week period following pregnancy or delivery.

(32) QAPI Plan--Quality Assessment and Performance Improvement Plan. QAPI is a data-driven and proactive approach to qual-

ity improvement. It combines two approaches - Quality Assessment (QA) and Performance Improvement (PI). QA is a process used to ensure services are meeting quality standards and assuring care reaches a defined level. PI is the continuous study and improvement process designed to improve system and patient outcomes.

(33) RAC--Regional Advisory Council as described in §157.123 of this title.

(34) Screening--Evaluation for the presence or absence of a disease or condition.

(35) 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.

(36) Telehealth service--A health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of health professional's license, certification, or entitlement, to a patient at a different physical location than the health professional using telecommunications or information technology as defined in Texas Occupations Code §111.001.

(37) Telemedicine medical service--A health care service delivered by a physician licensed in this state, or health professional acting under the delegation and supervision of a physician licensed in this state and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or technology as defined in Texas Occupations Code §111.001.

(38) TSA--Trauma Service Area as described in §157.122 of this title.

(39) Urgent--Requiring action or attention within 30 minutes of notification.

§133.203. General Requirements.

(a) The department reviews the applicant documents and approves the appropriate level of facility designation.

(b) A facility is defined under this subchapter as a single location where inpatients receive hospital services or each location if there are multiple buildings where inpatients receive hospital services and are covered under a single hospital license.

(c) Each location must be considered separately for designation and the department approves the designation level for each location based on the location's ability to demonstrate designation criteria are met.

(d) The department determines requirements for the levels of maternal designation. Facilities seeking Levels II, III, and IV maternal designation must meet department-approved requirements validated by a department-approved survey organization.

(e) Facilities seeking Level I maternal designation must submit a self-survey and attest to meeting department-approved requirements.

(f) The four levels of maternal designation are:

(1) Level I (Basic Care). The Level I maternal designated facility must:

(A) provide care for pregnant and postpartum patients who are generally healthy and do not have medical, surgical, or obstetrical conditions that present a significant risk of maternal morbidity or mortality; and

(B) have skilled personnel with documented training, competencies, and annual continuing education specific for the patient population served.

(2) Level II (Specialty Care). The Level II maternal designated facility must:

(A) provide care for pregnant and postpartum patients with medical, surgical, or obstetrical conditions that present a low to moderate risk of maternal morbidity or mortality; and

(B) have skilled personnel with documented training, competencies, and annual continuing education specific for the patient population served.

(3) Level III (Subspecialty Care). The Level III maternal designated facility must:

(A) provide care for pregnant and postpartum patients with low risk conditions to significant complex medical, surgical, or obstetrical conditions that present a high risk of maternal morbidity or mortality;

(B) ensure access to consultation to a full range of medical and maternal subspecialists and surgical specialists, and behavioral health specialists;

(C) ensure capability to perform major surgery on-site;

(D) have physicians with critical care training available at all times to actively collaborate with Maternal Fetal Medicine physicians or Obstetrics and Gynecology physicians with obstetrics training and privileges in maternal care;

(E) have skilled personnel with documented training, competencies, and annual continuing education, specific for the population served;

(F) facilitate transports; and

(G) provide outreach education related to trends identified through the QAPI Plan, specific requests, and system needs to lower level designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(4) Level IV (Comprehensive Care). The Level IV maternal designated facility must:

(A) provide comprehensive care for pregnant and postpartum patients with low risk conditions to the most complex medical, surgical or obstetrical conditions and their fetuses, that present a high risk of maternal morbidity or mortality;

(B) ensure access to on-site consultation to a comprehensive range of medical and maternal subspecialists, surgical specialists, and behavioral health specialists;

(C) ensure capability to perform major surgery on-site;

(D) have physicians with critical care training available at all times to actively collaborate with Maternal Fetal Medicine physicians or Obstetrics and Gynecology physicians with obstetrics training, experience and privileges in maternal care;

(E) have a maternal fetal medicine critical care team with expertise and privileges to manage or co-manage highly complex, critically ill or unstable maternal patients;

(F) have a placenta accreta spectrum disorder multidisciplinary care team with expertise to complete risk factor screening, evaluation, diagnosis, consultation, and management of patients with

anticipated or unanticipated placenta accreta spectrum disorder, including postpartum care;

(G) have skilled personnel with documented training, competencies, and annual continuing education, specific for the patient population served;

(H) facilitate transports; and

(I) provide outreach education related to trends identified through the QAPI Plan, specific requests, and system needs to lower level designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(g) Facilities seeking maternal designation must undergo an on-site or virtual survey as outlined in this section and:

(1) are responsible for scheduling a maternal designation survey through a department-approved survey organization;

(2) must notify the department of the maternal designation survey date;

(3) are responsible for expenses associated with the maternal designation survey;

(4) must not accept surveyors with any conflict of interest; and

(5) must provide the survey team access to records and documentation regarding the QAPI Plan and process related to maternal patients.

(h) If a conflict of interest is present for a facility seeking maternal designation, the facility must decline the assigned surveyor through the surveying organization. A conflict of interest exists when a surveyor has a direct or indirect financial, personal, or other interest which would limit or could reasonably be perceived as limiting the surveyor's ability to serve in the best interest of the public. The conflict of interest may include a surveyor that personally trained a key member of the facility's leadership in residency or fellowship, collaborated with a key member of the facility's leadership professionally, participated in a designation consultation with the facility, had a previous working relationship with the facility or facility leaders, or conducted a designation survey for the facility within the past four years.

(1) Surveyors cannot be from the same PCR or TSA region or a contiguous region of the facility's location.

(2) Designation site survey summary and record reviews performed by a surveyor with an identified conflict of interest may not be accepted by the department.

(i) The survey team evaluates the facility's evidence that department-approved designation requirements are met and documents all requirements that are not met in the maternal designation site survey and medical record reviews.

§133.204. Designation Process.

(a) A facility seeking maternal designation or renewal of designation must submit a completed application packet.

(1) The completed application packet includes:

(A) an accurate and complete maternal designation application for the requested level of designation;

(B) a completed maternal attestation and self-survey report for Level I applicants or the documented maternal designation site survey summary that validates that department-approved designation requirements are met and the medical record reviews for Levels II, III, and IV applicants, submitted to the department no later than 90 days after the maternal designation site survey date;

(C) If the facility has three or more department-approved designation requirements that are defined as not met, the facility must contact the department's designation unit within 10 business days to discuss the Plan of Correction (POC).

(D) if required by the department, a POC that addresses all designation requirements defined as "not met" in the maternal designation site survey summary. The POC must include:

(i) a statement of the cited designation requirement not met;

(ii) a statement describing the corrective action taken by the facility seeking maternal designation to meet the requirement;

(iii) the title of the individuals responsible for ensuring the corrective actions are implemented;

(iv) the date the corrective actions were implemented;

(v) how the corrective actions will be monitored; and

(vi) documented evidence that the POC was implemented within 90 days of the designation survey;

(E) written evidence of annual participation in the applicable PCRs; and

(F) any subsequent documents submitted by the date requested by the department.

(2) The application includes full payment of the non-refundable, non-transferrable designation fee listed:

(A) Level I maternal facility applicants, the fees are as follows:

(i) â‰¤100 licensed beds, the fee is $250.00; or

(ii) >100 licensed beds, the fee is $750.00.

(B) Level II maternal facility applicants, the fee is $1,500.00.

(C) Level III maternal facility applicants, the fee is $2,000.00.

(D) Level IV maternal facility applicants, the fee is $2,500.00.

(b) The application will not be processed if a facility seeking maternal designation fails to submit the required application documents and total designation fee.

(c) The maternal designation renewal process, or a request to designate at a different level of care, or a change in ownership, or change in physical address requires the facility to complete a designation renewal, which follows the same requirements outlined in subsection (a)(1) and (2) of this section.

(d) The facility must submit the required documents described in subsection (a)(1) and (2) of this section to the department no later than 90 days before the facility's current maternal designation expiration date for all designation renewals.

(e) The facility has the right to withdraw its application for maternal designation any time before a designation approval.

(f) The facility must seek maternal designation renewal to maintain continual designation and prevent an interruption in designation.

(g) The facility's maternal designation will expire if the facility fails to provide a complete maternal designation application packet to the department.

(h) The maternal designation application packet in its entirety, including any recommendations or follow-up from the department, and any opportunities for improvement must be a written element of the facility's maternal QAPI Plan, and must be reviewed through this process, which is all subject to confidentiality as described in Texas Health and Safety Code, §241.184, Confidentiality; Privilege.

(i) The department reviews the application packet to determine and approve the facility's level of maternal designation.

(j) The department defines the final maternal designation level awarded to the facility and this designation may be different than the level requested based on the maternal designation site survey summary.

(k) If the department determines the facility meets the requirements for maternal designation, the department provides the facility with a designation award letter and a designation certificate.

(1) The facility must display its maternal designation certificate in a public area of the licensed premises that is readily visible to patients, employees, and visitors.

(2) The facility must not alter the maternal designation certificate. Any alteration voids maternal designation for the remainder of that designation period.

(l) The survey organization must provide the facility with a written, signed maternal designation site survey summary, including medical record reviews, regarding their evaluation and validation of the facility's demonstration that maternal designation requirements are met. This maternal designation site survey summary must be forwarded to the facility no later than 30 days after the completion date of the survey. The facility is responsible for submitting a copy of the maternal designation site survey summary and medical record reviews to the department with the required documents to continue the designation process within 90 days of completion of the site survey.

(m) The department will approve designation of a facility that demonstrates the requirements are met.

(n) A maternal level of care designation must not be denied to a facility that meets the designation requirements for that level of care designation.

(o) If a facility does not meet the designation requirements for the level of designation requested, the department will designate the facility at the highest level for which designation requirements are met.

(p) If the department determines a facility does not meet the designation requirements for the level of designation requested, the department must provide written notification to the facility of the designation requirements not met and provide a Corrective Action Plan (CAP) to assist the facility in meeting the designation requirement. The CAP may include requiring the facility to have a focused survey or a complete re-survey.

(1) The facility must submit to the department reports required and outlined in the CAP. The department may require a second survey to ensure they meet the designation requirements. The cost of the second survey will be at the expense of the facility.

(2) If the department substantiates actions taken by the facility demonstrating documented evidence that designation requirements are met, the department removes the contingencies.

(q) If a facility disagrees with the designation level awarded by the department, it may request an appeal in writing to the EMS/Trauma Systems Section Director not later than 30 days after the designation award. The written appeal must be from the facility's Chief Executive Officer, Chief Medical Officer, or Chief Nursing Officer with documented evidence of how the facility meets the requirements for the requested designation level.

(1) The EMS/Trauma Systems Section will establish a three-person appeal panel and follow approved appeal panel guidelines to assess the facility's designation appeal as referenced in Texas Health and Safety Code §241.1836.

(2) If the designation appeal panel recommends the original determination, the EMS/Trauma Systems Section Director will give written notice of such to the facility not later than 30 days after the appeal panel's recommendation.

(3) If the designation appeal panel disagrees with the department's original designation determination, the panel will recommend the appropriate level of maternal designation to the department.

(4) If a facility disagrees with the designation appeal panel's recommendation regarding its designation level, the facility can request a second appeal review with the department's Associate Commissioner for Consumer Protection Division. If the Associate Commissioner upholds the designation appeal panel's recommendation, the designation status will remain the same. If the Associate Commissioner disagrees with the designation appeal panel's recommendation, the Associate Commissioner will define the appropriate level and award designation. The department will send a notification letter of the second appeal decision within 30 days of receiving the second appeal request.

(5) If the facility continues to disagree with the second level of appeal, the facility has a right to a hearing in the manner referenced in §133.121 of this title (relating to Enforcement Action).

(r) Exceptions and Notifications.

(1) A designated maternal facility must provide written or electronic notification of any significant change to the maternal program impacting patient care. The notification must be provided to the following:

(A) all emergency medical services (EMS) providers that transfer maternal patients to or from the designated maternal facility;

(B) the hospitals to which it customarily transfers out or transfers in maternal patients;

(C) applicable PCRs and RACs; and

(D) the department.

(2) If the designated maternal facility is unable to comply with requirements to maintain its current designation, it must submit to the department a POC as described in subsection (a)(1)(D)(i) - (vi) of this section, and a request for a temporary exception to the designation requirements. Any request for an exception must be submitted in writing from the Chief Executive Officer of the facility and define the facility's timeline to meet the designation requirements. The department reviews the request and the POC, and either grants the exception, with a specific timeline based on the public interest, geographic maternal care capabilities, and access to care, or denies the exception. If the facility is not granted an exception, or it does not meet the designation

requirements at the end of the exception period, the department will elect one of the following:

(A) re-designate the facility at the level appropriate to its revised capabilities;

(B) outline an agreement with the facility to satisfy all designation requirements for the level of care designation within a time specified under the agreement, which may not exceed the first anniversary of the effective date of the agreement; or

(C) waive one specific designation requirement for a level of care designation if the facility meets all other designation requirements for the level of care designation and the department determines the waiver is justified considering:

(i) the expected impact on accessibility of maternal care in the geographic area served by the facility if the waiver is not granted and the expected impact on the quality of care and patient safety; or

(ii) whether these services can be met by other facilities in the area or with telehealth/telemedicine services.

(3) Waivers expire with the expiration of the current designation but may be renewed. The department may specify any conditions for ongoing reporting during this time.

(4) The department maintains a current list on their internet website of designated facilities that have an approved waiver with the department and an aggregated list of the requirements waived.

(5) Facilities that have contingency agreements or an approved waiver with the department must post on the facility's internet website the nature and general terms of the agreement.

(s) An application for a higher or lower level of maternal designation may be submitted to the department at any time.

(1) A designated maternal facility that is increasing its maternal capabilities may choose to apply for a higher level of designation at any time. The facility must follow the designation process as described in subsection (a)(1) and (2) of this section to apply for the higher level.

(2) A designated maternal facility that is unable to maintain the facility's current level of maternal designation may choose to apply for a lower level of designation at any time.

(t) If the facility is relinquishing its maternal designation, the facility must provide 30 days written, advance notice of the relinquishment to the department, the applicable PCRs/RACs, EMS providers, and facilities it customarily transfers out or transfers in maternal patients. The facility is responsible for continuing to provide maternal care services or ensuring a plan for maternal care continuity for the 30 days following the written notice of relinquishing its maternal designation.

(u) A hospital providing maternal services must not use the terms "designated maternal facility," or similar terminology in its signs, advertisements, facility internet website, social media, or in the printed materials and information it provides to the public, unless the facility is currently designated at that level of maternal care.

(v) During a virtual, on-site or focused designation review, conducted by the department or survey organization, the department or surveyor has the right to review and evaluate maternal patient records, maternal multidisciplinary QAPI Plan documents, and any action specific to improving maternal care and outcomes, as well as any other documents relevant to maternal care in a designated maternal facility or facility seeking maternal facility designation to validate designation requirements are met.

(w) The department and survey organization will comply with all relevant laws related to the confidentiality of records.

(x) The department may deny, suspend, or revoke designation if a designated maternal facility ceases to provide services to meet or maintain the designation requirements of this section.

§133.205. Program Requirements.

(a) Maternal Program Philosophy. Designated facilities must have a family centered philosophy. The facility environment for perinatal care must meet the physiologic and psychosocial needs of the mothers, infants, and families. Parents must have reasonable access to their infants at all times and be encouraged to participate in the care of their infants.

(b) Maternal Program Plan. The facility must develop a written maternal operational plan for the maternal program that includes a detailed description of the scope of services and clinical resources available for all maternal patients and families. The plan will define the maternal patient population evaluated, treated, transferred, or transported by the facility consistent with clinical guidelines based on current standards of maternal practice ensuring the health and safety of patients.

(1) The written Maternal Program Plan must be reviewed and approved by Maternal Program Oversight and be submitted to the facility's governing body for review and approval. The governing body must ensure that the requirements of this section are implemented and enforced.

(2) The written Maternal Program Plan must include, at a minimum:

(A) clinical guidelines based on current standards of maternal practice, and policies and procedures that are adopted, implemented, and enforced by the maternal program;

(B) a process to ensure and validate that these clinical guidelines based on current standards of maternal practice, policies, and procedures are reviewed and revised a minimum of every three years;

(C) written triage, stabilization, and transfer guidelines for pregnant and postpartum patients that include consultation and transport services;

(D) written guidelines or protocols for prevention, early identification, early diagnosis, and therapy for conditions that place the pregnant or postpartum patient at risk for morbidity or mortality;

(E) the role and scope of telehealth/telemedicine practices if utilized, including:

(i) documented and approved written policies and procedures that outline the use of telehealth/telemedicine for inpatient hospital care, or for inpatient consultation, including appropriate situations, scope of care, and documentation that is monitored through the QAPI Plan and process; and

(ii) written and approved procedures to gain informed consent from the patient or designee for the use of telehealth/telemedicine, if utilized, that are monitored for compliance;

(F) written guidelines for discharge planning instructions and appropriate follow up appointments for all mothers and infants;

(G) written guidelines for the hospital disaster response, including a defined mother and infant evacuation plan and process to

relocate mothers and infants to appropriate levels of care with identified resources, and this process must be evaluated annually to ensure maternal care can be sustained and adequate resources are available;

(H) requirements for minimal credentials for all staff participating in the care of maternal patients;

(I) provisions for providing continuing staff education, including annual competency and skills assessment that is appropriate for the patient population served;

(J) a perinatal staff registered nurse as a representative on the nurse staffing committee under §133.41 of this title (relating to Hospital Functions and Services); and

(K) the availability of all necessary equipment and services to provide the appropriate level of care and support of the patient population served.

(3) The facility must have a documented QAPI Plan. The maternal program must measure, analyze, and track quality indicators and other aspects of performance that the facility adopts or develops that reflect processes of care and is outcome based.

(A) The Chief Executive Officer, Chief Medical Officer, and Chief Nursing Officer must implement a culture of safety for the facility and ensure adequate resources are allocated to support a concurrent, data-driven maternal QAPI Plan.

(B) The facility must demonstrate that the maternal QAPI Plan consistently assesses the provision of maternal care provided. The assessment will identify variances in care, the impact to the patient, and the appropriate levels of review. This process will identify opportunities for improvement and develop a plan of correction to address the variances in care or the system response. An action plan will track and analyze data through resolution or correction of the identified variance.

(C) Maternal facilities must review their incidence and management of placenta accreta spectrum disorder through the QAPI Plan and report the incidence and outcomes through the Maternal Program Oversight.

(D) The Maternal Medical Director (MMD) must have the authority to make referrals for peer review, receive feedback from the peer review process, and ensure maternal physician representation in the peer review process for maternal cases.

(E) The MMD and the Maternal Program Manager (MPM) must participate in the PCR meetings, QAPI regional initiatives, and regional collaboratives, and submit requested data to assist with data analysis to evaluate regional outcomes as an element of their maternal QAPI Plan.

(F) The facility must have documented evidence of maternal QAPI summary reports reviewed and reported by Maternal Program Oversight that monitor and ensure the provision of services or procedures through the telehealth and telemedicine, if utilized, is in accordance with the standard of care applicable to the provision of the same service or procedure in an in-person setting.

(G) The facility must have documented evidence of maternal QAPI summary reports to support that aggregate maternal data are consistently reviewed to identify developing trends, opportunities for improvement, and necessary corrective actions. Summary reports must be provided through Maternal Program Oversight, available for site surveyors, and submitted to the department as requested.

(c) Medical Staff. The facility must have an organized maternal program that is recognized by the facility's medical staff and approved by the facility's governing body.

(1) The credentialing of the maternal medical staff must include a process for the delineation of privileges for maternal care.

(2) The maternal medical staff must participate in ongoing staff and team-based education and training in the care of the maternal patient.

(d) Medical Director. There must be an identified MMD and an identified Transport Medical Director (TMD) if the facility has its own transport program. The MMD and TMD must be credentialed by the facility for treatment of maternal patients and have their responsibilities and authority defined in a job description. The MMD is responsible for the provision of maternal care services and:

(1) examining qualifications of medical staff requesting maternal privileges and making recommendations to the appropriate committee for such privileges;

(2) assuring maternal medical staff competency in managing obstetrical emergencies, complications and resuscitation techniques;

(3) monitoring maternal patient care from transport if applicable, to admission, stabilization, operative intervention(s) if applicable, through discharge, and inclusive of the QAPI Plan;

(4) participating in ongoing maternal staff and team-based education and training in the care of the maternal patient;

(5) overseeing the inter-facility maternal transport;

(6) collaborating with the MPM in areas to include developing or revising policies, procedures and guidelines, assuring medical staff and personnel competency, education and training; and the QAPI Plan;

(7) frequently leading the maternal QAPI meetings with the MPM and participating in Maternal Program Oversight and other maternal meetings as appropriate;

(8) ensuring that the QAPI Plan is specific to maternal and fetal care, is ongoing, data-driven and outcome-based;

(9) participating as a clinically active and practicing physician in maternal care at the facility where medical director services are provided;

(10) maintaining active staff privileges as defined in the facility's medical staff bylaws; and

(11) developing collaborative relationships with other MMD(s) of designated facilities within the applicable Perinatal Care Region.

(e) MPM. The facility must identify a MPM who has the authority and oversight responsibilities written in his or her job description for the provision of maternal services through all phases of care, including discharge and identifying variances in care for inclusion in the QAPI Plan and:

(1) be a registered nurse with perinatal experience;

(2) be a clinically active and practicing registered nurse participating in maternal care at the facility where program manager services are provided;

(3) has the authority and responsibility to monitor the provision of maternal patient care services from admission, stabilization, operative intervention(s) if applicable, through discharge, and inclusive of the QAPI Plan;

(4) collaborates with the MMD in areas to include developing or revising policies, procedures and guidelines; assuring staff competency, education, and training and the QAPI Plan;

(5) frequently leads the maternal QAPI meetings and participates in Maternal Program Oversight and other maternal meetings as appropriate;

(6) ensures that the QAPI Plan is specific to maternal and fetal care, is ongoing, data-driven and outcome based, including telehealth/telemedicine utilization, when used; and

(7) develops collaborative relationships with other MPM(s) of designated facilities within the applicable Perinatal Care Region.

§133.206. Maternal Designation Level I.

(a) Level I (Basic Care). The Level I maternal designated facility must:

(1) provide care for pregnant and postpartum patients who are generally healthy, and do not have medical, surgical, or obstetrical conditions that present a significant risk of maternal morbidity or mortality; and

(2) have skilled personnel with documented training, competencies, and annual continuing education specific for the patient population served.

(b) Maternal Medical Director (MMD). The MMD must be a physician who:

(1) is a family medicine physician or an obstetrics and gynecology physician, with obstetrics training and experience, and with privileges in maternal care;

(2) demonstrates administrative skills and oversight of the Quality Assessment and Performance Improvement (QAPI) Plan; and

(3) has completed annual continuing education specific to maternal care.

(c) Program Functions and Services.

(1) Triage and assessment of all patients admitted to the perinatal service.

(A) Pregnant patients who are identified at high risk of delivering a neonate that requires a higher level of neonatal care than the scope of their neonatal facility must be transferred to a higher level neonatal designated facility before delivery unless the transfer is unsafe.

(B) Pregnant or postpartum patients identified with conditions or complications that require a higher level of maternal care must be transferred to a higher level maternal designated facility unless the transfer is unsafe.

(2) Provide care for patients with uncomplicated pregnancies with the capability to detect, stabilize, and initiate management of unanticipated maternal-fetal or maternal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a higher level of neonatal or maternal care.

(3) An obstetrics and gynecology physician with obstetrics training and experience must be available for consultation, at all times.

(4) Medical, surgical and behavioral health specialists must be available at all times for consultation appropriate to the patient population served.

(5) Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies.

(6) The family medicine physician, primary physician, or certified nurse midwife with competence in the care of pregnant patients, whose credentials have been reviewed by the MMD and is on call:

(A) must arrive at the patient bedside within 30 minutes of an urgent request; and

(B) must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.

(7) Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

(A) must operate under guidelines reviewed and approved by the MMD; and

(B) must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:

(i) provide back-up and consultation;

(ii) arrive at the patient bedside within 30 minutes of an urgent request; and

(iii) meet requirements for medical staff as described in §133.205 of this title (relating to Program Requirements) respectively.

(8) An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

(9) Ensure that physicians providing back-up coverage must arrive at the patient bedside within 30 minutes of an urgent request.

(10) Appropriate anesthesia, laboratory, pharmacy, radiology, respiratory therapy, ultrasonography and blood bank services must be available on a 24-hour basis as described in §133.41 of this title (relating to Hospital Functions and Services) respectively.

(A) Anesthesia personnel with training and experience in obstetric anesthesia must be available at all times and arrive to the patient bedside within 30 minutes of an urgent request.

(B) Laboratory and blood bank services must have guidelines or protocols for:

(i) massive blood component transfusion;

(ii) emergency release of blood components; and

(iii) management of multiple blood component therapy.

(C) Medical Imaging Services.

(i) If preliminary reading of imaging studies pending formal interpretation is performed, the preliminary findings must be documented in the medical record.

(ii) There must be regular monitoring of the preliminary versus final reading in the QAPI Plan.

(iii) Basic ultrasonographic imaging for maternal or fetal assessment, including interpretation available at all times.

(iv) A portable ultrasound machine immediately available at all times to the labor and delivery and antepartum unit.

(D) A pharmacist must be available for consultation at all times.

(11) Obstetrical Services.

(A) The ability to begin an emergency cesarean delivery and ensure the availability of a physician with the training, skills, and privileges to perform the surgery within a time period consistent with current standards of professional practice and maternal care.

(B) Ensure the availability and interpretation of nonstress testing, and electronic fetal monitoring.

(C) A trial of labor for patients with prior cesarean delivery must have the capability of anesthesia, cesarean delivery, and maternal resuscitation on-site during the trial of labor.

(12) Resuscitation. The facility must have written policies and procedures specific to the facility for the stabilization and resuscitation of the pregnant or postpartum patient based on current standards of professional practice. The facility:

(A) ensures staff members, not responsible for the neonatal resuscitation, are immediately available on-site at all times who demonstrate current status of successful completion of ACLS, or a department-approved equivalent course, and the skills to perform a complete resuscitation; and

(B) ensures that resuscitation equipment, including difficult airway management equipment for pregnant and postpartum patients, is immediately available at all times to the labor and delivery, antepartum and postpartum areas.

(13) The facility must have a written hospital preparedness and management plan for patients with placenta accreta spectrum disorder who are undiagnosed until delivery, including educating hospital and medical staff who may be involved in the treatment and management of placenta accreta spectrum disorder about risk factors, diagnosis, and management.

(14) The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

(A) massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;

(B) obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;

(C) placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of both anticipated and unanticipated placenta accreta spectrum disorder cases, including postpartum care;

(D) hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;

(E) sepsis or systemic infection in the pregnant or postpartum patient;

(F) venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;

(G) shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and

(H) behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

(15) Perinatal Education. A registered nurse with experience in maternal care must provide the supervision and coordination of staff education. Perinatal education for high risk events must be provided at frequent intervals to prepare medical, nursing, and ancillary staff for these emergencies.

(16) Support personnel with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

(17) Social services, pastoral care and bereavement services must be provided as appropriate to meet the needs of the patient population served.

(18) Dietician or nutritionist available with appropriate training and experience for population served in compliance with the requirements in §133.41 of this title.

§133.207. Maternal Designation Level II.

(a) Level II (Specialty Care). The Level II maternal designated facility must:

(1) provide care for pregnant and postpartum patients with medical, surgical, or obstetrical conditions that present a low to moderate risk of maternal morbidity or mortality; and

(2) have skilled personnel with documented training, competencies, and annual continuing education specific for the patient population served.

(b) Maternal Medical Director (MMD). The MMD must be a physician who:

(1) is a family medicine physician, an obstetrics and gynecology physician, or maternal fetal medicine physician, all with obstetrics training and experience, and with privileges in maternal care;

(2) demonstrates administrative skills and oversight of the Quality Assessment and Performance Improvement (QAPI) Plan; and

(3) has completed annual continuing education specific to maternal care, including complicated conditions.

(c) Program Functions and Services.

(1) Triage and assessment of all patients admitted to the perinatal service.

(A) Pregnant patients identified at high risk of delivering a neonate that requires a higher level of neonatal care than the scope of their neonatal facility must be transferred to a higher level neonatal designated facility before delivery unless the transfer is unsafe.

(B) Pregnant or postpartum patients identified with conditions or complications that the managing physician determines require patient transfer to a higher level of maternal care must be transferred to a higher level maternal designated facility unless the transfer is unsafe.

(2) Provide care for pregnant patients with the capability to detect, stabilize, and initiate management of unanticipated maternal-fetal or maternal problems that occur during the antepartum, intra-

partum, or postpartum period until the patient can be transferred to a higher level of neonatal or maternal care.

(3) An obstetrics and gynecology physician or family medicine physician with obstetrics training and experience, including operative training, and with maternal privileges, must be available at all times and arrive at the patient bedside within 30 minutes of an urgent request. Facilities that utilize family medicine physicians in this role must have a written plan for responding to obstetrical emergencies that require services or procedures outside the scope of privileges granted to the family physician, and regularly monitor outcomes in their QAPI Plan.

(4) A board-certified or board-eligible maternal fetal medicine physician must be available at all times for consultation.

(5) Medical and surgical physicians must be available at all times and arrive at the patient bedside within 30 minutes of an urgent request.

(6) Specialists, including behavioral health, must be available at all times for consultation appropriate to the patient population served.

(7) Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies.

(8) The primary provider caring for a pregnant or postpartum patient who is a family medicine physician with obstetrics training and experience, obstetrics and gynecology physician, maternal fetal medicine physician, or a certified nurse midwife, physician assistant or nurse practitioner with appropriate physician back-up, whose credentials have been reviewed by the MMD and is on-call:

(A) must arrive at the patient bedside within 30 minutes of an urgent request; and

(B) must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.

(9) Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

(A) must operate under guidelines reviewed and approved by the MMD; and

(B) must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:

(i) provide back-up and consultation;

(ii) arrive at the patient bedside within 30 minutes of an urgent request; and

(iii) meet requirements for medical staff as described in §133.205 of this title (relating to Program Requirements) respectively.

(10) An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

(11) Ensure that the physician providing back-up coverage must arrive at the patient bedside within 30 minutes of an urgent request.

(12) The appropriate anesthesia, laboratory, pharmacy, radiology, respiratory therapy, ultrasonography and blood bank services must be available on a 24-hour basis as described in §133.41 of this title (relating to Hospital Functions and Services) respectively.

(A) Anesthesia personnel with training and experience in obstetric anesthesia must be available at all times and arrive to the patient bedside within 30 minutes of an urgent request.

(B) An anesthesiologist with training or experience in obstetric anesthesia must be available at all times for consultation.

(C) Laboratory and blood bank services must be capable of:

(i) providing ABO-Rh specific or O-Rh negative blood, fresh frozen plasma or cryoprecipitate on-site at all times;

(ii) implementing a massive transfusion protocol;

(iii) ensuring guidelines for emergency release of blood components; and

(iv) managing multiple blood component therapy.

(D) Medical Imaging Services.

(i) If preliminary reading of imaging studies pending formal interpretation is performed, the preliminary findings must be documented in the medical record.

(ii) There must be regular monitoring of the preliminary versus final reading in the QAPI Plan.

(iii) Computed Tomography (CT) imaging and interpretation available at all times.

(iv) Basic ultrasonographic imaging for maternal or fetal assessment, including interpretation must be available at all times.

(v) A portable ultrasound machine immediately available at all times to the labor and delivery and antepartum unit.

(E) A pharmacist must be available for consultation at all times.

(13) Obstetrical Services.

(A) The ability to begin an emergency cesarean delivery and ensure the availability of a physician with the training, skills, and privileges to perform the surgery within a time period consistent with current standards of professional practice and maternal care.

(B) Ensure the availability and interpretation of nonstress testing, and electronic fetal monitoring.

(C) A trial of labor for patients with prior cesarean delivery must have the capability of anesthesia, cesarean delivery, and maternal resuscitation on-site during the trial of labor.

(14) Resuscitation. The facility must have written policies and procedures specific to the facility for the stabilization and resuscitation of the pregnant or postpartum patient based on current standards of professional practice. The facility:

(A) ensures staff members, not responsible for the neonatal resuscitation, are immediately available on-site at all times who demonstrate current status of successful completion of ACLS, or a department-approved equivalent course, and the skills to perform a complete resuscitation; and

(B) ensures that resuscitation equipment, for pregnant and postpartum patients, is readily available in the labor and delivery, antepartum and postpartum areas. Difficult airway management equipment must be immediately available at all times to these areas.

(15) The facility must have a written hospital preparedness and management plan for patients with placenta accreta spectrum disorder who are undiagnosed until delivery, including educating hospital and medical staff who may be involved in the treatment and manage-

ment of placenta accreta spectrum disorder about risk factors, diagnosis, and management.

(16) The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

(A) massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;

(B) obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;

(C) placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of both anticipated and unanticipated placenta accreta spectrum disorder cases, including postpartum care;

(D) hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;

(E) sepsis or systemic infection in the pregnant or postpartum patient;

(F) venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;

(G) shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and

(H) behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

(17) The facility must have nursing leadership and staff with training and experience in the provision of maternal nursing care who must coordinate with respective neonatal services.

(18) Perinatal Education. A registered nurse with experience in maternal care, including moderately complex and ill obstetric patients, must provide the supervision and coordination of staff education. Perinatal education for high risk events must be provided at frequent intervals to prepare medical, nursing, and ancillary staff for these emergencies.

(19) Support personnel with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

(20) Social services, pastoral care and bereavement services must be provided as appropriate to meet the needs of the patient population served.

(21) Dietician or nutritionist available with appropriate training and experience for population served in compliance with the requirements in §133.41 of this title.

§133.208. Maternal Designation Level III.

(a) A Level III (Subspecialty Care). The Level III maternal designated facility must:

(1) provide care for pregnant and postpartum patients with low risk conditions to significant complex medical, surgical or obstetrical conditions that present a high risk of maternal morbidity or mortality;

(2) ensure access to consultation to a full range of medical and maternal subspecialists, surgical specialists, and behavioral health specialists;

(3) ensure capability to perform major surgery on-site;

(4) have physicians with critical care training available at all times to actively collaborate with Maternal Fetal Medicine physicians or Obstetrics and Gynecology Physicians with obstetrics training and privileges in maternal care;

(5) have skilled personnel with documented training, competencies, and annual continuing education, specific for the population served;

(6) facilitate transports; and

(7) provide outreach education related to trends identified through the QAPI Plan, specific requests, and system needs to lower level designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(b) Maternal Medical Director (MMD). The MMD must be a physician who:

(1) is a board-certified obstetrics and gynecology physician with obstetrics training and experience, or a board-certified maternal fetal medicine physician, both with privileges in maternal care;

(2) demonstrates administrative skills and oversight of the QAPI Plan; and

(3) has completed annual continuing education specific to maternal care, including complicated conditions.

(c) If the facility has its own transport program, there must be an identified Transport Medical Director (TMD). The TMD must be a physician who is a board-certified maternal fetal medicine specialist or board-certified obstetrics and gynecology physician with privileges and experience in obstetrical care and maternal transport.

(d) Program Functions and Services.

(1) Triage and assessment of all patients admitted to the perinatal service.

(A) Pregnant patients who are identified at high risk of delivering a neonate that requires a higher level of neonatal care than the scope of their neonatal facility must be transferred to a higher level neonatal designated facility before delivery unless the transfer is unsafe.

(B) Pregnant or postpartum patients identified with conditions or complications that require a higher level of maternal care must be transferred to a higher level maternal designated facility unless the transfer is unsafe.

(2) Provide care for pregnant patients with the capability to detect, stabilize, and initiate management of unanticipated maternal-fetal or maternal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a higher level of neonatal or maternal care.

(3) Supportive and emergency care must be delivered by appropriately trained personnel for unanticipated maternal-fetal problems that occur requiring a higher level of maternal care, until the patient is stabilized or transferred;

(4) An obstetrics and gynecology physician with maternal privileges must be on-site at all times and available for urgent situations.

(5) A board-certified or board-eligible Maternal Fetal Medicine physician with inpatient privileges must be available at all times for inpatient consultation and arrive at the patient bedside within 30 minutes of an urgent request to co-manage patients.

(A) When telehealth or telemedicine is utilized for maternal fetal medicine co-management for non-urgent inpatient situations where an in-person response is not required, the facility must have the following:

(i) a written plan for the appropriate use of telehealth/telemedicine for inpatient hospital care that is compliant with the Texas Medical Board Telemedicine rules, Texas Administrative Code, Title 22, Chapter 174, and the Texas Occupations Code, Chapter 111;

(ii) a process for informed consent and agreement from the patient for the use of telehealth or telemedicine; and

(iii) a maternal fetal medicine physician with inpatient privileges at the facility, who regularly participates in the on-site care of patients at the facility, has access to the patient's medical record, and participates as needed in the QAPI Plan and process for the facility's maternal program.

(B) The facility has processes to monitor the compliance and outcomes of maternal telehealth and telemedicine encounters through the QAPI Plan.

(C) The use of telemedicine for on call consultation does not substitute for the requirement of maternal fetal medicine availability for in-person consultation on complex and critically ill patients on a regular basis.

(6) Intensive Care Services. The facility must provide critical care services for critically ill pregnant or postpartum patients, including fetal monitoring in the Intensive Care Unit (ICU), respiratory failure and ventilator support, procedure for emergency cesarean, coordination of nursing care, and consultative or co-management roles to facilitate collaboration.

(7) Level III maternal designated facilities that serve as referral centers for placenta accreta spectrum disorder must fulfill all of the Level IV requirements for a Placenta Accreta Spectrum Disorder Team defined in §133.209 of this title (relating to Maternal Designation Level IV).

(8) Medical and surgical physicians, including critical care specialists, must be available at all times and arrive at the patient bedside within 30 minutes of an urgent request.

(9) Consultation by a behavioral health professional, with training or experience in maternal counseling must be available at all times and arrive by telemedicine or in-person when requested within a time period consistent with current standards of professional practice and maternal care.

(10) Ensure that a qualified physician, or a certified nurse midwife with appropriate physician back-up, is available to attend all deliveries or other obstetrical emergencies.

(11) The primary provider caring for a pregnant or postpartum patient who is a family medicine physician with obstetrics training and experience, obstetrics and gynecology physician, maternal fetal medicine physician, or a certified nurse midwife, physician assistant or nurse practitioner with appropriate physician back-up, whose credentials have been reviewed by the MMD and is on call:

(A) must arrive at the patient bedside within 30 minutes for an urgent request; and

(B) must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated and critical conditions.

(12) Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

(A) must operate under guidelines reviewed and approved by the MMD; and

(B) must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:

(i) provide back-up and consultation;

(ii) arrive at the patient bedside within 30 minutes of an urgent request; and

(iii) meet requirements for medical staff as described in §133.205 of this title (relating to Program Requirements) respectively.

(13) An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

(14) Ensure that the physician providing back-up coverage must arrive at the patient bedside within 30 minutes for an urgent request.

(15) Anesthesia Services must comply with the requirements found at §133.41 of this title (relating to Hospital Functions and Services) and must have:

(A) anesthesia personnel with experience and expertise in obstetric anesthesia must be available on-site at all times;

(B) a board-certified anesthesiologist with training or experience in obstetric anesthesia in charge of obstetric anesthesia services;

(C) a board-certified or board-eligible anesthesiologist with training or experience in obstetric anesthesia, including critically ill obstetric patients available for consultation at all times, and arrive at the patient bedside within 30 minutes for urgent requests; and

(D) anesthesia personnel on call, including back-up contact information, posted and readily available to the facility and maternal staff and posted in the labor and delivery area.

(16) Laboratory Services must comply with the requirements found at §133.41 of this title and must have:

(A) laboratory personnel on-site at all times;

(B) a blood bank capable of:

(i) providing ABO-Rh specific or O-Rh negative blood, fresh frozen plasma, cryoprecipitate, and platelet components on-site at the facility at all times;

(ii) implementing a massive transfusion protocol;

(iii) ensuring guidelines for emergency release of blood components; and

(iv) managing multiple blood component therapy; and

(C) perinatal pathology services available.

(17) Medical Imaging Services must comply with the requirements found at §133.41 of this title and must have:

(A) personnel appropriately trained in the use of x-ray equipment available on-site at all times;

(B) advanced imaging, including computed tomography (CT), magnetic resonance imaging (MRI), and echocardiography available at all times;

(C) interpretation of CT, MRI and echocardiography within a time period consistent with current standards of professional practice and maternal care;

(D) basic ultrasonographic imaging for maternal or fetal assessment, including interpretation available at all times; and

(E) a portable ultrasound machine available in the labor and delivery and antepartum unit.

(18) Pharmacy services must comply with the requirements found in §133.41 of this title and must have a pharmacist with experience in perinatal pharmacology available at all times.

(19) Respiratory Therapy Services must comply with the requirements found at §133.41 of this title and have a respiratory therapist immediately available on-site at all times.

(20) Obstetrical Services.

(A) The ability to begin an emergency cesarean delivery within a time period consistent with current standards of professional practice and maternal care.

(B) Ensure the availability and interpretation of nonstress testing, and electronic fetal monitoring.

(C) A trial of labor for patients with prior cesarean delivery must have the capability of anesthesia, cesarean delivery, and maternal resuscitation on-site during the trial of labor.

(21) Resuscitation. The facility must have written policies and procedures specific to the facility for the stabilization and resuscitation of the pregnant or postpartum patient based on current standards of professional practice. The facility:

(A) ensures staff members, not responsible for the neonatal resuscitation, are immediately available on-site at all times who demonstrate current status of successful completion of ACLS, or a department-approved equivalent course, and the skills to perform a complete resuscitation; and

(B) ensures that resuscitation equipment, including difficult airway management equipment for pregnant and postpartum patients, is readily available in the labor and delivery, antepartum and postpartum areas.

(22) The facility must have a written hospital preparedness and management plan for patients with placenta accreta spectrum disorder who are undiagnosed until delivery, including educating hospital and medical staff who may be involved in the treatment and management of placenta accreta spectrum disorder about risk factors, diagnosis, and management.

(23) The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

(A) massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;

(B) obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;

(C) placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of both anticipated and unanticipated placenta accreta spectrum disorder cases, including postpartum care;

(D) hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;

(E) sepsis or systemic infection in the pregnant or postpartum patient;

(F) venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;

(G) shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and

(H) behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

(24) The facility must have nursing leadership and staff with training and experience in the provision of maternal nursing care who must coordinate with respective neonatal services.

(25) The facility must have a program for genetic diagnosis and counseling for genetic disorders, or a policy and process for consultation referral to an appropriate facility.

(26) Perinatal Education. A registered nurse with experience in maternal care, including moderately complex and ill obstetric patients, must provide the supervision and coordination of staff education. Perinatal education for high risk events must be provided at frequent intervals to prepare medical, nursing, and ancillary staff for these emergencies.

(27) Support personnel with knowledge and skills in breastfeeding to meet the needs of maternal patients must be available at all times.

(28) A certified lactation consultant must be available at all times.

(29) Social services, pastoral care and bereavement services must be provided as appropriate to meet the needs of the patient population served.

(30) Dietician or nutritionist available with training and experience in maternal nutrition and can plan diets that meet the needs of the pregnant and postpartum patient must comply with the requirements in §133.41 of this title.

§133.209. Maternal Designation Level IV.

(a) A Level IV (Comprehensive Care). The Level IV maternal designated facility must:

(1) provide comprehensive care for pregnant and postpartum patients with low risk conditions to the most complex medical, surgical or obstetrical conditions and their fetuses, that present a high risk of maternal morbidity or mortality;

(2) ensure access to on-site consultation to a comprehensive range of medical and maternal subspecialists, surgical specialists and behavioral health specialists;

(3) ensure capability to perform major surgery on-site;

(4) have physicians with critical care training available at all times to actively collaborate with Maternal Fetal Medicine physicians or Obstetrics and Gynecology physicians with obstetrics training, experience and privileges in maternal care;

(5) have a maternal fetal medicine critical care team with expertise and privileges to manage or co-manage highly complex, critically ill or unstable maternal patients;

(6) have a placenta accreta spectrum disorder multidisciplinary care team with expertise to complete risk factor screening, evaluation, diagnosis, consultation, and management of patients with anticipated or unanticipated placenta accreta spectrum disorder, including postpartum care;

(7) have skilled personnel with documented training, competencies, and annual continuing education, specific for the patient population served;

(8) facilitate transports; and

(9) provide outreach education related to trends identified through the QAPI Plan, specific requests, and system needs to lower level designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

(b) Maternal Medical Director (MMD). The MMD must be a physician who:

(1) is a board-certified obstetrics and gynecology physician with expertise in the area of critical care obstetrics; or a board-certified maternal fetal medicine physician, both with privileges in maternal care;

(2) demonstrates administrative skills and oversight of the QAPI Plan; and

(3) has completed annual continuing education specific to maternal care, including complicated conditions.

(c) If the facility has its own transport program, there must be an identified Transport Medical Director (TMD). The TMD must be a physician who is a board-certified maternal fetal medicine physician or board-certified obstetrics and gynecology physician with obstetrics privileges, with expertise and experience in critically ill maternal transport.

(d) Program Functions and Services.

(1) Triage and assessment of all patients admitted to the perinatal service.

(A) Pregnant patients who are identified at high risk of delivering a neonate that requires a higher level of neonatal care must be transferred to a higher level neonatal designated facility prior to delivery unless the transfer is unsafe.

(B) Pregnant or postpartum patients identified with conditions or complications that require a service not available at the facility, must be transferred to an appropriate maternal designated facility unless the transfer is unsafe.

(2) Supportive and emergency care must be delivered by appropriately trained personnel, for unanticipated maternal-fetal problems that occur during labor and delivery, through the disposition of the patient.

(3) A board-certified or board-eligible obstetrics and gynecology physician with maternal privileges must be on-site at all times and available for urgent situations.

(4) Ensure that a qualified physician, or a certified nurse midwife with appropriate physician back-up, is available to attend all deliveries or other obstetrical emergencies.

(5) Intensive Care Services. The facility must have an adult Intensive Care Unit (ICU) and critical care capabilities for maternal patients, including:

(A) a comprehensive range of medical and surgical critical care specialists and advanced subspecialists on the medical staff;

(B) a maternal fetal medicine critical care team with experience and expertise in the care of complex or critically ill maternal patients available to co-manage maternal patients; and

(C) availability of obstetric nursing and support personnel with experience in care for critically ill maternal patients.

(6) Maternal Fetal Medicine Critical Care Team. The facility must have a Maternal Fetal Medicine (MFM) critical care team whose members have expertise to assume responsibility for pregnant or postpartum patients who are in critical condition or have complex medical conditions, including;

(A) co-management of ICU-admitted obstetric patients;

(B) a MFM team member with full obstetrical privileges available at all times for on-site consultation and management, and to arrive at the patient bedside within 30 minutes of an urgent request; and

(C) a board-certified MFM physician with expertise in critical care obstetrics to lead the team.

(7) Management of critically ill pregnant or postpartum patients, including fetal monitoring in the ICU, respiratory failure and ventilator support, procedure for emergency cesarean, coordination of nursing care, and consultative or co-management roles to facilitate collaboration.

(8) The facility must have a Placenta Accreta Spectrum Disorder Team whose members have expertise in the diagnosis and management of pregnant or postpartum patients with anticipated and unanticipated placenta accreta spectrum disorder, including:

(A) a multidisciplinary primary response team must be comprised of a minimum of the following:

(i) an anesthesiologist with training and expertise in obstetrical anesthesiology;

(ii) obstetrics and gynecology physician or maternal fetal medicine physician;

(iii) surgeon or surgeons with expertise in pelvic, urologic, or gastroenterological surgery;

(iv) neonatologist;

(v) experienced nursing staff; and

(vi) experienced operating room personnel;

(B) a secondary response team must be comprised of a minimum of the following:

(i) a radiologist with interventional radiology skills; and

(ii) a blood bank or transfusion medicine specialist;

(C) all primary and secondary response team members must have full hospital privileges; and

(i) a representative of each component of the primary response team must be available at all times for inpatient consultation and management, and arrive at the bedside within 30 minutes of an urgent request to attend to a patient with placenta accreta spectrum disorder;

(ii) a representative of each component of the secondary response team must be available at all times for consultation and management, and be available to arrive at the patient bedside within a time frame commensurate with the clinical situation and consistent with current standards;

(D) representatives of each component of the primary and secondary response teams must participate in regular, ongoing staff and team-based education and training to care for patients with placenta accreta spectrum disorder;

(E) a board-certified maternal fetal medicine physician or a board-certified obstetrics and gynecology physician, who has expertise in the diagnosis and management of placenta accreta spectrum disorder, must lead the team;

(F) evidence that the facility participates in regular, ongoing outreach and education specific to placenta accreta spectrum disorder to other maternal facilities not specializing in placenta accreta spectrum disorder, inclusive of QAPI Plan;

(G) a documented on-call schedule of primary and secondary response team members is readily available to the facility and maternal staff on the labor and delivery unit and operating suite; and

(H) evidence that representatives of the primary and secondary response teams participate in the maternal program's QAPI process for the review of all placenta accreta spectrum disorder cases and assist the PCR with the review of placenta accreta spectrum disorder cases, as requested.

(9) Behavioral Health Services.

(A) Consultation by a behavioral health professional, with experience in maternal or neonatal counseling must be available on-site at all times for in-person visits when requested for prenatal, peri-operative, and postnatal needs of the patient within a time period consistent with current standards of professional practice and maternal care.

(B) Consultation by a psychiatrist, with experience in maternal or neonatal counseling must be available for in-person visits when requested within a time period consistent with current standards of professional practice and maternal care.

(10) The primary provider caring for a pregnant or postpartum patient who is a family medicine physician with obstetrics training and experience, obstetrics and gynecology physician, maternal fetal medicine physician, or a certified nurse midwife, physician assistant or nurse practitioner with appropriate physician back-up, whose credentials have been reviewed by the MMD and is on call:

(A) must arrive at the patient bedside within 30 minutes for an urgent request; and

(B) must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated and critical conditions.

(11) Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

(A) must operate under guidelines reviewed and approved by the MMD; and

(B) must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:

(i) provide back-up and consultation;

(ii) arrive at the patient bedside within 30 minutes of an urgent request; and

(iii) meet requirements for medical staff as described in §133.205 of this title (relating to Program Requirements) respectively.

(12) An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

(13) Ensure that the physician providing back-up coverage must arrive at the patient bedside within 30 minutes for an urgent request.

(14) Anesthesia Services must comply with the requirements found at §133.41 of this title (relating to Hospital Functions and Services) and must have:

(A) anesthesia personnel with experience and expertise in obstetric anesthesia must be available on-site at all times;

(B) a board-certified anesthesiologist with training or experience in obstetric anesthesia in charge of obstetric anesthesia services;

(C) a board-certified or board-eligible anesthesiologist with training or experience in obstetric anesthesia, including critically ill obstetric patients available for consultation at all times, and arrive at the patient bedside within 30 minutes for urgent requests; and

(D) anesthesia personnel on call, including back-up contact information, posted and readily available to the facility and maternal staff and posted in the labor and delivery area.

(15) Laboratory Services must comply with the requirements found at §133.41 of this title and must have:

(A) laboratory personnel on-site at all times;

(B) a blood bank capable of:

(i) providing ABO-Rh specific or O-Rh negative blood, fresh frozen plasma, cryoprecipitate, and platelet components on-site at all times;

(ii) implementing a massive transfusion protocol;

(iii) ensuring guidelines for emergency release of blood components; and

(iv) managing multiple blood component therapy; and

(C) perinatal pathology services available.

(16) Medical Imaging Services must comply with the requirements found at §133.41 of this title and must have:

(A) personnel appropriately trained in the use of x-ray equipment available on-site at all times;

(B) advanced imaging, including computed tomography (CT), magnetic resonance imaging (MRI), and echocardiography available at all times;

(C) interpretation of CT, MRI and echocardiography within a time period consistent with current standards of professional practice and maternal care;

(D) a radiologist with critical interventional radiology skills available at all times;

(E) advanced ultrasonographic imaging for maternal or fetal assessment, including interpretation available at all times; and

(F) a portable ultrasound machine available in the labor and delivery and antepartum unit.

(17) Pharmacy services must comply with the requirements found in §133.41 of this title and must have a pharmacist with experience in perinatal pharmacology available at all times.

(18) Respiratory Therapy Services must comply with the requirements found at §133.41 of this title and must have a respiratory therapist immediately available on-site at all times.

(19) Obstetrical Services.

(A) The ability to begin an emergency cesarean delivery within a time period consistent with current standards of professional practice and maternal care.

(B) Ensure the availability and interpretation of nonstress testing, and electronic fetal monitoring.

(C) A trial of labor for patients with prior cesarean delivery must have the capability of anesthesia, cesarean delivery, and maternal resuscitation on-site during the trial of labor.

(20) Resuscitation. The facility must have written policies and procedures specific to the facility for the stabilization and resuscitation of the pregnant or postpartum patient based on current standards of professional practice. The facility:

(A) ensures staff members, not responsible for the neonatal resuscitation, are immediately available on-site at all times who demonstrate current status of successful completion of ACLS, or a department-approved equivalent course, and the skills to perform a complete resuscitation; and

(B) ensures that resuscitation equipment, including difficult airway management equipment for pregnant and postpartum patients, is readily available in the labor and delivery, antepartum and postpartum areas.

(21) The facility must have a written hospital preparedness and management plan for patients with placenta accreta spectrum disorder who are undiagnosed until delivery, including educating and training hospital and medical staff who may be involved in the treatment and management of placenta accreta spectrum disorder about risk factors, diagnosis, and management.

(22) The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

(A) massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;

(B) obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;

(C) placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment, and multidisciplinary management of both anticipated and unanticipated placenta accreta spectrum disorder cases, including postpartum care;

(D) hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;

(E) sepsis or systemic infection in the pregnant or postpartum patient;

(F) venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;

(G) shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and

(H) behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

(23) The facility must have nursing leadership and staff with training and experience in the provision of maternal critical care who must coordinate with respective neonatal services.

(24) The facility must have a program for genetic diagnosis and counseling for genetic disorders, or a policy and process for consultation referral to an appropriate facility.

(25) Perinatal Education. A registered nurse with experience in maternal care, including moderately complex and ill obstetric patients, must provide the supervision and coordination of staff education. Perinatal education for high risk events must be provided at frequent intervals to prepare medical, nursing, and ancillary staff for these emergencies.

(26) Support personnel with knowledge and skills in breastfeeding to meet the needs of maternal patients must be available at all times.

(27) A certified lactation consultant must be available at all times.

(28) Social services, pastoral care and bereavement services must be provided as appropriate to meet the needs of the patient population served.

(29) Dietician or nutritionist available with training and experience in maternal nutrition and can plan diets that meet the needs of the pregnant and postpartum patient and critically ill maternal patient must comply with the requirements in §133.41 of this title.

§133.210. Survey Team.

(a) The survey team composition must be as follows:

(1) Level I facilities maternal program staff must conduct a self-survey, documenting the findings on the approved department survey form. The department may periodically require validation of the survey findings, by an on-site review conducted by department staff.

(2) Level II facilities must be surveyed by a multidisciplinary team that includes at a minimum one obstetrics and gynecology physician and one maternal nurse who:

(A) have completed a survey training course;

(B) have observed a minimum of one maternal survey;

(C) are currently active in the management of maternal patients and active in the maternal QAPI Plan and process at a facility providing the same or higher level of maternal care; and

(D) meet the criteria outlined in the department survey guidelines.

(3) Level III facilities must be surveyed by a multidisciplinary team that includes at a minimum, one obstetrics and gynecology physician or maternal fetal medicine physician and one maternal nurse, who:

(A) have completed a survey training course;

(B) have observed a minimum of one maternal survey;

(C) are currently active in the management of maternal patients and active in the maternal QAPI Plan and process at a facility providing the same or higher level of maternal care; and

(D) meet the criteria outlined in the department survey guidelines.

(4) Level III facilities that serve as referral centers for placenta accreta spectrum disorder, must have a survey team that includes a maternal fetal medicine physician and a maternal nurse from a Level IV facility.

(5) Level IV facilities must be surveyed by a multidisciplinary team that includes at a minimum, one obstetrics and gynecology physician, a maternal fetal medicine physician, and one maternal nurse, who:

(A) have completed a survey training course;

(B) have observed a minimum of one maternal survey;

(C) are currently active in the management of maternal patients and active in the maternal QAPI plan and process at a facility providing Level IV maternal care; and

(D) meet the criteria outlined in the department survey guidelines.

(b) All members of the survey team, except department staff, must come from a Perinatal Care Region outside the facility's region or a contiguous region.

(c) Survey team members cannot have a conflict of interest:

(1) A conflict of interest exists when a surveyor has a direct or indirect financial, personal, or other interest which would limit or could reasonably be perceived as limiting the surveyor's ability to serve in the best interest of the public. The conflict of interest may include a surveyor personally trained a key member of the facility's leadership in residency or fellowship, collaborated with a key member of the facility's leadership professionally, participated in a designation consultation with the facility, had a previous working relationship with the facility or facility leaders, or conducted a designation survey for the facility within the past four years. Surveyors cannot be from the same PCR or TSA region or a contiguous region of the facility's location.

(2) If a designation survey occurs with a surveyor who has an identified conflict of interest, the maternal designation site survey summary and medical record reviews may not be accepted by the department.

(d) The survey team must follow the department survey guidelines to evaluate and validate that the facility demonstrates the designation requirements are met.

(e) All information and materials submitted by a facility to the department and a survey organization under Texas Health and Safety Code, §241.183(d) or this subchapter, are subject to confidentiality as articulated in Texas Health and Safety Code, §241.184, Confidentiality; Privilege, and are not subject to disclosure under Texas Government Code, Chapter 552, or discovery, subpoena, or other means of legal compulsion for release to any person.

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

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 113. STANDARDS OF PERFORMANCE FOR HAZARDOUS AIR POLLUTANTS AND FOR DESIGNATED FACILITIES AND POLLUTANTS SUBCHAPTER C. NATIONAL EMISSION STANDARDS FOR HAZARDOUS AIR POLLUTANTS FOR SOURCE CATEGORIES (FCAA, §112, 40 CFR PART 63)

30 TAC §§113.100, 113.106, 113.110, 113.120, 113.130, 113.170, 113.180, 113.190, 113.200, 113.220, 113.230, 113.240, 113.250, 113.260, 113.280, 113.290, 113.300, 113.320, 113.330, 113.340, 113.350, 113.360, 113.380, 113.390, 113.400, 113.410, 113.420, 113.430, 113.440, 113.500, 113.510, 113.520, 113.540, 113.550, 113.560, 113.600, 113.610, 113.620, 113.640, 113.650, 113.660, 113.670, 113.690, 113.700, 113.710, 113.720, 113.730, 113.740, 113.750, 113.770, 113.780, 113.790, 113.810, 113.840, 113.860, 113.870, 113.880, 113.890, 113.900, 113.910, 113.920, 113.930, 113.940, 113.960, 113.970, 113.980, 113.990, 113.1000, 113.1010, 113.1020, 113.1030, 113.1040, 113.1050, 113.1060, 113.1070, 113.1080, 113.1090, 113.1100, 113.1110, 113.1120, 113.1130, 113.1140, 113.1150, 113.1160, 113.1170, 113.1180, 113.1190, 113.1200, 113.1210, 113.1220, 113.1230, 113.1250, 113.1260, 113.1270, 113.1280, 113.1290, 113.1300, 113.1320, 113.1350, 113.1370, 113.1380, 113.1425, 113.1435, 113.1445, 113.1450, 113.1460, 113.1465, 113.1470, 113.1475, 113.1485, 113.1500, 113.1505, 113.1510, 113.1520, 113.1525, 113.1530, 113.1555

(Editor's note: In accordance with Texas Government Code, §2002.014, which permits the omission of material which is "cumbersome, expensive, or otherwise inexpedient," the figure in 30 TAC Chapter 113 - Preamble is not included in the print version of the Texas Register. The figure is available in the on-line version of the December 30, 2022, issue of the Texas Register.)