April 24, 2019

Virginia K. Hoelscher
Chair, Opinion Committee
Attorney General of Texas
P.O. Box 12548
Austin, Texas 78711-2548

Via Email: Opinion.Committee@oag.texas.gov

Re: Regulatory Authority Over the Administration of Anesthesia Delegated by a Physician to a Nurse Anesthetist (RQ-0278-KP)

Dear Ms. Hoelscher:

The Texas Medical Association ("TMA") was organized in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and the improvement of public health. With more than 53,000 physician and medical student members, TMA is the nation's largest state medical society.

The Texas Society of Anesthesiologists ("TSA") is the Texas component of the American Society of Anesthesiologists and counts among its members over 4,000 physicians who practice the medical specialty of anesthesiology in healthcare facilities throughout Texas.

The Texas Medical Association and the Texas Society of Anesthesiologists appreciate the opportunity to comment on the Texas Medical Board's request for an attorney general opinion regarding regulatory authority over the administration of anesthesia when delegated by a physician to a nurse anesthetist (RQ-0278-KP). For reasons discussed in this letter, TMA and TSA believe that providing anesthesia to patients is the practice of medicine, that the Texas Medical Board has continuing regulatory authority over a physician's decision and process for delegating administration of anesthesia to a certified registered nurse anesthetist ("CRNA"), and that CRNAs cannot administer anesthesia in the absence of delegation by a physician and do not practice independently.

BACKGROUND

In Texas, anesthesia services are generally administered by anesthesia practitioners, including physician anesthesiologists, anesthesiologist assistants, and certified registered nurse anesthetists.[1] Physician anesthesiologists are medical doctors who have completed a bachelor's degree, medical school, and an anesthesiology residency, typically four years in length. Anesthesiologist assistants are non-physician anesthesia practitioners who complete a bachelor's degree and a two-year graduate anesthesia program, and who work only under the medical

direction or supervision of physician anesthesiologists. CRNAs are licensed as advanced practice registered nurses ("APRN") and have completed a bachelor's degree and a two- or three-year nurse anesthesia graduate program. CRNAs also work under the medical direction or supervision of physician anesthesiologists, but in some instances, a CRNA's administration of anesthesia may be delegated and supervised by a physician who is not an anesthesiologist but who assumes responsibility for satisfying requirements found in state law and federal Medicare regulations pertaining to delegation of medical acts and supervision of nurse anesthetists.

As pointed out by the American Society of Anesthesiologists in its statement on the Anesthesia Care Team, all types of anesthesia carry risks. Whether a physician anesthesiologist or a surgeon or another physician delegates anesthesia care to a non-physician, medical, anesthetic and surgical complications may arise unexpectedly and require immediate medical diagnosis and treatment.[2] The administration of anesthesia to surgical patients extends far beyond the common perception of "putting the patient to sleep." Anesthesia is a complex and potentially dangerous medical discipline that requires the constant vigilance of a well-trained and experienced physician. Among the integral parts that make up the anesthesia service are the diagnosis and assessment of the patient's overall physical condition and the administration of appropriate drugs and medications which lessen the inherent risk associated with the administration of anesthesia.

Anesthesiologist assistants and CRNAs play valuable roles in the delivery of health care in Texas. However, the American Association of Nurse Anesthetists ("AANA") and its Texas affiliate, the Texas Association of Nurse Anesthetists ("TANA") have aggressively lobbied for independent practice in Texas and elsewhere. For example, one need look no further than TANA's website to find the following statements:[3]

- The role of the certified registered nurse anesthetist (CRNA) is vital to healthcare in Texas. **CRNAs work as independent providers and are independently licensed and legally responsible and accountable for their own practices in Texas (emphasis added).** They may practice as private practitioners on the basis of their own clinical privileges within hospitals or surgery centers; and may independently contract for the provision of anesthesia services and facilities; or they may be employed by a hospital, surgical center, a group of MDs, or a surgeon.
- **When anesthesia is administered by a nurse anesthetist, it is recognized as the practice of nursing; when administered by an anesthesiologist, it is recognized as the practice of medicine (emphasis added).**
- The delivery of anesthesia services by a CRNA in Texas is the practice of professional nursing. CRNAs are licensed by the Texas Board of Nursing and a **CRNA's scope of practice is clearly defined by the American Association of Nurse Anesthetists (emphasis added).**
- When a CRNA administers anesthesia, **the individual is engaged in the practice of nursing, rather than performing a delegated act of medicine (emphasis added).**
- **CRNAs practice as a sole anesthesia provider working independently (emphasis added)** with physicians providing surgical, interventional, and obstetric care to Texans.

- And, we take seriously the role we play in providing high quality, safe anesthesia care for Texans, both when CRNAs practice independently and when we are part of an Anesthesia Care Team.

TANA also actively lobbies on behalf of its members' economic well being. In the current 86th Legislative Session, for example, TANA has aggressively lobbied against House Bill 3878, which would provide for licensure of anesthesiologist assistants. Though anesthesiologists testified that licensing anesthesiologist assistants—competitors to CRNAs—would increase access to care, TANA and its members opposed the bill, for reasons including that licensing anesthesiologist assistants would convey legitimacy to the profession. An example of TANA's lobbying efforts against this bill is attached. (Attachment A)

It is relevant to note that TANA has additionally represented the following to members of the legislature:

- CRNAs provide quality care independently, and are licensed to make case decisions without delay.
- CRNAs are educated and trained to work independently (without an anesthesiologist).
- CRNAs and anesthesiologists can work independent of one another or together by law to insure patient's access to surgical, obstetrical, emergency and pain management services in rural and urban locations across the state. (See Attachment A)

TMA and TSA believe that TANA's representations to the legislature and to the citizens of Texas are relevant to the Texas Medical Board's ("TMB") request for an attorney general opinion, because these are not hypothetical questions and because delivery of quality health care to the citizens of Texas should not be compromised by misrepresentations of state law and economic interests.

Certified Registered Nurse Anesthetists' ("CRNA") scope of practice is indeed a controversial topic in Texas. For example, TANA and AANA frequently cite a publication which analyzed rates of death and number of complications from surgery in 14 states that have "opted out" of the requirement for CRNAs to be supervised by an anesthesiologist or surgeon in order to receive Medicare reimbursement.[4] This publication states that incidents of patient deaths or complications did not increase in states that chose to opt out of the supervision requirement.

The American Society of Anesthesiologists ("ASA") reacted quickly, pointing out that the publication was funded by the American Association of Nurse Anesthetists and highlighting what ASA contends are shortcomings of the publication, including:

a) the article's methodology relied only on billing data which tends to understate input by anesthesiologists and surgeons and overstate care characterized as "independent" CRNA practice;

b) the study reviewed only 480,000 cases, which would have a predicted anesthesia-related mortality in two cases, resulting in an analysis of anesthesia-related mortality that is grossly under powered and does not permit distinguishing between surgical and anesthesia complications or mortality. National data showed one death per 200,000 – 300,000 anesthetics administered.[5]

c) Anesthesiologists not only care for patients undergoing the most complex procedures, but also the sicker patients undergoing all procedures. According to the ASA, these considerations would suggest dramatically better outcome for CRNAs, but this has not been seen. In fact, data described in the HealthAffairs article related to Medicare cases billed under the QZ modifier (CRNA without medical direction by an anesthesiologist) showed worsening mortality and complications.[6]

d) As an illustration of the depth of the conflict, ASA issued a media statement which concluded that the paper was ". . . an advocacy manifesto masquerading as science and does a disservice to the public."[7]

In contrast, a 2000 study funded by the Agency for Healthcare Research and Quality found that the presence of an anesthesiologist prevented more than six excess deaths per 1,000 cases in which anesthesia or surgical complications occurred.[8] The authors found that after factoring out variables based on patient condition and hospital characteristics, there were 2.5 excess deaths per 1,000 cases within 30 days of admission when an anesthesiologist was not involved in the patient's care. The study covered only general surgical and orthopedic procedures, extrapolated to the estimated 20 million Medicare surgical procedures of all types performed annually.

Regardless of how one interprets the literature, it is clear that the training of nurse anesthetists and physician anesthesiologists is not equivalent. Nurse anesthetists receive approximately 2-1/2 years of training following a Bachelor's degree and anesthesiologists spend at least eight years preparing for practice after a pre-medical undergraduate education. The training and experience demanded to become a board certified anesthesiologist prepares a physician to do more than administer anesthetic drugs and perform procedural tasks. It provides physicians with the ability to rescue patients who experience significant peri-operative problems, and to address underlying medical complications.

QUESTION 1(a). Is providing anesthesia the practice of medicine?

ANSWER: Yes.

Any discussion of CRNA scope of practice in Texas must begin with an understanding that the administration of anesthesia to a surgical patient has long been recognized by Texas law to be the practice of medicine.[9]

The Medical Practice Act allows physicians to delegate medical acts to non-physicians under certain circumstances. When considering delegation of administration of anesthesia to a

CRNA, the Medical Practice Act provides a two-step analysis. Texas Occupations Code, Section 157.001. *General Authority of Physician to Delegate* reads in part:

> (a) A physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician:
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> (1) the act:
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> (A) can be properly and safely performed by the person to whom the medical act is delegated;
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> (B) is performed in its customary manner; and
>
> (C) is not in violation of any other statute; and
>
> (2) the person to whom the delegation is made does not represent to the public that the person is authorized to practice medicine.
>
> (b) the delegating physician remains responsible for the medical acts of the person performing the delegated medical acts.
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> . . .

Section 157.058 of the Occupations Code. *Delegation to Certified Nurse Anesthetist* is also implicated:

> (a) In a licensed hospital or ambulatory surgical center, a physician may delegate to a certified registered nurse anesthetist the ordering of drugs and devices necessary for the nurse anesthetist to administer an anesthetic or an anesthesia-related service ordered by the physician.
>
> (b) The physician's order for anesthesia or anesthesia-related services is not required to specify a drug, dose, or administration technique.
>
> (c) Pursuant to the physician's order and in accordance with facility policies or medical staff bylaws, the nurse anesthetist may select, obtain, and administer those drugs and apply the medical devices appropriate to accomplish the order and maintain the patient within a sound physiological status.
>
> (d) This section shall be liberally construed to permit the full use of safe and effective medication orders to use the skills and services of certified registered nurse anesthetists.

The scope of "professional nursing" includes performance of those medical acts delegated by a physician under authority of the Medical Practice Act.[10] Thus, when a CRNA administers anesthesia pursuant to a physician order, the CRNA is providing a service within the scope of professional nursing. A physician who delegates professional medical acts to a person whom the physician knows or should know is unqualified to perform the acts may be disciplined.[11]

Under state law, a CRNA may not administer an anesthetic that is a controlled substance outside the presence of a physician.[12] Nor may a CRNA obtain an anesthetic that is a dangerous drug unless a physician has listed that CRNA as the physician's designated agent.[13]

Administration of anesthesia is the practice of medicine, including but not limited to preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel that support these activities. As noted by a Texas Court of Appeals:

"The evidence showed that the practice of anesthesia is a specialized practice of medicine by a physician – an anesthesiologist. An anesthesiologist is also trained in the practice of taking care of a patient just as any other physician is trained. An anesthesiologist is the most highly trained person who practices anesthesia. A certified registered nurse anesthetist (CRNA) is a registered nurse who has additionally completed a two-year study in nurse anesthesia and has been certified by the American Association of Nurse Anesthetists. A nurse anesthetist may administer anesthesia, but only under the medical direction or supervision of a physician. Nurse anesthetists cannot practice medicine." *Denton Reg'l Med. Ctr. v. LaCroix* 947 S.W.2d 941, 943 (Tex. App.—Fort Worth 1997, writ dis'd).

Section 301.002(2)(G) of the Nursing Practice Act states that a nurse licensed by BON may perform medical acts delegated by a physician under authority provided by the Medical Practice Act (Tex. Occ. Code, Chapter 157). Administration of anesthesia by a nurse is nowhere referenced in the Nursing Practice Act, except indirectly as a medical act that may be performed by a nurse if delegated by a physician in accordance with the Medical Practice Act.[14]

QUESTION 1(b). When a physician delegates the providing and administration of anesthesia to a certified registered nurse anesthetist (CRNA) does TMB, via the Medical Practice Act, continue regulatory authority over the physician's decision and process for delegating that authority to a CRNA?

ANSWER: Yes.

This is not the first time an attorney general has been asked this question. In 1984, Attorney General Jim Mattox authored opinion number JM-173, responding to the following inquiry from Senator Chet Brooks:

> Does the Board of Medical Examiners (now the Texas Medical Board) have the authority to regulate the details and means and manner of physicians' delegations of authority to non-physicians acting under the control or supervision or at the instruction of one licensed by the Texas State Board of Medical Examiners?

Focusing on then-Article 4495(b)§3.06(d)(1), now Texas Occupations Code §157.001, Attorney General Mattox concluded that a nurse's performance of a delegated medical act falls within the scope of the Texas Nursing Practice Act and that the TMB has authority to regulate the details, means, and manner of delegating medical acts to a nurse to be done under a physician's control or supervision or at his or her instruction.[15]

Texas Occupations Code §157.001(c) states:

c. The board may determine whether:

(1) an act constitutes the practice of medicine, not inconsistent with this chapter; and

(2) a medical act may be properly or safely delegated by physicians.

The Texas Medical Board issued an opinion on September 9, 1998 which concluded:

> The Texas State Board of Medical Examiners fully supports the opinion in Dr. Levy's letter. We agree that the administration of anesthesia is the practice of medicine and that this act may be delegated to a properly trained and qualified CRNA. In addition, the delegating physician remains ultimately responsible for the acts delegated to the CRNA under the physician's delegated authority. In the opinion of the Board, the Medical Practice Act does not confer independent authority on CRNAs to independently administer anesthesia outside the supervision of a delegating physician. (Attachment B)

TMB's opinion, as well as the referenced letter authored by its executive director are included as Attachments B and C.

On September 28, 1999, Texas Attorney General John Cornyn issued opinion number JC-0117[16] in response to a request from the Texas State Board of Nurse Examiners (now BON). As restated by the attorney general, the BON's position was summarized as follows:

> The Board of Nurse Examiners has 'for many years,' considered the selection and administration of anesthesia and the care of anesthetized patient by a certified nurse anesthetist to be the practice of professional nursing rather than the delegated practice of medicine requiring oversight/supervision by a physician.

Attorney General Cornyn responded:

> We conclude that your construction is correct only in part. Under the Nursing Practice Act....and under the Medical Practice Act...the practice of professional nursing includes the selection and administration of anesthesia and the care of an anesthetized patient by CRNA, but only when those tasks are delegated by a physician. Accordingly, we generally conclude that the Board of Nurse Examiners has authority to regulate the selection and administration of anesthesia

> and the care of an anesthetized patient by CRNA. We further conclude that neither the Nursing Practice Act nor the Medical Practice Act requires a physician to delegate the selection or administration of anesthesia or the care of the anesthetized patient.

The nature of a physician's responsibilities for medical acts delegated to a CRNA is discussed at length in the opinion. The Attorney General noted that when a CRNA performs a delegated medical act, there is necessarily some overlap between the practice of medicine and the practice of nursing. "[T]hese tasks are within the practice of nursing for a CRNA, but only when the tasks are properly delegated to the CRNA by a physician."

The term "delegate" is not defined in the Medical Practice Act, and the Attorney General drew on other sources to state ". . . the term 'delegate' denotes a deputization of one person, e.g., a CRNA, to act as the agent of the other, e.g., the physician." While concluding that the Medical Practice Act does not require a physician to directly supervise a CRNA in the performance of delegated anesthesia-related tasks, the Attorney General noted ". . . nor does it absolve a physician of responsibility for an imprudent delegation."

Attorney General Cornyn's opinion is entirely consistent with the opinion issued by TMB in 1998. The attorney general's opinion finds that a CRNA may select and administer anesthesia only when those acts have been delegated by a physician and that there is nothing in the Medical Practice Act or the Nursing Practice Act that requires a physician to delegate those acts.

As noted by Attorney General Cornyn's opinion, the definition of "professional nursing" contained in the Nursing Practice Act includes the performance of acts delegated by a physician. Tex. Occ. Code §301.002(2)(G). The definition includes a reference to §157.058 of the Texas Occupation Code, which allows a physician to delegate anesthesia-related services to a CRNA consistent with the Medical Practice Act.

But, in Section 301.004(c)(4) of the Nursing Practice Act, the legislature directed that the Nursing Practice Act does not apply to: "(c)(4) an act performed by a person under the delegated authority of a person licensed by the Texas Medical Board."[17]

Thus, the Nursing Practice Act is consistent with the Texas Medical Board's continuing jurisdiction over the decision and process utilized by a physician in delegating performance of medical acts to a CRNA and the proper performance of those medical acts by the CRNA. Attorney General Cornyn's opinion also cites other relevant portions of the Medical Practice Act, which provide that, while a physician may delegate medical acts to a non-physician, the physician remains responsible for the outcome of the delegated acts. Tex. Occ. Code §157.002.

Section 157.058 of the Occupations Code is limited to delegating and administering anesthesia in a licensed hospital or ambulatory surgical setting. That portion of the statute does not address other settings such as outpatient procedures in a physician's office. For issues related to those practice settings, Attorney General Cornyn cited §157.002 of the Texas Occupations Code, which does provide authority to a physician to delegate medical acts to a properly trained and qualified non-physician in a physician's office. Again, in doing so, "the

delegating physician remains responsible for the medical acts of the person performing the delegated medical acts." Tex. Occ. Code §157.001(b), §157.002, §157.005

Attorney General Cornyn's opinion clarified some of the ambiguities surrounding the delegation of medical acts by physicians to non-physicians; in this case, the selection and administration of anesthetics and the care of anesthetized patients. In doing so, the opinion confirmed that anesthesia-related services are the practice of medicine and that physician may delegate those acts to properly trained and qualified CRNAs. The extent to which the delegating physician is required to supervise the performance of a CRNA's acts is a complicated question that requires the sound exercise of medical judgment by the delegating physician. However, regardless of whether the delegating physician is required to directly supervise the CRNA, the delegating physician remains responsible to TMB and to their patients for acts performed by a CRNA under the physician's delegated authority.

Note, it is not surprising that the attorney general did not make a specific finding that the selection and administration of anesthetic agents is the practice of medicine. This is because §157.001 of the Medical Practice Act gives TMB the authority to determine which acts constitute the practice of medicine. And TMB, acting under the authority conferred by the Medical Practice Act, concluded in 1998 that the administration of anesthesia is the practice of medicine.

One case classification that differs from the supervision analysis provided by Attorney General Cornyn is a requirement when treating Medicare patients. Currently, federal regulations concerning Medicare coverage and conditioning hospital participation in Medicare and Medicaid programs require a CRNA to be supervised by a physician when the CRNA administers anesthesia.[18]

QUESTION 2. Does a CRNA have independent authority to administer anesthesia without delegation by a physician?

ANSWER: No.

Section 301.151 of the Texas Occupations Code says the Board of Nursing may adopt and enforce rules consistent with the Nursing Practice Act. Section 301.152 authorizes BON to adopt rules for licensure of registered nurses as Advanced Practice Registered Nurses (APRNs), and provides guidance for education, training and prescriptive authority requirements.

As an APRN, a CRNA is still bound by the scope of practice for nursing, and there is no expanded scope of practice for APRNs. The scope of nursing as defined in 301.002(2)(G) of the Nursing Practice Act includes certain acts that must be delegated first by a physician, including administration of anesthesia. By virtue of the fact that the Nursing Practice Act requires physician delegation of these medical acts, they *cannot* be independent—that is quite literally the definition of being dependent.

The Board of Nursing does not agree with TANA's representation of independent practice by CRNAs. In the February 22, 2019 issue of the Texas Register, the Board of Nursing published notice of its adoption of amendments to 22 Texas Administrative Code §§221.2-

221..5, 221.7-221.10. These rules address and regulate practice by Advanced Practice Registered Nurses, including CRNAs. Concerns were raised by commenters regarding BON's references to the APRN Consensus Model developed by the National Council of State Boards of Nursing. In response, BON stated:

> The Consensus Model was intended to address existing licensing inconsistencies among states, which can limit the mobility of APRNs and in turn, affect the availability of competent healthcare providers. However, the Board recognizes that its provisions are only suggestive and not controlling law in the state of Texas, particularly where the model's provisions conflict with existing state statute....However, neither the Board's preamble nor the Board's proposed rules contain provisions that contradict existing state statute. In fact, the Board has not proposed any rule amendment that authorizes the independent practice of APRNs in Texas, implies independent practice, or that changes the existing authorized scope of practice for a APRN, the existing standards of nursing practice for an APRN, or the requirements of the Medical Practice Act that relate to physician delegation, collaboration, supervision or prescriptive authority.
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> . . .
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> A commenter states that the Medical Practice Act includes numerous examples of the Texas legislature's clear intent that APRNs perform medical acts only when those acts are delegated by a physician and performed under adequate physician supervision or a prescriptive authority agreement. BON does not disagree, nor has BON proposed any amendment that would alter this interpretation of Texas law. The Board agrees that an APRN may only perform medical aspects of care through proper physician delegation, supervision, and collaboration.
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> To this end, the Board re-iterates that its reference to the Consensus Model in the preamble to the rule proposal should not be construed to mean that all elements of the Consensus Model apply in Texas or that an APRN may function in a manner that is not expressly authorized under, or is in conflict with, Texas law.[19]

The Texas Medical Association and the Texas Society of Anesthesiologists appreciate the opportunity to offer comments. Please advise if you have questions. Thank you for your attention to these matters.

Sincerely yours,

Texas Society of Anesthesiologists

Gerald Ray Callas, MD
President

Texas Medical Association

Douglas W. Curran, MD
President

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[1] Certain forms of anesthesia care may also be administered and delegated by dentists who are certified by the Texas State Board of Dental Examiners. See 22 T.A.C. Chapter 110.

[2] American Society of Anesthesiologists, Statement of Anesthesia Care Team (Last amended October 17, 2018)

[3] https://www.txana.org (Last accessed on April 16, 2019)

[4] Fleming, C., Nurse Anesthetists Provide Safe Care Without Supervision. Health Affairs blog. August 3, 2010. Available at http://healthaffairs.org/blog/2010/08/03/nurse-anesthetists-provide safe-care-without-doctor-supervisioin. Dulisse, B., Cromwell, J., *Health Affairs* 29, No. 8 (2010).

[5] Committee on Quality of Healthcare in America, Institute of Medicine: To Err is Human, Building a Safer Health System. Edited by Kohn, L., Corrigan, J., Donaldson, M. Washington, National Academy Press, 1999, p. 241.

[6]Hannenberg, A., Letter to ASA membership 08.03.2010

[7] ASA Statement regarding AANA-sponsored paper published in *Health Affairs*, August 2010; August 5, 2010

[8] Silber, J.H., Kennedy, S.K., et al.; Anesthesiologist Direction and Patient Outcomes. Anesthesiology; 2000; 93: 152-163.

[9] Tex. Occ. Code § 151.002 (13) (defining "[p]racticing medicine"); *McKinney v. Tromly*, 386 S.W.2d 564, 565 (Tex. Civ. App. – Tyler 1964, writ ref'd n.r.e.); *Denton Reg'l Med. Ctr. v. LaCroix*, 947 S.W.2d 941, 943 (Tex. App. – Fort Worth 1997, pet. dism'd); *Weyandt v. State*, 35 S.W.3d 144 (Tex. App. – Houston [14th Dist.] 2001, no pet.)

Footnote 3.
We disagree with Amici American Association of Nurse Anesthetists and Texas Association of Nurse Anesthetists, who argue that peripheral nerve stimulators, such as the one used by appellant are routinely—and properly—used by all anesthesia providers, including nurse anesthetists, in their anesthesia practice. The legislature has restricted a CRNA's practice to the administration of anesthesia and maintenance of an anesthesia patient—all of which must be done under the delegation of a physician *See* Tex. Rev. Civ. Stat.Ann. art. 4495b, § 3.06(d)(6)(l) (Vernon Pamph. 1999) (current version at Tex. Occup.Code Ann. § 157.058(c)); Op.Tex.Att' Gen. No. JC-0117 (1999).

[10] Tex. Occ. Code § 301.002(2)(G)

[11] Tex. Occ. Code § 164.053(a)(9)

[12] Tex. Health & Safety Code § § 481.002(1)(A), .071(a)

[13] Tex. Health & Safety Code § § 483.001(4), .022(a)

[14] Tex. Occ. Code § 301.002(2)(G)

[15] Op. Tex. Att'y Gen. No. JM-173

[16] Op. Tex. Att'y Gen. No. JC-0117

[17] Tex. Occ. Code § 301.004(c)(4)

[18] 42 CFR § § 416.42(b)(2), 482.52(a)(4), 485.639(c)(1)(v), (2)

[19] Tex. Reg., Vol. 44, No. 8, February 22, 2019