

# ADOPTED RULES

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

## TITLE 1. ADMINISTRATION

### PART 7. STATE OFFICE OF ADMINISTRATIVE HEARINGS

#### CHAPTER 155. RULES OF PROCEDURE

The State Office of Administrative Hearings (SOAH) adopts repeals, new rules, and amendments to 1 TAC, Part 7, Chapter 155 concerning Rules of Procedure. SOAH amends Subchapter A, §§155.1, 155.3, 155.5, and 155.7; Subchapter B, §155.51 and §155.53; Subchapter D, §§155.151, 155.153, and 155.155; Subchapter E, §155.201; Subchapter G, §§155.301, 155.305, and 155.307; Subchapter H, §155.351; Subchapter I, §§155.401, 155.405, 155.407, 155.411, 155.419, 155.421, 155.423, 155.425, 155.427, 155.429, and 155.431; and Subchapter J, §§155.501, 155.503, 155.505, and 155.507. SOAH adopts the repeal of §155.101 and §155.103 in Subchapter C; §155.251 in Subchapter F; and §155.413 in Subchapter I. SOAH adopts new §§155.101, 155.103, and 155.105 in Subchapter C; new §155.152 in Subchapter D; new §155.203 in Subchapter E; new §§155.251, 155.253, 155.255, 155.257, and 155.259 in Subchapter F; and new §155.509 in Subchapter J.

Sections 155.3, 155.5, 155.101, 155.103, 155.259, 155.425, and 155.501 are adopted with changes to the proposed text as published in the May 13, 2016, issue of the *Texas Register* (41 TexReg 3365) and will be republished. Sections 155.1, 155.7, 155.51, 155.53, 155.105, 155.151, 155.152, 155.153, 155.155, 155.201, 155.203, 155.251, 155.253, 155.255, 155.257, 155.301, 155.305, 155.307, 155.351, 155.401, 155.405, 155.407, 155.411, 155.419, 155.421, 155.423, 155.427, 155.429, 155.431, 155.503, 155.505, 155.507, 155.509 are adopted without changes to the proposed text as published in the May 13, 2016, issue of the *Texas Register* (41 TexReg 3365) and will not be republished.

The adopted amendments, repeals, and new sections provide clearer, more uniform, and better organized procedures for participants in administrative proceedings at SOAH.

SOAH received comments concerning the proposed amendments during the comment period of May 13, 2016, through June 13, 2016, from the Texas Comptroller of Public Accounts, the Texas Real Estate Commission, the Texas Appraiser Licensing and Certification Board, the Texas Department of Insurance, and the Texas Board of Nursing. SOAH received one late comment from an individual.

#### SUBCHAPTER A. GENERAL

1 TAC §§155.1, 155.3, 155.5. 155.7

Comment: One commenter raised concerns with proposed §155.5 because it omits the definitions of "case," "contested

case," and "final decision" contained in the current rule. The commenter noted that those terms continue to be used elsewhere in SOAH's rules and that "contested case" is defined in the Administrative Procedures Act (APA).

Response: SOAH removed those definitions (and several others) in proposed §155.5 because the definitions are unnecessary. SOAH believes that the meaning of those terms is readily discernible from the context in which they are used in other sections of chapter 155 and that attempting to separately define them in §155.5 had the potential to add confusion, rather than clarity. As the commenter noted, "contested case" is already defined in the APA, and it is not necessary to have a redundant definition in SOAH's rules.

#### SUBCHAPTER B. DOCKETING--FILING A CONTESTED CASE

1 TAC §155.51, §155.53

Comment: One commenter objected to proposed §155.53(c), and specifically the proposed language that "SOAH will attempt to set the hearing on the date and time requested, but the setting will be based on the availability of hearing rooms and judges." The commenter stated that this rule might negatively affect its ability to receive timely hearings.

Response: It has always been SOAH's practice to set hearings in compliance with any applicable statutory deadline and, whenever feasible, on the specific date requested by the parties. Proposed §155.53(c) states this practice in express terms. It does not represent a change in policy or practice.

#### SUBCHAPTER C. FILING AND SERVICE OF DOCUMENTS

1 TAC §§155.101, 155.103, 155.105

Comment: One commenter objected to the requirement in §155.101(b)(1)(C) that documents be filed in "text-searchable portable document format (PDF)." The commenter asserted that this requirement would be unnecessarily burdensome or impossible for its staff to comply with.

Response: SOAH's proposed rule was modeled after Rule 21(f) in the Texas Rules of Civil Procedure (TRCP), which also requires all electronically filed documents to be in "text-searchable portable document format." Although the proposed rule required documents to be filed in text-searchable PDF format, it did not require that all documents be "directly converted," or saved, in that format. Instead, the proposed rule asked for direct formatting, "if possible." In response to the comment, SOAH has revised the rule to recognize a distinction between a document created by an agency or attorney, such as a pleading, and a document the agency or attorney has received from a third party. The revised rule requires an agency or attorney to directly format a *pleading* by saving it as a PDF before it is uploaded to CIS. For a *non-pleading* document (such as an exhibit or attachment) the

revised rule only requires that it be scanned as a PDF, and if possible, be text-searchable.

Comment: One commenter objected to proposed §155.101(b) because the commenter lacks the capacity to provide electronic signatures on filings.

Response: SOAH has added a subsection to the rule (now §155.101(b)(1)(F)) that expressly allows electronic signatures either by using an imaged signature or simply signing by "/s/" with the signer's typed name. This follows the practice in state court under TRCP 21(f)(7) and also comports with the long-standing practice in federal court. SOAH is confident that agencies and attorneys can easily adapt to using electronic signatures in administrative hearings.

Comment: One commenter expressed concern that proposed §155.101(b)(3) gave SOAH's docketing department the ability to reject and return filings that are not submitted in the correct format.

Response: Although SOAH does not believe the proposed rule granted SOAH's docketing department the power to reject filings, for clarity SOAH has added a sentence to §155.101(b)(3), stating that "SOAH's docketing department may not refuse to file a document that fails to conform with this rule." This new provision follows the practice in state court under TRCP 21(f)(11).

In addition, to avoid potential confusion, SOAH added subsection 155.101(b)(1)(C) to state that filings in CIS must comply with the requirements and procedures set forth on SOAH's website and electronic filing page.

Comment: One commenter asserted that proposed §155.103(a) creates an ambiguity or inconsistency with regard to what documents or information would qualify as "confidential." Specifically, the commenter noted that proposed §155.103(a) states that documents are accessible to the public "unless the proceeding is made confidential by law or the documents are designated as confidential pursuant to this rule," while §155.103(a)(1) states that confidential information "is information made confidential by law." The commenter also suggested that any information that would be considered non-disclosable under the Texas Public Information Act, Tex. Gov't Code Chapter 552, should qualify as confidential for purposes of this rule.

Response: In response to this comment, SOAH has revised §155.103(a)(1) to expand the definition of confidential information by stating that it "includes," among other things, "information otherwise protected from disclosure by law." The word "includes" is used as a term of enlargement and not of limitation or exclusive enumeration.

SOAH does not find a conflict between the introductory sentence of §155.103(a), referencing documents designated as confidential pursuant to this rule, and §155.103(a)(1), which defines confidential information for purposes of SOAH's rules. The introductory sentence simply explains which documents are accessible through SOAH's public website. The provisions are not inconsistent.

Comment: Two commenters suggested that SOAH should expand §155.103 to address circumstances where hearings are non-confidential and open to the public, but a significant portion of the evidence used at the hearing is designated as confidential by law.

Response: SOAH handles many cases under these circumstances and does not agree that additional or more specific

procedural rules are needed. The current and proposed rules include the following provisions that may be invoked in public (non-confidential) hearings that involve confidential information:

Proposed §155.103 instructs parties on how to file documents that are confidential in whole or in part. Parties can redact the confidential information and publicly file the redacted documents pursuant to proposed §155.103(b). Alternatively, documents that are entirely confidential document may be filed under seal pursuant to proposed §155.103(c).

Both the proposed and current versions of §155.423(g) authorize the presiding judge to seal the record in whole or in part in order to preserve the confidentiality of any evidence discussed at the hearing. Likewise, the current and proposed versions of §155.429 authorize the presiding judge to exclude witnesses from the hearing room so that they may not hear the proceedings. And both the current and proposed versions of §155.153 authorize ALJs to take steps and make any orders necessary to conduct the hearings. SOAH believes that these provisions provide ample authority to exclude non-parties from attending those portions of public hearings where confidential information is discussed.

Comment: One commenter objected to the provision in §155.105(a), which would authorize service of documents by email. The commenter stated that email service could be deemed non-compliant with the requirements of the APA or the agency's authorizing statute.

Response: The provision allowing email service is not new, as SOAH's rules have authorized email service since 2008. The objected-to language is found in SOAH's current §155.103(a), and there has been no controversy with parties who have elected to use email service. Email service is also well-established and used in both federal and state courts. Fed. R. Civ. P. 5(b); Tex. R. Civ. P. 21a(a). In addition, the APA authorizes service of orders and final decisions by email, if agreed to by the party to be notified. Tex. Gov't Code §2001.142(a)(2). In both the current and proposed rules, email service at SOAH is authorized only "upon agreement of the parties." Moreover, email service is not mandatory under SOAH's rule; it is one option for service. If an agency believes that email service is not compliant with its authorizing statute, the rule allows for service by hand-delivery, certified or registered mail, or by fax. However, email service should remain available to other parties with cases pending at SOAH.

#### SUBCHAPTER D. JUDGES

1 TAC §§155.151, 155.152, 155.153, 155.155

Comment: One commenter objected to proposed §155.151(c), which permits more than one judge to be assigned to a matter without specifying the criteria for such assignment. The commenter suggested that assigning more than one judge to a case could affect scheduling or result in disagreement on substantive issues raised in the case.

Response: The proposed rule makes only minor, non-substantive changes to current §155.151(d). While the vast majority of SOAH cases are assigned to a single judge, it has been SOAH's longstanding practice to assign more than one judge to a case when necessary, such as cases with large records where a single judge might not be able to meet the statutory deadline for issuing a decision or proposal for decision. The concerns raised in the comment have not occurred, and there is no basis to change this longstanding practice.

Comment: Two commenters suggested that §155.153(b)(11) be amended to specify that, in Proposals for Decision, an ALJ's recommended sanction must be set out separately from the findings of fact and conclusions of law.

Response: Texas appellate courts have made clear that whether a proposed sanction is classified as a "recommendation" or a "conclusion of law": (1) the proposed sanction is not binding on the referring agency; and (2) the referring agency must comply with Tex. Gov't Code §2001.058(e) if it elects to alter the ALJ's proposed sanction. *Froemming v. Texas State Bd. of Dental Examiners*, 380 S.W.3d 787, 792 (Tex. App.-Austin 2012, no pet.); *Granek v. Texas St. Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex. App.-Austin 2005, no pet.); *Texas State Bd. of Dental Exam'rs v. Brown*, 281 S.W.3d 692, 697 (Tex. App.-Corpus Christi 2009, pet. denied). Because the law does not distinguish between proposed sanctions expressed as "recommendations" or as "conclusions of law," there is no reason to create such a distinction in SOAH's rules.

#### SUBCHAPTER E. REPRESENTATION OF PARTIES

1 TAC §155.201, §155.203

SOAH received no comments concerning these rules.

#### SUBCHAPTER F. DISCOVERY

1 TAC §§155.251, 155.253, 155.255, 155.257, 155.259

Comment: Three commenters objected to the provisions in §155.255(a) that would limit a party to 25 separate requests for production (RFPs), and would limit the use of Requests for Admissions (RFAs) to address only jurisdictional facts and genuineness of documents.

Response: SOAH proposed these amendments to address recurring discovery abuses, particularly in cases against unrepresented parties. Agency lawyers sometimes serve voluminous discovery requests, and then seek case-dispositive sanctions or summary disposition based on the opposing party's failure to respond. This practice is concerning, as the Texas Supreme Court has cautioned that deemed admissions should not be used to preclude a hearing on the merits of a case, especially against an unrepresented party. *Marino v. King*, 355 S.W.3d 629 (Tex. 2011); *Wheeler v. Green*, 157 S.W.3d 439 (Tex. 2005).

Most cases heard at SOAH involve limited issues and little or no discovery, and SOAH anticipates that few parties will feel constrained by the limitations in proposed §155.255(a). In addition, the proposed rule begins with the clause: "Unless otherwise ordered by the judge . . ." Thus, when more extensive discovery is warranted in a case, the proposed rule authorizes the judge to expand the number of discovery requests permitted. Parties may file a motion requesting such relief.

Also, in most cases, the parties can stipulate to undisputed fact issues without the need to serve requests for admissions. Also, SOAH's rules authorize sanctions when a party abuses the discovery process in resisting discovery. 1 TAC §155.157. SOAH carefully considered the objections of the commenters, but SOAH continues to believe that the limits in proposed §155.255(a) are necessary to prevent discovery abuse and preserve the due process rights of all parties, while still allowing parties to conduct the discovery necessary to develop their claims and defenses.

Comment: One commenter objected to proposed §155.255(c), which expands the time to respond to discovery from 20 days (in the current rule) to 30 days (in the proposed rule). The com-

menter expressed concern that allowing more time to file discovery answers would reduce the time before a hearing to file a motion to compel discovery, if the discovery answers were inadequate.

Response: Both federal and Texas state rules of civil procedure allow 30 days to respond to discovery, and SOAH judges have found that many parties are caught off-guard by the shorter response period in SOAH's current rules. The proposed change in 155.255(c) is intended to eliminate this confusion and promote consistency with other venues.

The commenter expressed concern that extending the response time to 30 days would make it impossible for parties to serve motions to compel, given that SOAH's proposed rules provide that written discovery must be served at least 30 days before the end of the discovery period, that the discovery period ends ten days before the hearing, and that motions to compel must be filed at least 10 days before the hearing. (Proposed sections 155.251(b), 155.255(b) and 155.259(c).) However, this concern would only materialize if a party waited until the last allowable day to serve a discovery request. Because SOAH's rules provide that discovery may commence as soon as SOAH acquires jurisdiction (§155.251(a)), the rules provide ample time for diligent parties to conduct discovery and challenge any deficient responses in a motion to compel. For the rare case where a party has diligently pursued discovery yet still does not have time under the rules to file a motion to compel, proposed §155.259(c) provides that the ALJ may allow late-filed motions to compel for good cause. SOAH does not agree that the commenter's concerns warrant changes to proposed §155.255(c).

#### SUBCHAPTER G. PLEADINGS AND MOTIONS

1 TAC §§155.301, 155.305, 155.307

Comment: One commenter objected to proposed §155.301(b)(1), which requires an agency to amend its notice of hearing not later than the seventh day before the hearing in cases when the agency has the burden of proof and intends to rely on a section of a statute or rule that has not previously been referenced in the notice of hearing. An agency may file such an amended notice of hearing during the hearing, but under those circumstances, the opposing party is entitled to a continuance of at least seven days. The commenter believes this proposed rule may create delays in certain hearings.

Response: The proposed changes to this rule follow the legislature's 2015 amendment to APA §2001.052(b), which contains the same seven-day deadline for filing such an amended notice and the granting of a continuance, if requested, when the amendment is made during a hearing. Because the proposed rule is required by the amended statute, SOAH does not agree that the proposed rule should be changed.

Comment: Proposed §155.305(c)(1)(a) sets out a general rule that, for most types of motions, a response to the motion is due five days after the motion is *filed*, "except as otherwise provided in this chapter or as ordered by the judge." One commenter correctly noted that proposed §155.307 does carve out exceptions to that general rule. Specifically, proposed §155.307(e), states that, unless otherwise ordered by the judge, a response to a motion for continuance should generally be made three days after *receipt* of the motion; and proposed rule 155.307(f) states that responses to motions to extend deadlines are due three days after *receipt* of the motion. The commenter was concerned that parties may be confused by these provisions that set a deadline

based on receipt of the motion, when the general rule sets a response deadline based on the date of filing.

Response: SOAH's current §155.305(c)(1) provides, as a general rule, that responses to most motions are due five days after receipt of the motion. The change in the proposed rules to set most response deadlines based on filing, rather than receipt, was a deliberate one. It was intended to eliminate the confusion that frequently arises regarding how to calculate a response deadline when parties are served by more than one method, or when there is conflicting evidence regarding when a motion was actually received. By contrast, there is rarely any dispute about when a motion is filed, and setting a response deadline based on the filing date allows the parties and judges to calculate the response deadline with more certainty.

However, SOAH also recognizes that the general rule requiring a response within five days of filing is unworkable in certain circumstances. That is why proposed §155.301(c)(1) includes language authorizing judges to alter the deadlines in a case when appropriate. That is also why proposed §155.307 makes two specific exceptions to the general rule that responses are due five days after a motion is filed. In proposed §155.307(c), motions for continuance or to extend a deadline must ordinarily be filed five days before the proceeding or deadline at issue. If the usual response deadline in §155.301(c)(1) applied, responses would not be due until the date at issue, depriving parties of an advance ruling on whether the hearing would proceed or whether a deadline would stand. Therefore, SOAH shortened the response time to three days, so that the motion could be ripe for ruling at least two days before the deadline at issue in most circumstances. At the same time, SOAH recognizes that there are occasions when a party may not actually receive a motion until three or more days after filing. It would not be fair for a response deadline to fall before a motion is actually received in cases where, for example, an agency served a motion for continuance on the opposing party by certified mail. That is why, in the limited circumstances set forth in proposed §155.307(e) and (f), the response deadline is based on when the motion is *received*, instead of when the motion is *filed*.

Because SOAH's current rules have led to uncertainty and confusion regarding how to determine response deadlines, proposed §155.305(c)(1) - which sets the response deadline for most motions at five days after filing - is a desirable change. While proposed §155.307(e) - (f) deviates from the general rule for responses to motions for continuance and motions to extend deadlines, these provisions are a necessary accommodation in view of the compressed timetables for those motions. Therefore, SOAH does not accept the commenter's proposed changes to these provisions.

Comment: One commenter suggested that SOAH should use the term "hearing" instead of "proceeding" in §155.307(e)(2), which provides that responses to motions for continuance should be filed by the earlier of three days after receipt of the motion or "the date and time of the proceeding."

Response: Using the term "hearing" in §155.307(e)(2), as suggested by the commenter, could create ambiguity for parties regarding whether the provision applies to settings for matters other than a hearing on the merits, such as scheduling conferences, prehearing conferences, summary-disposition hearings, and mediations. The term "proceeding" was used throughout §155.307 to be clear that all such settings can be continued by a motion for continuance filed pursuant to proposed §155.307(a).

## SUBCHAPTER H. MEDIATION

### 1 TAC §155.351

SOAH received no comments concerning this amended rule.

## SUBCHAPTER I. HEARINGS AND PREHEARINGS

### 1 TAC §§155.401, 155.405, 155.407, 155.411, 155.413, 155.419, 155.421, 155.423, 155.425, 155.427, 155.429, 155.431

Comment: Two commenters suggested that §155.423(b) may exceed SOAH's authority or conflict with a referring agency's rules by requiring the party to provide a court reporter to make a stenographic record for any proceeding set to last longer than one day.

Response: This provision is in SOAH's current rules at §155.423(b), which was adopted in 2008. Proposed §155.423(b) does not represent a change in SOAH's practice or procedure. SOAH is authorized to adopt rules that govern procedures related to hearings conducted by SOAH, and this rule falls within SOAH's authority.

Comment: Three commenters objected to proposed §155.423(d)(1) - (2), which would apply in cases where the judge orders that a transcript of the court reporter's record be prepared. Proposed §155.423(d)(1) would authorize SOAH to assess the cost of a transcript to one or more of the parties, and proposed §155.423(d)(2) would require a party to pay the cost of a transcript ordered by that party unless otherwise ordered by the judge. The commenters suggested that SOAH could exceed its statutory authority by requiring parties to bear some or all of the cost of preparing a transcript. One of the commenters contended that the costs associated with a transcript should be borne solely by the party who requested it.

Response: The vast majority of cases at SOAH have hearings that last one day or less, for which no court reporter or transcript is necessary. However, some cases can involve lengthy records and voluminous evidence, and a transcript is essential for the judge to prepare an accurate and timely decision or proposal for decision. The APA, Tex. Gov't Code §2001.059 authorizes a state agency, such as SOAH, to "pay the cost of a transcript or . . . assess the cost to one or more parties." Proposed §155.423(d) falls within this statutory authority.

Comment: Two commenters objected to proposed §155.423, relating to charging the costs of a transcript, to the extent it conflicts with referring agencies' procedural rules, which may contain other cost-allocation provisions.

Response: Tex. Gov't Code §2003.050 provides that, notwithstanding other law, a referring agency's procedural rules govern procedural matters related to a hearing at SOAH only to the extent that SOAH has adopted the referring agency's procedural rules by reference. In all other cases, SOAH's procedural rules govern. SOAH has not adopted by reference the procedural rules of most agencies that refer cases to SOAH, and SOAH's rules govern in those cases.

Comment: Proposed §155.425(c) states that an allegation set forth in a notice of hearing or complaint that is not addressed during the proceeding may be deemed waived. One commenter proposed alternative language for this rule, urging that more specificity is needed. The commenter proposed changing the language about an allegation "that is not addressed during the proceeding" to instead refer to an allegation "that is not argued,

briefed, or for which no evidence or testimony is presented during the contested case."

Response: SOAH has had recurring issues with cases where a party alleged a multitude of claims or defenses, but then did not offer any evidence or argument about some of the claims or defenses during the hearing or in post-hearing briefs. Proposed §155.425(c) makes express what has long been the practice of SOAH judges, which is to deem an allegation waived or withdrawn if a party has made no effort to prove it. The commenter's proposed language addresses most ways a claim may be raised during a case, but SOAH does not agree that the language is necessary to provide clarity to the rule. As drafted, SOAH's proposed §155.425(c) retains flexibility for judges to decide, on a case-by-case basis, whether an allegation has been addressed and, if not, whether it should be deemed waived. In addition, SOAH has revised the proposed rule to include allegations made in a "notice of hearing, complaint, or other pleading," to make clear that it applies to allegations made in answers, dispositive motions, and other pleadings.

#### SUBCHAPTER J. DISPOSITION OF CASE

##### 1 TAC §§155.501, 155.503, 155.505, 155.507, 155.509

Comment: Proposed §155.501 is SOAH's rule concerning default proceedings. The proposed amendments are designed to streamline and clarify the default process. Two commenters expressed confusion and concern about the separate procedures for default decisions and default proposals for decision.

Response: SOAH has revised proposed §155.501(d) to make explicit that SOAH only issues default decisions in cases in which SOAH is authorized by law to issue a final decision. The provisions relating to default decisions have no applicability to cases in which SOAH issues proposals for decision.

Comment: Proposed §155.501 also provides that an ALJ may, in the context of a default, issue an order conditionally dismissing the case and conditionally remanding it to the referring agency. The purpose of the conditional order is to allow time for a respondent to file a motion to set aside the default. One commenter asserted that a conditional order of dismissal and remand may not be appropriate because SOAH loses jurisdiction over the case when it remands the case to the referring agency.

Response: The procedure established under proposed §155.501 does not violate the principles concerning SOAH's jurisdiction over a case. "Conditional" means subject to one or more conditions being met. Therefore, upon issuance of the order conditionally dismissing the case from SOAH's docket and conditionally remanding it to the referring agency, jurisdiction does not transfer from SOAH to the referring agency. However, SOAH has revised proposed §155.501(e) to clarify that both the dismissal and the remand are conditional, and that jurisdiction remains at SOAH until 15 days after the issuance of the conditional order (if no motion to set aside default is filed) or until the judge rules on a timely-filed motion to set aside the default.

Comment: One commenter raised a concern that proposed §155.501 would conflict with its own default rules and possibly the rules of other agencies that refer cases to SOAH.

Response: The commenter did not specify in what ways it foresees a conflict between its rules and §155.501. However, SOAH notes that a referring agency's rules do not apply to SOAH proceedings unless SOAH has adopted those rules by reference; thus, SOAH sees no reason to take action in response to this comment.

In addition, SOAH has added a subsection 155.501(e)(4) to clarify that a default dismissal removes a case from the SOAH docket without a decision on the merits. This parallels §155.503(a)(5), regarding dismissals for failure to prosecute.

#### SUBCHAPTER A. GENERAL

##### 1 TAC §§155.1, 155.3, 155.5, 155.7

The amendments are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

##### §155.3. *Application and Construction of this Chapter.*

(a) SOAH proceedings shall be conducted in accordance with the APA, when applicable, and with this chapter. The judge may modify and supplement the requirements of this chapter to promote the fair and efficient handling of the case and to facilitate resolution of issues, if doing so will not unduly prejudice the rights of any person or contravene applicable statutes.

(b) If there is a conflict between an agency's rules or prior decisions and statutory provisions applicable to the case, and the rules or decisions cannot be harmonized with the statute, the statute controls.

(c) The procedural rules of a state agency govern SOAH proceedings only to the extent that SOAH's rules adopt the agency's procedural rules by reference, unless otherwise required by law.

(d) If there is a conflict between SOAH's rules and the procedural rules of the TCEQ adopted in §155.1 of this chapter, the TCEQ rules will control.

(e) If there is a conflict between SOAH's rules and the procedural rules of the PUC adopted in §155.1 of this chapter, the PUC rules will control.

(f) If there is a conflict between SOAH's rules and the procedural rules of ERS referenced in §155.1 of this chapter, the ERS rules will control.

(g) This chapter shall be construed to ensure the just and expeditious determination of every matter referred to SOAH. Not all contested procedural issues will be susceptible to resolution by reference to the APA and other applicable statutes, this chapter, and case law. When they are not, the presiding judge will consider applicable policy of the referring agency documented in the record in accordance with §155.419 of this chapter, the Texas Rules of Civil Procedure (TRCP) as interpreted and construed by Texas case law, and persuasive authority established in other forums.

(h) Unless otherwise expressly provided, the past, present, and future tense shall each include the others; the masculine, feminine, and neuter gender shall each include the others; and the singular and plural number shall each include the other.

(i) Words and phrases shall be read in context and construed according to the rules of grammar and common usage. Words and phrases that have acquired a technical or particular meaning, whether by legislative definition or otherwise, shall be construed accordingly. The principles of statutory construction and of the Code Construction Act, Tex. Gov't Code Chapter 311, apply.

##### §155.5. *Definitions.*

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

(1) Administrative law judge or judge--An individual appointed to serve as a presiding officer by SOAH's chief judge under Tex. Gov't Code Chapter 2003.

(2) Alternative Dispute Resolution or ADR--Processes used at SOAH to resolve disputes outside or in connection with contested cases, including mediation, mini-trials, early neutral evaluation, and arbitration.

(3) APA--The Administrative Procedure Act, Tex. Gov't Code Chapter 2001.

(4) Arbitration--A form of ADR, governed by an agreement between the parties or special rules or statutes providing for the process in which a third-party neutral issues a decision after a streamlined and simplified hearing. Arbitrations may be binding or non-binding, depending on the agreement, statutes, or rules. See Chapters 156 and 163 of this title for procedural rules specifically governing the arbitration of certain nursing home and assisted living facility enforcement cases referred by the Texas Department of Aging and Disability Services.

(5) Authorized representative--An attorney authorized to practice law in the State of Texas or, if authorized by applicable law, a non-attorney designated by a party to represent the party.

(6) Business day--A weekday on which state offices are open.

(7) Chief Judge--The chief administrative law judge of SOAH.

(8) Discovery--The process of compulsory disclosure by a party, upon another party's request, of information, including facts and documents, relating to a contested case.

(9) Evidence--Testimony and exhibits admitted into the record to prove or disprove the existence of an alleged fact.

(10) Exhibits--Documents, records, photographs, and other forms of data compilation, regardless of media, or other tangible objects offered by a party as evidence.

(11) IDEA--The Individuals with Disabilities Education Act.

(12) Media or media agency--A person or organization regularly engaged in news gathering or reporting, including any newspaper, radio or television station or network, news service, magazine, trade paper, professional journal, or other news reporting or news gathering entity.

(13) Mediation--A confidential, informal dispute resolution process in which an impartial person, the mediator, facilitates communication among the parties to promote settlement, reconciliation, or understanding.

(14) Party--A person named or admitted to participate in a case before SOAH.

(15) Person--An individual, representative, corporation, or other entity, including a public or non-profit corporation, or an agency or instrumentality of federal, state, or local government.

(16) Pleading--A filed document that requests procedural or substantive relief, makes claims, alleges facts, makes legal argument(s), or otherwise addresses matters involved in the case.

(17) PUC--The Public Utility Commission of Texas.

(18) Referring agency--A state board, commission, department, agency, or other governmental entity that refers a contested case or other matter to SOAH.

(19) SOAH--The State Office of Administrative Hearings.

(20) Stipulation--A binding agreement among opposing parties concerning a relevant issue or fact.

(21) TAC--The Texas Administrative Code.

(22) TCEQ--The Texas Commission on Environmental Quality.

(23) TRCP--The Texas Rules of Civil Procedure. The TRCP are found on the website of the Texas Supreme Court.

(24) TRE--The Texas Rules of Evidence. The TRE are found on the website of the Texas Supreme Court.

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 October 14, 2016.

TRD-201605294  
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State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



## SUBCHAPTER B. DOCKETING--FILING A CONTESTED CASE

### 1 TAC §155.51, §155.53

The amendments are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605295  
Thomas H. Walston  
General Counsel  
State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



## SUBCHAPTER C. FILING AND SERVICE OF DOCUMENTS

### 1 TAC §155.101, §155.103

The repeals are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted repeals affect Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605296

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State Office of Administrative Hearings

Effective date: January 1, 2017

Proposal publication date: May 13, 2016

For further information, please call: (512) 475-1276



### 1 TAC §§155.101, 155.103, 155.105

The new rules are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

#### §155.101. *Filing Documents.*

(a) Filing and service required.

(1) All pleadings and other documents, except for confidential materials (as described in §155.103), shall be filed using one of the methods described in this rule.

(2) On the same date a document is filed, it shall also be served on all other parties using one of the methods described in §155.105.

(b) Method and format of filing in all cases other than PUC, TCEQ, or IDEA cases.

(1) Filing by Electronic Case Information System.

(A) Except as otherwise provided in this subchapter, attorneys, state agencies, and other governmental entities are required to file all documents in SOAH's electronic Case Information System (CIS). CIS may be accessed and filings uploaded using SOAH's internet home page, [www.soah.texas.gov](http://www.soah.texas.gov). Parties not represented by an attorney are strongly encouraged to use CIS but may use alternative methods of filing described in paragraph (2) of this subsection.

(B) The electronic version of a document maintained in CIS shall be given the same legal status as the originally filed document, without regard to the original means of filing.

(C) In addition to the other requirements of this rule, filings in CIS must comply with all requirements and procedures set forth on SOAH's website and electronic filing page.

(D) Formatting. A pleading filed in CIS must:

(i) be in text-searchable portable document format (PDF);

(ii) be directly converted to PDF rather than scanned;

(iii) not be locked;

(iv) include the email address of a party, attorney, or representative of a state agency who electronically files a document; and

(v) include the SOAH docket number and the name of the case in which it is filed.

(E) Formatting. Other documents filed in CIS, such as attachments to pleadings, exhibits, affidavits, letters, and appendices, must:

(i) be in PDF format and, if possible, be text-searchable;

(ii) be directly converted to PDF rather than scanned, if possible;

(iii) not be locked;

(iv) if scanned, be at least 300 dots per inch (dpi) resolution;

(v) if not attached to a pleading or document that already contains this information, include the email address of a party, attorney, or representative of a state agency who electronically files a document; and

(vi) if not attached to a pleading or document that already contains this information, include the SOAH docket number and the name of the case in which it is filed.

(F) A pleading or document that is filed in CIS is considered signed if the document includes:

(i) an "/s/" and name typed in the space where the signature would otherwise appear, unless the document is notarized or sworn; or

(ii) an electronic image or scanned image of the signature.

(G) Time of filing. The time and date of documents filed electronically shall be determined by the time and date of receipt recorded by CIS.

(H) If deemed necessary by SOAH, alternative means of filing or maintaining documents may be established, including the filing and maintenance of the official file in a paper format.

(I) Testimony and exhibits offered at a hearing will not be filed in CIS. Confidential material filed or submitted pursuant to §155.103 will not be publicly available in CIS.

(2) Non-CIS filings.

(A) For unrepresented parties who do not use CIS, documents may be filed with SOAH:

(i) by mail addressed to SOAH at P.O. Box 13025, Austin, Texas 78711-3025;

(ii) by hand-delivery to SOAH at 300 West 15th Street, Room 504;

(iii) by fax to SOAH at (512) 322-2061; or

(iv) at the SOAH field office where the case is assigned, using the field office address or fax number, which are available at SOAH's website.

(B) All documents must include the SOAH docket number and the name of the case in which it is filed.

(C) Time of filing. With respect to documents filed by mail, fax, or hand-delivery, the time and date of filing shall be determined by the file stamp affixed by SOAH. Documents received when SOAH is closed shall be deemed filed the next day SOAH is open.

(3) Non-conforming documents. SOAH's docketing department may not refuse to file a document that fails to conform with this rule. When a filed document fails to conform to this rule, the presiding judge or SOAH's docketing department may identify the errors to be corrected and state a deadline for the person, attorney, or agency to resubmit the document in conforming format.

(c) Method of filing in cases referred by the PUC.

(1) Except for exhibits offered at a prehearing conference or hearing, the original of all documents shall be filed at the PUC in accordance with the PUC rules.

(2) The party filing a document with the PUC (except documents provided in the discovery process that are not the subject of motions filed in a discovery dispute) shall serve the judge with a copy of the document by delivery to SOAH on the same day as the filing.

(3) The court reporter shall provide the transcript and exhibits to the judge at the same time the transcript is provided to the requesting party. SOAH shall maintain the transcript and exhibits until they are released to the PUC by the judge. If no court reporter was requested by a party, SOAH shall maintain the recording of the hearing and the exhibits until they are released to the PUC by the judge.

(d) Methods of filing in cases referred by the TCEQ.

(1) Except for exhibits offered at a prehearing conference or hearing, the original of all documents shall be filed with the TCEQ's chief clerk in accordance with the TCEQ rules.

(2) The time and date of filing of these materials shall be determined by the file stamp affixed by the chief clerk, or as evidenced by the file stamp affixed to the document or envelope by the TCEQ mail room, whichever is earlier.

(3) The party filing a document with the TCEQ (except documents provided in the discovery process that are not the subject of motions filed in a discovery dispute) shall serve the judge with a copy of the document by delivery to SOAH on the same day as the filing.

(4) The court reporter shall provide the transcript and exhibits to the judge at the time the transcript is provided to the requesting party. SOAH shall maintain the transcript and exhibits until they are released to the TCEQ by the judge. If no court reporter was requested by a party, SOAH shall maintain the recording of the hearing and the exhibits until they are released to the TCEQ by the judge.

§155.103. *Public and Confidential Information.*

(a) Documents filed in proceedings at SOAH are accessible to the public through SOAH's website unless the proceeding is designated

as confidential by SOAH or the documents are designated as confidential pursuant to this rule. A party filing or offering documents that contain confidential information and personal identifiers shall comply with this rule to prevent inadvertent public disclosure of such documents.

(1) For purposes of this chapter, confidential information includes:

(A) information made confidential by law;

(B) information otherwise protected from disclosure by law; and

(C) documents filed *in camera*, solely for the purpose of obtaining a ruling on the discoverability or admissibility of such documents.

(2) A "personal identifier" is information that identifies a specific individual. Personal identifiers include: Social Security numbers, taxpayer identification numbers, driver's license numbers, passport numbers, other similar government-issued personal identification numbers, bank account numbers, credit card numbers or other financial account numbers, dates of birth, full names of minors, full names of patients or clients in a health care setting, full names of persons who are victims of crimes, addresses and telephone numbers of commissioned peace officers, expunged criminal records, or records subject to a non-disclosure order issued by a court unless allowed by law.

(b) Redaction required. A person who files documents at SOAH in proceedings accessible to the public, including exhibits offered at hearing, shall redact from the documents all confidential information and personal identifiers that are unnecessary for resolution of the case. A party may not file an entire document as confidential and non-public except as provided in subsection (c) of this section.

(c) Confidential documents.

(1) A party may designate an entire document or exhibit as confidential and non-public only if:

(A) the entire document or exhibit contains confidential information or is a personal identifier;

(B) redaction of the document or exhibit would remove confidential information or personal identifiers necessary to the resolution of the case; or

(C) it would be unduly burdensome to redact confidential information or personal identifiers from the document or exhibit.

(2) Filing confidential documents. A party filing confidential documents in a proceeding accessible to the public must file them by delivery in a sealed and labeled package, accompanied by an explanatory cover letter. The cover letter shall identify the docket number and style of the case and shall explain the nature of the sealed materials. The outside of the package shall identify the docket number, style of the case, and name of the submitting party and shall be marked "CONFIDENTIAL" in bold print at least one inch in size. Each page of the confidential document shall be marked "CONFIDENTIAL" in bold print, 12-point type.

(d) Challenging confidentiality designations. A party may file a motion to challenge the redaction or confidential filing of any information, or the judge can raise the issue. If a confidentiality designation is challenged, the designating party has the burden of showing that the document should remain confidential.

(1) If the judge determines that a confidential filing under subsection (c) of this section is appropriate, the judge may allow the filing to remain inaccessible to the public on SOAH's website, admit

the information into the evidentiary record under seal, or employ appropriate protective measures.

(2) If the judge determines that a confidential filing under subsection (c) of this section is not appropriate, the offering party must redact the confidential information or the personal identifiers before resubmitting the document.

(e) Designation of a document as confidential in a SOAH proceeding is not determinative of whether that document would be subject to disclosure under Tex. Gov't Code Chapter 552 or other applicable law.

(f) Documents in non-public cases. Certain SOAH proceedings are designated confidential. Hearings in those cases are not open to the public, and filings in these cases are not accessible through SOAH's public website.

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 October 14, 2016.

TRD-201605297  
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General Counsel  
State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



## SUBCHAPTER D. JUDGES

### 1 TAC §§155.151 - 155.153, 155.155

The new rules and amendments are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605303  
Thomas H. Walston  
General Counsel  
State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



## SUBCHAPTER E. REPRESENTATION OF PARTIES

### 1 TAC §155.201, §155.203

The new rules and amendments are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605306  
Thomas H. Walston  
General Counsel  
State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



## SUBCHAPTER F. DISCOVERY

### 1 TAC §155.251

The repeal is adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted repeal affects Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605307  
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General Counsel  
State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



### 1 TAC §§155.251, 155.253, 155.255, 155.257, 155.259

The new rules are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

§155.259. *Discovery Motions.*

(a) Certificate of conference. The parties and their authorized representatives shall cooperate in discovery and shall endeavor to make any agreements reasonably necessary for the efficient disposition of the case. All discovery motions shall include a certificate of conference complying with §155.305(b)(2) of this chapter.

(b) Motions for protection. A person from whom discovery is sought may file a motion within the time permitted for a response to request an order protecting that person from the discovery sought. A motion for protection shall include the relevant portion of the discovery request at issue. A person must comply with a discovery request to the extent protection is not sought unless it is unreasonable under the circumstances to do so before obtaining a ruling on the motion.

(c) Motions to compel. A person alleging failure to comply with discovery shall file a motion to compel as soon as practicable. A motion to compel shall include the relevant portion of the discovery response at issue. A motion to compel shall not be filed less than 10 days before the first day of the hearing on the merits, unless good cause is shown. A judge may deny or limit relief sought in a motion to compel if the judge determines that the discovery requests at issue are improper or unduly burdensome.

(d) *In camera* inspections. If a party's assertion of a privilege or an exemption under the TRCP is made the subject of a motion for protection or a motion to compel, the party resisting discovery must request an *in camera* inspection (inspection by the judge) and provide the documents for review under seal. The request shall state the factual and legal basis that support the claimed privilege or exemption and shall comply with the provisions of §155.103 of this chapter.

(e) Responses to discovery motion. Responses to discovery motions shall be filed in accordance with §155.305(c).

(f) Discovery materials. Motions and responses in a discovery dispute shall include only the relevant portions of the discovery materials at issue.

(g) Confidentiality. Confidential information contained in or attached to a discovery motion or response must be filed in compliance with §155.103 of this chapter.

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 October 14, 2016.

TRD-201605308  
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State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



**SUBCHAPTER G. PLEADINGS AND MOTIONS**

**1 TAC §§155.301, 155.305, 155.307**

The amendments are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605312  
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General Counsel  
State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



**SUBCHAPTER H. MEDIATION**

**1 TAC §155.351**

The amendment is adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rule affects Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605313  
Thomas H. Walston  
General Counsel  
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Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



**SUBCHAPTER I. HEARINGS AND PREHEARINGS**

**1 TAC §§155.401, 155.405, 155.407, 155.411, 155.419, 155.421, 155.423, 155.425, 155.427, 155.429, 155.431**

The amendments are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government

Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

§155.425. *Procedure at Hearing.*

(a) Control of the hearing. The judge shall exercise reasonable control over the mode and order of presenting preliminary matters, pending motions, opening statements, witness testimony and other evidence, oral or written closing argument, and other processes in the hearing.

(b) Designation of order of parties' presentations. The judge will designate the order in which the parties will present evidence and argument. Generally, the party with the burden of proof will present evidence first and will open and conclude oral argument. The judge shall designate the party with the burden of proof in accordance with §155.427 of this chapter.

(c) Waiver of allegations. An allegation contained in the notice of hearing, complaint, or other pleading that is not addressed during the proceeding may be deemed waived.

(d) Closing arguments. Closing arguments may be made orally or, when ordered by the judge, in writing.

(e) Closing the evidentiary record. Unless otherwise ordered by the judge, the record will close at the later of:

- (1) the end of the hearing; or
- (2) the date the final brief is due, when closing arguments are made in writing.

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 October 14, 2016.

TRD-201605314  
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State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



**1 TAC §155.413**

The repeal is adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted repeal affects Government Code, Chapters 2001 and 2003.

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 October 14, 2016.

TRD-201605316  
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State Office of Administrative Hearings  
Effective date: January 1, 2017  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 475-1276



**SUBCHAPTER J. DISPOSITION OF CASE**

**1 TAC §§155.501, 155.503, 155.505, 155.507, 155.509**

The new rules and amendments are adopted under Government Code, Chapter 2003, §2003.050, which requires SOAH to adopt procedural rules that relate to the hearings it conducts, and Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures.

The adopted rules affect Government Code, Chapters 2001 and 2003.

§155.501. *Default Proceedings.*

(a) If a party who does not bear the burden of proof and to whom a notice of hearing with factual allegations is served or provided fails to appear for the hearing, the judge may proceed in that party's absence on a default basis.

(b) A default proceeding under this section requires adequate proof of the following:

(1) the notice of hearing included a disclosure in at least 12-point, bold-face type that the factual allegations listed in the notice could be deemed admitted and that the relief sought in the notice of hearing might be granted by default against the party that fails to appear at the hearing;

(2) the notice of hearing satisfies the requirements of Tex. Gov't Code, §2001.051 and §2001.052, and §155.401 of this chapter; and

(3) the notice of hearing was:

(A) received by the defaulting party; or

(B) sent by first class or certified mail to the party's last known address as shown by the referring agency's records, and the referring agency's statute or rules authorize service of the notice of hearing by sending it to the party's last known address.

(c) In the absence of adequate proof to support a default, the judge shall continue the case and direct the party responsible to provide adequate notice of hearing. If the responsible party persists in failing to provide adequate notice, the judge may dismiss the case from the SOAH docket without prejudice to refile.

(d) Upon receiving the required showing of proof to support a default, the judge may issue one of the following:

(1) Default dismissal and remand. In default proceedings where SOAH is not authorized by law to render a final decision in the proceeding, the judge may issue an order finding adequate notice, conditionally dismissing the case from the SOAH docket, and conditionally remanding the case to the referring agency for informal disposition on a default basis in accordance with Tex. Gov't Code §2001.056.

(2) Default proposal for decision. In default proceedings where SOAH is not authorized by law to render a final decision in the proceeding, the judge may deem admitted the factual allegations in the notice of hearing and issue a proposal for decision.

(3) Default decision. In default proceedings where SOAH is authorized by law to render a final determination in the proceeding, the judge may deem admitted the factual allegations in the notice of hearing and issue a default decision.

(e) Default dismissals and remands.

(1) A conditional order of dismissal and remand issued under subsection (d) of this section shall inform the party of the opportunity to have the default set aside under this subsection by filing an adequate motion no later than 15 days after the issuance of the conditional order of dismissal and remand.

(2) If a motion to set aside a default is filed within 15 days after the issuance of a conditional order of dismissal and remand, the judge will rule on the motion and either:

(A) grant the motion, set aside the default, and reopen the hearing for good cause shown or in the interests of justice; or

(B) deny the motion and issue a final order of dismissal and remand.

(3) In the absence of a timely motion to set aside a default, a conditional order of dismissal and remand shall become final on the sixteenth day after its issuance without further action by the judge.

(4) Dismissal under this section removes the case from the SOAH docket without a decision on the merits.

(f) Default proposals for decision.

(1) A default proposal for decision issued under subsection (d) of this section shall inform the party of the opportunity to have the default set aside under this subsection by filing an adequate motion no later than 15 days after the issuance of the default proposal for decision.

(2) If a motion to set aside a default is filed within 15 days after the issuance of a default proposal for decision, the judge may grant the motion, set aside the default, and reopen the hearing for good cause shown or in the interests of justice.

(g) Default decisions.

(1) Default decisions are subject to motions for rehearing as provided for in the APA.

(2) A default decision issued under subsection (d) of this section shall inform the party of the opportunity to have the default set aside by filing a motion for rehearing under Tex. Gov't Code Chapter 2001, Subchapter F.

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 October 14, 2016.

TRD-201605321

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State Office of Administrative Hearings

Effective date: January 1, 2017

Proposal publication date: May 13, 2016

For further information, please call: (512) 475-1276

## TITLE 19. EDUCATION

### PART 2. TEXAS EDUCATION AGENCY

#### CHAPTER 61. SCHOOL DISTRICTS

##### SUBCHAPTER AA. COMMISSIONER'S RULES ON SCHOOL FINANCE

###### 19 TAC §61.1013, §61.1014

The Texas Education Agency adopts new §61.1013 and §61.1014, concerning school finance. The new sections are adopted without changes to the proposed text as published in the August 19, 2016, issue of the *Texas Register* (41 TexReg 6143) and will not be republished. The adopted new rules implement the Texas Education Code (TEC), §42.2524 and §41.0931, by addressing the reimbursement of disaster remediation costs for schools in a designated disaster area.

**REASONED JUSTIFICATION.** The TEC, §42.2524 and §41.0931, provide for the reimbursement of disaster remediation costs for school districts in an area declared a disaster area by the governor under Texas Government Code, Chapter 418. A school district or charter school may apply for assistance with paid disaster remediation costs that it does not anticipate recovering through insurance, federal disaster relief payments, or other sources.

Adopted new 19 TAC §61.1013 implements the statutory requirements of TEC, §42.2524, by establishing provisions for a grant program that would be created should FSP funds become available. The new section establishes what qualifies for eligible disaster remediation costs, the application process, eligibility and reporting requirements, the amount of the grant, prioritization of applicants, the finality of the award, and how funds would be distributed.

Adopted new 19 TAC §61.1014 implements the statutory requirements of TEC, §41.0931, by establishing provisions for a credit against recapture costs for districts subject to the wealth equalization provisions of TEC, Chapter 41. The new section establishes what qualifies for eligible disaster remediation costs, the application process, eligibility and reporting requirements, the amount of the credit, the finality of the award, and how funds would be distributed.

**SUMMARY OF COMMENTS AND AGENCY RESPONSES.** The public comment period on the proposal began August 19, 2016, and ended September 19, 2016. Following is a summary of the public comment received and corresponding agency response regarding proposed new 19 TAC Chapter 61, School Districts, Subchapter AA, Commissioner's Rules on School Finance, §61.1013, Foundation School Program Funding for Reimbursement of Disaster Remediation Costs, and §61.1014, Credit Against Recapture for Reimbursement of Disaster Remediation Costs.

**Comment.** The Equity Center commented that the different treatment provided to Chapter 41 school districts under 19 TAC §61.1014 and districts which receive state aid under 19 TAC §61.1013 does not adhere to the standard of neutrality and provision of substantially equal access to similar revenue per student set out in the TEC, §42.001. The Equity Center stated that 19 TAC §61.1013 makes the availability of reimbursement contingent upon excess funds or a specific appropriation, while

19 TAC §61.1014 does not recognize this limitation for funding requests made under the TEC, §41.0931. The Equity Center stated that the legislature did not intend for the unequal results that could occur from the proposed rules and maintained that since the TEC, §42.2524, makes grant aid to all districts, including Chapter 41 districts, contingent upon specific appropriation or surplus, it follows that the TEC, §41.0931, merely authorizes such grant aid, if provided for, to be used as a credit against recapture for Chapter 41 districts.

**Agency Response.** The agency disagrees and maintains language as proposed. The agency has determined that there are clearly different requirements for reimbursement under the TEC, §42.2524, and the TEC, §41.0931, which govern the different treatment provided for under 19 TAC §61.1013 and §61.1014.

**STATUTORY AUTHORITY.** The new sections are adopted under the Texas Education Code (TEC), §42.2524, which requires the commissioner to adopt rules for the reimbursement of disaster remediation costs for school districts located in an area declared a disaster area by the governor under Texas Government Code, Chapter 418, if excess Foundation School Program funds are available; and the TEC, §41.0931, which requires the commissioner to adopt rules to provide a credit against recapture costs for districts subject to the wealth equalization provisions of TEC, Chapter 41, that are located in an area declared a disaster area by the governor under Texas Government Code, Chapter 418, and that have incurred disaster remediation costs.

**CROSS REFERENCE TO STATUTE.** The new section implements the Texas Education Code, §42.2524 and §41.0931.

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 October 12, 2016.

TRD-201605230

Cristina De La Fuente-Valadez

Director, Rulemaking

Texas Education Agency

Effective date: November 1, 2016

Proposal publication date: August 19, 2016

For further information, please call: (512) 475-1497



## **TITLE 28. INSURANCE**

### **PART 1. TEXAS DEPARTMENT OF INSURANCE**

#### **CHAPTER 3. LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES**

##### **SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS**

###### **DIVISION 1. GENERAL REQUIREMENTS**

###### **28 TAC §3.3705, §3.3708**

The Texas Department of Insurance adopts amendments to 28 TAC Chapter 3, Subchapter X, Division 1, §3.3705 (relating to Nature of Communications with Insureds; Readability, Manda-

tory Disclosure Requirements, and Plan Designations) and §3.3708 (relating to Payment of Certain Basic Benefit Claims and Related Disclosures). Both sections are adopted with changes to the proposed text published in the May 27, 2016, issue of the *Texas Register* (41 TexReg 3832).

**REASONED JUSTIFICATION.** The amendments to the rules are necessary because of amendments made to Texas Insurance Code Chapter 1467. Senate Bill 481, 84th Legislature, Regular Session (2015), amended Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution). As a result, the department must make conforming changes to 28 TAC Chapter 3, Subchapter X.

Parts of both §3.3705 and §3.3708 relate to the mediation process mandated by Chapter 1467. Senate Bill 481 lowered the threshold for mediation to amounts greater than \$500 for services provided on or after September 1, 2015. The rules at §3.3705 and §3.3708 need to be updated to include these provisions and to make nonsubstantive changes to conform to agency style and usage guidelines.

The department has made the following changes to the proposed language in response to comments:

1. left the word "facility" in the fifth bullet in the figure for 28 TAC §3.3705(f)(1), made the fifth bullet more closely track the language in Insurance Code §1467.051, and added "including the amount unpaid by the administrator or insurer" when describing the amount billed; and
2. added "in a preferred hospital" after "[w]hen services are rendered to an insured by a nonpreferred facility-based physician," changed the term "facility-based physician" to "hospital-based physician" and added a reference to the definition in 28 TAC §21.5003(6) in §3.3708(e).

#### **SUMMARY OF COMMENTS AND AGENCY RESPONSE.**

**Commenters:** The department received timely written comments from two commenters. Commenters on the proposal were: one individual and the Texas Medical Association. The commenters were for the proposal, with changes.

##### **General Comment.**

One commenter stated that the proposed amendments do not address a situation where an individual is balance billed by the health care provider for special equipment used in a surgical operation. The commenter stated that many consumers of health care are familiar with the issue of inadvertently receiving care from an out-of-network doctor, even though the treatment was at an in-network hospital, but that most people probably are unaware that an in-network doctor's surgical equipment might be classified as out-of-network. The commenter suggested that a global solution to the issue of inadvertent out-of-network charges should be undertaken to obviate mediation services. The commenter noted that the solution must apply to any major medical health insurance plan and not be limited to hospital-based physicians.

##### **Agency Response to General Comment.**

The department appreciates the comment and acknowledges that balance billing can occur in contexts other than the physician services covered in Insurance Code Chapter 1467. However, the Insurance Code does not currently provide for the global solution advocated by the commenter. The department therefore respectfully declines to make the changes suggested by the commenter.

Comment on Figure: 28 TAC §3.3705(f)(1).

One commenter expressed concern about the department's proposal to change "hospital" to "facility" in the fifth bullet in the figure for 28 TAC §3.3705(f)(1). The commenter contended that this change might be construed to broaden the scope of Texas' mediation law because a hospital is the only type of facility at which certain physician services are rendered that are subject to mediation. The commenter recommended that the fifth bullet more closely track the language in Insurance Code §1467.051, and that the department should add "including the amount unpaid by the administrator or insurer" when describing the amount billed.

Agency Response to Comment on Figure: 28 TAC §3.3705(f)(1).

The department agrees that the proposed change might cause some confusion, and agrees to make the changes suggested by the commenter.

Comment on §3.3708(e).

One commenter suggested that notices provided on explanations of benefits might be misleading by giving the impression that mediation is available when it is not. The commenter suggested that adding "in a preferred hospital" after "[w]hen services are rendered to an insured by a nonpreferred facility-based physician" in §3.3708(e) would make this less likely, as would adding a definition of "facility-based physician."

Agency Response to Comment on §3.3708(e).

The department agrees that the first proposed change might lessen the possibility of confusion and has made the change. However, the department believes that adding a definition of "facility-based physician" would not be as useful as simply changing the term to "hospital-based physician" and referring to the definition in 28 TAC §21.5003(6), because this would require amending only one section of the department's rules should the definition change in the future. The department has made these changes.

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1467.001, 1467.003, 1467.051, 1301.007, 1301.0042, and 36.001, and amendments made by Section 5 of SB 481, 84th Legislature, Regular Session (2015), to Insurance Code §1467.051(a)(1).

Insurance Code §1467.001 contains definitions, including a definition for the facility-based physicians to whom Chapter 1467 applies.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467. Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of Texas.

Insurance Code §1301.0042 provides that a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan, except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the de-

partment's powers and duties under the Insurance Code and other laws of this state.

§3.3705. *Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.*

(a) *Readability.* All health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this chapter (relating to Plain Language Requirements).

(b) *Disclosure of terms and conditions of the policy.* The insurer is required, on request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. The written description must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written description or as otherwise required by law;

(2) a toll free number, unless exempted by statute or rule, and address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding pre-existing conditions;

(9) any authorization requirements, including preauthorization review, concurrent review, post-service review, and post-payment review; and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients. Both of these items may be provided electronically, if notice is also provided in the disclosure required by this subsection regarding how a nonelectronic copy may be obtained free of charge;

(13) the service area(s); and

(14) information that is updated at least annually regarding the following network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis:

(A) the number of insureds in the service area or region;

(B) for each provider area of practice, including at a minimum internal medicine, family/general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of preferred providers, as well as an indication of whether an active access plan pursuant to §3.3709 of this title (relating to Annual Network Adequacy Report; Access Plan) applies to the services furnished by that class of provider in the service area or region and how such access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 of this title applies to hospital services in that service area or region and how the access plan may be obtained or viewed.

(15) information that is updated at least annually regarding whether any waivers or local market access plans approved pursuant to §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) apply to the plan and that complies with the following:

(A) if a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the preferred provider benefit plan is not offered on a statewide service area basis, and, if by county, the aggregate of counties is not more than those within a region; or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the local market access plan.

(c) Filing required. A copy of the written description required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if applicable, must be submitted to the following email address: LifeHealth@tdi.texas.gov. Nonelectronic filings must be submitted to the department at: Life/Health and HMO Intake Team,

Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(d) Promotional disclosures required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of basic benefits, except in the case of an exclusive provider benefit plan.

(e) Internet website disclosures. Insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must provide:

(1) an Internet-based provider listing for use by current and prospective insureds and group contract holders;

(2) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP Code area, as applicable, that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) an Internet-based listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1) for a preferred provider benefit plan that is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2) for an exclusive provider benefit plan, in all policies, certificates, disclosures of policy terms and conditions provided to comply with subsection (b) of this section, and outlines of coverage in at least 12-point font:

(1) Preferred provider benefit plan notice.  
Figure: 28 TAC §3.3705(f)(1)

(2) Exclusive provider benefit plan notice.  
Figure: 28 TAC §3.3705(f)(2)

(g) Untrue or misleading information prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure concerning access to preferred provider listing. The insurer must provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required updates of available provider listings. The insurer must ensure that it updates all electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of provider listing required in certain cases. If no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative

method of delivery if an alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance on provider listing in certain cases. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(b) - (d) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725(d) - (f) of this title (relating to Payment of Certain Out-of-Network Claims), as applicable, if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

- (A) a provider listing; or
- (B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) - (9) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

§3.3708. *Payment of Certain Basic Benefit Claims and Related Disclosures.*

(a) An insurer must comply with the requirements of subsections (b) and (c) of this section when a preferred provider is not rea-

sonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:

(1) requiring emergency care;

(2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and

(3) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider.

(b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer must:

(1) pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;

(2) pay the claim at the preferred benefit coinsurance level; and

(3) in addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for charges for covered services that were above and beyond the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

(1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;

(2) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(3) is updated no less than once per year;

(4) does not use data that is more than three years old; and

(5) is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) An insurer is required to pay all covered basic benefits for services obtained from health care providers or physicians at least at the plan's basic benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan shall not be a basis for denial of a claim.

(e) When services are rendered to an insured by a nonpreferred hospital-based physician in an in-network hospital and the difference between the allowed amount and the billed charge is at least \$500, the insurer must include a notice on the applicable explanation of benefits that the insured may have the right to request mediation of the claim of an uncontracted facility-based provider under Insurance Code Chapter 1467 and may obtain more information at [www.tdi.texas.gov/consumer/cpmediation.html](http://www.tdi.texas.gov/consumer/cpmediation.html). An insurer is not in violation of this subsection if it provides the required notice in connection with claims that are not eligible for mediation. In this paragraph, "facility-based physician" has the meaning given to it by §21.5003(6) of this title (relating to Definitions).

(f) This section does not apply to an exclusive provider benefit plan.

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 October 14, 2016.

TRD-201605289

Norma Garcia

General Counsel

Texas Department of Insurance

Effective date: November 3, 2016

Proposal publication date: May 27, 2016

For further information, please call: (512) 676-6584



## CHAPTER 21. TRADE PRACTICES

### SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

The Texas Department of Insurance adopts amendments to 28 TAC §§21.2101 - 21.2103 and 21.2105 - 2107, and the repeal of §21.2104, concerning Mandatory Benefit Notice Requirements. The amendments to §21.2101 and §21.2105 and the repeal of §21.2104 are adopted without changes to the proposed text as published in the May 13, 2016, issue of the *Texas Register* (41 TexReg 3426), and will not be republished. Sections 21.2102, 21.2103, 21.2106, and 21.2107 are adopted with non-substantive changes to the proposed text to improve clarity and conform the text to current agency style, such changes being at §§21.2102(2)(D) and 4(B), 21.2103(b)(3), 21.2106(b)(1), and §21.2107.

In response to comment, TDI modified §21.2103(b) to clarify that a form of the notice for any substantially similar language notice must be approved by the commissioner prior to use and forms already being used must be approved by the commissioner by March 1, 2017. In addition, a change is made in §21.2103(a)(5) as proposed to revise a reference to paragraph (4) of the subsection, and changes are made throughout §21.2103(a) to revise references to §21.2306 to follow agency style.

The modification and changes do not introduce new subject matter, create additional costs, or affect persons other than those previously on notice from the proposal.

**REASONED JUSTIFICATION.** The amendments to §§21.2101 - 21.2103 and 21.2105 - 21.2107, and the repeal of §21.2104, are necessary to implement HB 2813, 84th Legislature, Regular Session (2015) and SB 979, 84th Legislature, Regular Session (2015).

HB 2813 amended Insurance Code §1370.002 and §1370.003 to require a health benefit plan to include an annual diagnostic screening test for early detection of ovarian cancer, specifically the CA 125 blood test, as part of its coverage. Section 1370.004 requires that a health benefit plan carrier provide written notice of the coverage required under Chapter 1370.

SB 979 amended Insurance Code §1201.104 to expand one category of individual accident and health insurance policy from "hospital confinement indemnity" to "hospital indemnity or other fixed indemnity." The amendments make conforming changes to the text of Chapter 21, Subchapter M.

Amendments to §21.2101 clarify definitions and remove notice requirements related to date limitations that are no longer relevant.

Amendments to §21.2103(a)(7) require that the mandatory benefit notice include language related to ovarian cancer screening, and clarify that the notice may be modified to omit the references to ovarian cancer and the CA 125 blood test if a plan is not required to provide a benefit for ovarian cancer screening due to the exception in Insurance Code §1370.002(b). Amendments to §21.2103(b) require that any notice that includes "substantially similar language," issued after the effective date of these amendments, must be filed with TDI for review and approval by the commissioner. Amendments to §21.2103(d) remove language relating to compliance prior to the section's effective date because that grandfathering language is no longer necessary. The section includes the requirement relocated from §21.2104, which was repealed, that notices be printed in no less than 10-point type.

Amendments to §21.2105 remove date requirements that are no longer relevant.

Amendments to §21.2106 update the TDI website address and provide for language regarding ovarian cancer to be added to the notice.

Amendments to §21.2107 clarify language and include the requirement relocated from repealed §21.2104, that notices must be printed in no less than 10-point type.

The adopted amendments also include nonsubstantive changes to the proposed text to conform the text to current agency style.

**SUMMARY OF COMMENTS AND AGENCY RESPONSE.** TDI received one written comment. The commenter in support of the proposal, with changes, was Texas Association of Health Plans. No hearing was requested or held.

**Comment:** A commenter requests that §21.2103(b) be amended to remove the requirement that any benefit notices not using the exact prescribed language be filed with TDI for review and approval. The commenter says that such a requirement: (a) is not necessary because the regulations as currently written provide sufficient protection, and (b) creates an unnecessary administrative burden and expense. As an example of the unnecessary administrative burden and expense associated with complying with the amended section, the commenter says that some health plans may modify the prescribed language so that notices may be used in multiple states and must comply with the current requirements applicable to substantially similar notice language. The commenter also requests that if TDI does pursue a filing requirement, the filing should be on an informational basis rather than requiring approval.

**Agency Response:** TDI disagrees with the commenter and declines to make the requested changes, but has revised the proposed text in order to provide additional time to bring forms into compliance. As adopted, the rule requires that notices that include "substantially similar language" must be filed with TDI for review and approval by the commissioner under Insurance Code Chapters 843 (concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), and 1701 (concerning Policy Forms). Substantially similar notices already in use must be approved for use by March 1, 2017. Although current regulations require that the substantially similar language be readable, clear, and accurately describe certain required in-

formation, TDI cannot determine if a notice complies with these requirements unless the notice is filed with TDI for review and approval. The requirement to file and receive commissioner approval ensures that the substantially similar notice protects the rights and interests of Texas consumers to at least the same extent as the corresponding prescribed notice.

## 28 TAC §§21.2101 - 21.2103, 21.2105 - 2107

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1357.006, 1357.056, 1362.004, 1363.004, 1366.058, 1370.004, 1201.104, and 36.001.

Section 1357.006 requires notice of coverage for mastectomies. Section 1357.056 requires notice of coverage required for hospital stays after mastectomies. Section 1362.004 requires notice of coverage for detection of prostate cancer. Section 1363.004 requires notice of coverage for detection of colorectal cancer. Section 1366.058 requires notice of coverage for maternity, childbirth, and in-home postdelivery care. Section 1370.004 requires notice of coverage for human papillomavirus, ovarian cancer, and cervical cancer screening. Section 1201.104 requires TDI to adopt rules establishing minimum benefit standards for individual accident and health insurance policies. Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

### §21.2102. Definitions.

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

(1) Another limited benefit--A plan that provides coverage, singularly or in combination, for benefits for a specifically named disease, accident, or combination of diseases or accidents, including, but not limited to:

- (A) heart attack;
- (B) stroke;
- (C) AIDS; or
- (D) travel, farm, or occupational accident.

(2) Carrier--The term includes:

(A) an insurance company, a group hospital service corporation, a fraternal benefit society, a stipulated premium insurance company, a health maintenance organization, a multiple employer welfare arrangement that holds a certificate of authority under Insurance Code Chapter 846, or an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Insurance Code Chapter 844;

(B) for the purposes of paragraph (4)(B) and (F) of this section, a reciprocal exchange operating under Insurance Code Chapter 942;

(C) for purposes of paragraph (4)(E) and (F) of this section, a Lloyds plan operating under Insurance Code Chapter 941; and

(D) for purposes of paragraph (4)(E) of this section, a risk pool created under Local Government Code Chapter 172.

(3) Enrollee--A person enrolled in and entitled to coverage under a health benefit plan, including covered dependents.

(4) Health Benefit Plan--Subject to subparagraphs (A), (B), (C), (D), (E), and (F) of this paragraph, a plan that is offered by a carrier and provides benefits for medical or surgical expenses incurred as a

result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement; a group hospital service contract; an individual or group evidence of coverage; or any similar coverage document. The term does not include a plan that provides coverage only for accidental death or dismemberment, disability income, supplement to liability insurance, Medicare supplement, workers' compensation, medical payment insurance issued as a part of a motor vehicle insurance policy, or a long-term care policy.

(A) For the inpatient mastectomy coverage notice required by §21.2103(a)(1) of this title (relating to Mandatory Benefit Notices), the definition of health benefit plan includes a plan that provides coverage only for a specific disease or condition for the treatment of breast cancer or for hospitalization. The term does not include a small employer health benefit plan issued under Insurance Code Chapter 1501, Subchapters A - H (concerning Health Insurance Portability and Availability Act).

(B) For the reconstructive surgery after mastectomy notices required by §21.2103(a)(2) of this title, the definition of health benefit plan does not include:

- (i) a plan that provides coverage for a specified disease or another limited benefit, except for cancer;
- (ii) a plan that provides only credit insurance;
- (iii) a plan that provides coverage only for dental or vision care; or
- (iv) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(C) For the prostate cancer examination notice required by §21.2103(a)(3) of this title, the definition of health benefit plan does not include:

- (i) a small employer health benefit plan written under Insurance Code Chapter 1501, Subchapters A - H;
- (ii) a plan that provides coverage only for a specified disease or another limited benefit; or
- (iii) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(D) For the inpatient maternity and childbirth coverage notice required by §21.2103(a)(4) and (5) of this title, the definition of health benefit plan does not include:

- (i) a plan that provides only credit insurance;
- (ii) a plan that provides coverage only for a specified disease or another limited benefit;
- (iii) a plan that provides coverage only for dental or vision care; or
- (iv) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(E) For the detection of colorectal cancer screening coverage notice required by §21.2103(a)(6) of this title, the definition of health benefit plan does not include:

- (i) a small employer health benefit plan written under Insurance Code Chapter 1501, Subchapters A - H;
- (ii) a plan that provides coverage only for a specified disease or another limited benefit; or
- (iii) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(F) For the detection of human papillomavirus and cervical cancer screening notice required by §21.2103(a)(7) of this title, the definition of health benefit plan includes a small employer health benefit plan written under Insurance Code Chapter 1501, but does not include:

- (i) a plan that provides coverage only for a specified disease or another limited benefit, other than a plan that provides benefits for cancer treatment or similar services;
- (ii) a plan that provides coverage only for dental or vision care;
- (iii) a plan that provides coverage only for indemnity or for hospital indemnity or other fixed indemnity;
- (iv) a credit insurance policy; or
- (v) a limited benefit policy that does not provide coverage for physical examinations or wellness exams.

(5) Primary Enrollee--For group coverage, the covered member or employee of the group. For individual coverage, the person first named on the application or enrollment form.

§21.2103. *Mandatory Benefit Notices.*

(a) Prescribed mandatory benefit notices consist of the following:

(1) For a health benefit plan that provides coverage or benefits for the treatment of breast cancer, a carrier must issue a notice that includes the language provided in Figure 1 of §21.2106(b) of this title (relating to Forms).

(2) For a health benefit plan that provides coverage or benefits for a mastectomy, a carrier must issue:

(A) an enrollment notice that includes the language provided in Figure 2 of §21.2106(b) of this title; and

(B) an annual notice that includes either:

(i) the language provided in Figure 3 §21.2106(b) of this title; or

(ii) the language provided in Figure 2 §21.2106(b) of this title.

(3) For a health benefit plan that provides coverage or benefits for diagnostic medical procedures, a carrier must issue a notice that includes the language provided in Figure 4 §21.2106(b) of this title.

(4) For a health benefit plan that provides coverage or benefits for maternity, including benefits for childbirth, a carrier must issue a notice that includes the language provided in Figure 5 §21.2106(b) of this title.

(5) If the health benefit plan described in paragraph (4) of this subsection includes benefits or coverage for in-home postdelivery care, the following language, or substantially similar language, must be inserted immediately before the "Prohibitions" portion of the notice language in Figure 5 §21.2106(b) of this title: "Since we provide in-home postdelivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay."

(6) For a health benefit plan that provides coverage or benefits for medical screening procedures, a carrier must issue a notice that includes the language provided in Figure 6 §21.2106(b) of this title.

(7) For a health benefit plan that provides coverage or benefits for medical screening procedures, a carrier must issue a notice that includes the language provided in Figure 7 §21.2106(b) of this title. If a plan is not required to provide a benefit for ovarian cancer screening due to the exception in Insurance Code §1370.002(b) (concerning Exceptions), the notice may be modified to omit the references to ovarian cancer and the CA 125 blood test.

(b) Instead of the prescribed notices outlined in subsection (a) of this section, a carrier may opt to provide notices with substantially similar language rather than the notices contained in §21.2106(b) of this title. A form that includes substantially similar language under this subsection must be filed for review and approval by the commissioner prior to use, in accordance with Insurance Code Chapters 843 (concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), and 1701 (concerning Policy Forms), except that a form already in use may not be used after March 1, 2017, unless approved by the commissioner. The substantially similar language must be in a readable and understandable format, and must include a clear, complete, and accurate description of these items in the following order:

(1) a heading in bold print and all capital letters indicating the information in the notice relates to mandated benefits;

(2) a statement that the notice is being provided to advise the enrollee of the appropriate coverage or benefits, including the carrier's complete licensed name;

(3) a heading in bold print describing the coverage or benefits being provided; for example, Examinations for Detection of Prostate Cancer;

(4) a description of the coverage or benefits for which the notice is being provided;

(5) for a carrier who issues a health benefit plan that provides coverage or benefits for a mastectomy, the following requirements apply:

(A) the enrollment notice required by subsection (a)(2)(A) of this section must disclose that the coverage or benefits must be provided in a manner determined to be appropriate, in consultation with the attending physician and the enrollee, and state the specific deductibles, copayments, and coinsurance, which may not be greater than the deductibles, copayments, and coinsurance applicable to other benefits under the health benefit plan; and

(B) the annual notice required by subsection (a)(2)(B) of this section must, at a minimum, describe that the health benefit plan provides coverage or benefits for reconstructive surgery after mastectomy, surgery and reconstruction of the other breast for symmetry, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema);

(6) for the notice required by subsection (a)(1), (2)(A), and (4) of this section, the heading "Prohibitions" in bold, followed by a summary of the prohibited acts by a carrier in providing the coverage or benefits for which the notice is being provided; and

(7) a statement identifying the carrier, and providing a phone number and address to which an enrollee may direct questions regarding the coverage or benefits for which the notice is being provided.

(c) If a health benefit plan provides coverage or benefits of more than one of the required notices described in subsection (a) of this section, the carrier may combine the language of the required notices into one notice.

(d) The notices must be printed in no less than 10-point type.  
§21.2106. *Forms.*

(a) The forms identified in §21.2103 of this title (relating to Mandatory Benefit Notices) are included in subsection (b) of this section in their entirety. The forms can be obtained from the Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or from the TDI website, [www.tdi.texas.gov](http://www.tdi.texas.gov).

(b) The forms referenced in this chapter are:

(1) Figure Number 1: Form Number 349 Mastectomy:  
Figure: 28 TAC §21.2106(b)(1) (No change.)

(2) Figure Number 2: Form Number 1764 Reconstructive Surgery After Mastectomy-Enrollment:  
Figure: 28 TAC §21.2106(b)(2) (No change.)

(3) Figure Number 3: Form Number 1764 Reconstructive Surgery After Mastectomy-Annual:  
Figure: 28 TAC §21.2106(b)(3) (No change.)

(4) Figure Number 4: Form Number 258 Prostate:  
Figure: 28 TAC §21.2106(b)(4) (No change.)

(5) Figure Number 5: Form Number 102 Maternity:  
Figure: 28 TAC §21.2106(b)(5) (No change.)

(6) Figure Number 6: Form Number 1467 Colorectal Cancer Screening:  
Figure: 28 TAC §21.2106(b)(6) (No change.)

(7) Figure Number 7: Form Number LHL391 Human Papillomavirus, Ovarian Cancer, and Cervical Cancer Screening:  
Figure: 28 TAC §21.2106(b)(7)

§21.2107. *Right to Medicare Supplement Coverage Notice.*

(a) At the time of an event described in §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons) that causes an individual to lose coverage or benefits due to the termination of a contract, agreement, policy, or plan, the entity, as defined in §3.3312 of this title, must:

(1) notify the individual of his or her rights under §3.3312(a), (c), (d), and (e) of this title, and the obligations of issuers of Medicare supplement policies under §3.3312(a) of this title; and

(2) communicate this notice at the same time as the notification of termination.

(b) At the time of an event described in §3.3312(b) of this title that causes an individual to cease enrollment under a contract, agreement, policy, or plan, the entity, as defined in §3.3312 of this title, that offers the contract or agreement, regardless of the basis for the cessation of enrollment or the licensed third-party administrator of the plan, must:

(1) notify the individual of his or her rights under §3.3312(a), (c), (d), and (e) of this title, and of the obligations of issuers of Medicare supplement policies under §3.3312(a) of this title; and

(2) communicate this notice within 10 working days of the entity's receipt of notification of disenrollment.

(c) The notices must be printed in no less than 10-point type.

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 October 13, 2016.

TRD-201605232  
Norma Garcia  
General Counsel  
Texas Department of Insurance  
Effective date: November 2, 2016  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 676-6584



## 28 TAC §21.2104

STATUTORY AUTHORITY. The repeal is adopted under Insurance Code §§1357.006, 1357.056, 1362.004, 1363.004, 1366.058, 1370.004, 1201.104, and 36.001.

Section 1357.006 requires notice of coverage for mastectomies. Section 1357.056 requires notice of coverage required for hospital stays after mastectomies. Section 1362.004 requires notice of coverage for detection of prostate cancer. Section 1363.004 requires notice of coverage for detection of colorectal cancer. Section 1366.058 requires notice of coverage for maternity, childbirth, and in-home postdelivery care. Section 1370.004 requires notice of coverage for human papillomavirus, ovarian cancer, and cervical cancer screening. Section 1201.104 requires TDI to adopt rules establishing minimum benefit standards for individual accident and health insurance policies. Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

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 October 13, 2016.

TRD-201605233  
Norma Garcia  
General Counsel  
Texas Department of Insurance  
Effective date: November 2, 2016  
Proposal publication date: May 13, 2016  
For further information, please call: (512) 676-6584



## SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

The Texas Department of Insurance adopts amendments to 28 TAC Chapter 21, Subchapter PP, §§21.5001 - 21.5003, 21.5010 - 21.5013, 21.5020, 21.5030, and 21.5031, (relating to Out-of-Network Claim Dispute Resolution). The amendments are adopted with changes to the proposed text published in the May 27, 2016, issue of the *Texas Register* (41 TexReg 3835).

REASONED JUSTIFICATION. The amendments are necessary because of changes made to Texas Insurance Code Chapter 1467. Senate Bill 481, 84th Legislature, Regular Session (2015), amended Insurance Code Chapter 1467 (concerning

Out-of-Network Claim Dispute Resolution). As a result, the department must make conforming changes to 28 TAC Chapter 21, Subchapter PP.

Both Chapter 1467 and Subchapter PP provide for mediation of certain claims by certain facility-based physicians for services provided to enrollees of preferred provider benefit plans issued under Insurance Code Chapter 1301 and to enrollees of health benefit plans, other than health maintenance organization plans, provided under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act).

Senate Bill 481 added assistant surgeons to the list of facility-based physicians subject to mediation. The department's rules at 28 TAC Chapter 21, Subchapter PP need to be updated to include this change. The rule amendments as proposed and adopted include "assistant surgeons" but do not include "surgical assistants" because surgical assistants who are not also assistant surgeons are not physicians whose claims are subject to mediation under the statute. Senate Bill 481 also lowered the threshold amount for mediation to amounts greater than \$500 for services provided on or after September 1, 2015. The rules have been updated to include these changes and adopt a new mediation request form. The amendments also make it clear that the statute does not allow claims to be unilaterally reduced to an amount below the mediation threshold to avoid mediation of a qualified claim and allow balance billing. The amendments also make nonsubstantive changes to conform to agency style and usage guidelines.

The department has made the following changes to the proposed language in response to comments:

1. did not implement the department's proposed deletion of the qualifying statement, "provided the claim is filed on or after November 1, 2010," in §21.5002(a)(1) and (a)(2);
2. made changes to §§21.5002(b), 21.5003(3), 21.5003(3)(B), and 21.5003(10) to avoid the proposed deletion of the "and/or" construct while preserving clarity, generally by substituting "A or B or both" for "A and/or B," and made the same kind of nonsubstantive changes to §21.5020 and §21.5030(b)(3) for the same reason;
3. retained the "contracted with an" administrator language in §21.5003(10); and
4. added the hospital-based physician and the hospital-based physician's representative to the list in proposed §21.0511(a)(7) of persons to whom authorized disclosures may be made.

#### SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received timely written comments from two commenters. Commenters on the proposal were: one individual and the Texas Medical Association. The commenters were for the proposal, with changes.

#### General Comment.

One commenter stated that the proposed amendments do not address a situation where an individual is balance billed for special equipment used in a surgical operation. The commenter stated that many consumers of health care are familiar with the issue of inadvertently receiving care from an out-of-network doctor, even though the treatment was at an in-network hospital, but that most people probably are unaware that an in-network doctor's surgical equipment might be classified as out-of-network. The commenter suggested that a global solution to the issue of inadvertent out-of-network charges should be undertaken to ob-

viate mediation services. The commenter noted that the solution must apply to any major medical health insurance plan and not be limited to hospital-based physicians.

#### Agency Response to General Comment.

The department appreciates the comment and acknowledges that balance billing can occur in contexts other than the physician services covered in Insurance Code Chapter 1467. However, the Insurance Code does not currently provide for the global solution advocated by the commenter. The department therefore respectfully declines to make the changes suggested by the commenter.

#### Comment on §21.5002(a).

One commenter opposed the department's proposed deletion of the qualifying statement, "provided the claim is filed on or after November 1, 2010," from §21.5002(a)(1) and (a)(2). The commenter noted that it was possible that a plan could audit a claim dated before this date, and said that the language adds clarity to the rules, as it makes it clear that the mediation process applies only after the effective date specified in the original bill. Were it changed, according to the commenter, claims dated before the bill enacting Chapter 1467 (HB 2256, 81st Legislature, Regular Session, 2009) might be eligible for mediation.

#### Agency Response to Comment on §21.5002(a).

While the department believes that this scenario is unlikely, and believes that Chapter 1467 makes it clear that claims filed before November 1, 2010, are not eligible for mediation, it agrees to leave the date references intact to avoid any possible confusion.

Comments on §§21.5002(b), 21.5003(3), 21.5003(3)(B), 21.5003(10), 21.5020, and 21.5030(b)(3).

One commenter opposed the proposed alteration of the "and/or" language in §§21.5002(b), 21.5003(3), 21.5003(3)(B), and 21.5003(10). The commenter asserted that this construct adds clarity, as it encompasses "A" or "B" or some combination thereof. The commenter did not mention §21.5020 or §21.5030(b)(3), but the department assumes the same concern would apply there.

Agency Response to Comments on §§21.5002(b), 21.5003(3), 21.5003(3)(B), and 21.5003(10).

The department now generally discourages the use of the "and/or" construct, but has made changes to the proposed deletions to preserve clarity. The department has made the same kind of nonsubstantive change to §21.5020 and §21.5030(b)(3) for the same reason.

#### Comment on §21.5003(10).

One commenter recommended retaining the "contracted with an" language in the current rules. The commenter contended that deleting "contracted with an" preceding "administrator" potentially alters the meaning of §21.5003(10). Deleting "contracted with an" makes the rule read as if, for a claim to be an "out-of-network claim," it must be a claim by a hospital-based physician who is not contracted as a preferred provider with a preferred provider benefit plan or with an administrator. The commenter noted that this language is imprecise because, although a physician may contract with the administrator of a state plan under Chapter 1551, he or she does not contract with the administrator "as a preferred provider" as defined in §21.5003(11).

Agency Response to Comment on §21.5003(10).

The department appreciates the commenter's concern, and agrees to retain the "contracted with an" language.

Comment on §21.5010(d).

One commenter opposed the language as currently drafted and contended that the language of Insurance Code Chapter 1467 does not contain an express exception that allows mediation requests for aggregate amounts falling below the statutory threshold due to unilateral reductions in enrollee responsibility. The commenter was concerned that the language in the rule proposal is broadly drafted and may have unintended consequences. The commenter urged the department to:

(1) Clarify that the unilateral reduction exception in proposed §21.5010(d) applies to a claim that meets the criteria for a qualified claim after claim adjudication. The commenter contended that it is important to add clarifying language, because: (a) physicians should have the flexibility to set or modify their charges prior to claim submission or adjudication, and (b) the department's concern about attempts to inappropriately circumvent mediation by reducing aggregate amounts due has no validity before claim adjudication, as the physician has no idea what an enrollee's ultimate payment responsibility will be until after the claim is adjudicated.

(2) Include exceptions for correction of errors and to allow use of established prompt pay discount policies to the proposed unilateral reduction exception. The commenter stated that the language of §21.5010(d) fails to acknowledge that there are many legitimate reasons for a unilateral reduction in the aggregate amount due, such as to correct a billing error, claim payment, or claim submission or adjudication. The commenter was concerned that §21.5010(d), as currently proposed, would inhibit the use of legitimate, established written prompt pay discount policies, because there may be confusion as to what constitutes "consent" for purposes of §21.5010(d)'s qualified claim status continuation provision. The commenter's suggested language provided that an enrollee who either agrees to pay or pays a prompt pay discounted amount under an established prompt pay billing policy is deemed to have consented to the reduction.

(3) The commenter commented that the department should include additional language in proposed §21.5010(d) to: (a) minimize the unintended consequences of the "consent" requirement language, and (b) ensure that the regulatory provision targets the specific behavior that it wants to address (such as inappropriate circumvention of mediations). The commenter's suggested language involved the aggregate amount for which the enrollee is responsible being reduced below the thresholds set out in the section if the reduction occurs: (a) without the consent of the enrollee, (b) after receipt of notice from the department that an enrollee has made a request for mediation, and (c) with the specific intent and for the sole purpose of avoiding mediation.

Agency Response to Comment on §21.5010(d).

First, the department notes that the statutes allow very little discretion on this matter. A claim qualifies for mandatory mediation under Insurance Code §1467.051(a) if: (1) the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than \$500; and (2) the health benefit claim is for a medical service or supply provided by an out-of-network, facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator. Once that qualification occurs, as §1467.051(b) provides, barring the exception for disclosures under §1467.051(c)

and (d), "if an enrollee requests mediation under this subchapter, the facility-based physician or the physician's representative and the insurer or the administrator, as appropriate, shall participate in the mediation." The statute provides no way for a claim to become "unqualified" or to be unilaterally removed from mediation under §§1467.054 - 1467.060, which contemplate the mediation process continuing until a resolution is reached. As §1467.056(d) puts it, "[t]he goal of the mediation is to reach an agreement among the enrollee, the facility-based physician, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based physician, the amount charged by the facility-based physician, and the amount paid to the facility-based physician by the enrollee." Indeed, §1467.055(h) provides that "[o]n receipt of notice from the department that an enrollee has made a request for mediation that meets the requirements of this chapter, the facility-based physician may not pursue any collection effort against the enrollee who has requested mediation for amounts other than copayments, deductibles, and coinsurance before the earlier of: (1) the date the mediation is completed, or (2) the date the request to mediate is withdrawn." This presents a significant barrier to any negotiations about amounts to be paid once the mediation process has begun. The department believes that the proposed rule accurately reflects the law.

Second, the small number of "unilateral claim reductions" with which the department is concerned in this subsection do not involve billing errors or prompt pay discounts, but appear to simply be unilateral reductions (sometimes referred to as the *Texas discount*). Their purpose appears to be solely to get the claim below the mediation threshold. While the department anticipates that this will become less of a problem with the new, lower, \$500 threshold, it is not a practice permitted by the statute.

With regard to the first change suggested in the comment above (clarifying that a claim qualifies or not after claim adjudication), the department's concern is that a small number of facility-based physicians attempt to inappropriately circumvent mediation by reducing aggregate amounts due after, and not before, claim adjudication by the insurer or administrator. Until a claim is adjudicated, it is impossible to determine "the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer" under §1467.051(1). Similarly, until the claim is adjudicated, it is difficult to tell whether the "claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator" under §1467.051(2). Thus, a claim qualifies (or does not qualify) for mandatory mediation under Insurance Code §1467.051 after, not before, claim adjudication. The department agrees to change the language in §21.5010(d) to make it clear that the amount involved is that remaining after claim adjudication.

With regard to the second change suggested in the comment above (regarding prompt payment discounts), the department notes that the amount of the claim would be the amount before the discount, since that is the amount claimed. The discount is an inducement to pay earlier rather than later, and would not be deducted from the amount of the claim for the purpose of determining whether the claim is under or over the threshold for mediation. The department declines to make the requested change.

With regard to the possibility of any party unilaterally reducing the aggregate amount due in order to correct a billing error, claim payment, or claim submission or adjudication, §1467.051 and

1467.054 - 1467.060 limit the actions of parties, as described above. The department cannot simply create an exemption from the requirements of those sections, and declines to make the requested change.

With regard to the third change suggested in the comment above (regarding adding additional language), the department does not believe the suggested changes or the intent language are useful or advisable in light of the statutory constraints set out above, and declines to make the suggested change.

Comment on §21.0511(a)(7).

One commenter did not object to the department's obtaining an authorization form if the department determines that the form is necessary, but questioned why the department did not include the hospital-based physician and the hospital-based physician's representative in the list of persons to whom authorized disclosures may be made under the authorization form. The commenter recommended that the department add the hospital-based physician and the hospital-based physician's representative to the list in proposed §21.0511(a)(7).

Agency Response to Comment on §21.0511(a)(7).

The department assumed that the hospital-based physician and the hospital-based physician's representative already had consent from the patient for the disclosures in question, and thus did not include them in the form. The department agrees to alter the form to make it clear that the hospital-based physician and the hospital-based physician's representative are included in the list of persons to whom authorized disclosures may be made.

## DIVISION 1. GENERAL PROVISIONS

### 28 TAC §§21.5001 - 21.5003

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1467.001, 1467.003, and 36.001.

Section 1467.001 contains definitions, including a definition for the facility-based physicians to whose billings Chapter 1467 applies.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

#### §21.5001. Purpose.

As authorized by Insurance Code §1467.003 (concerning Rules), the purpose of this subchapter is to:

- (1) prescribe the process for requesting and initiating mandatory mediation of claims as authorized in Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution); and
- (2) facilitate the process for the investigation and review of a complaint filed with the department that relates to the settlement of an out-of-network claim under Insurance Code Chapter 1467.

#### §21.5002. Scope.

(a) This subchapter applies to a qualified claim filed under health benefit plan coverage:

- (1) issued by an insurer as a preferred provider benefit plan under Insurance Code Chapter 1301 (concerning Preferred Provider

Benefit Plans), provided the claim is filed on or after November 1, 2010; or

- (2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act), provided the claim is filed on or after November 1, 2010.

(b) This subchapter does not apply to a claim for health benefits, including medical and health care services or supplies or both, that is not a covered claim under the terms of the health benefit plan coverage.

#### §21.5003. Definitions.

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

(1) Administrator--An administering firm or a claims administrator for a health benefit plan, other than a health maintenance organization (HMO) plan, providing coverage under Insurance Code Chapter 1551, (concerning Texas Employees Group Benefits Act).

(2) Chief administrative law judge--The chief administrative law judge of the State Office of Administrative Hearings.

(3) Claim--A request to a health benefit plan for payment for health benefits under the terms of the health benefit plan's coverage, including medical and health care services or supplies or both, provided that the services or supplies or both:

(A) are furnished for a single date of service; or

(B) if furnished for more than one date of service, are provided as a continuing or related course of treatment, or a continuing and related course of treatment, over a period of time for a specific medical problem or condition, or in response to the same initial patient complaint.

(4) Enrollee--An individual who is eligible to receive benefits through a health benefit plan.

(5) Health benefit plan--A plan that provides coverage under:

(A) a preferred provider benefit plan offered by an insurer under Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans); or

(B) a plan, other than an HMO plan, under Insurance Code Chapter 1551.

(6) Hospital-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon if the assistant surgeon's services are provided on or after September 1, 2015:

(A) to whom the hospital has granted clinical privileges; and

(B) who provides services to patients of the hospital under those clinical privileges.

(7) Insurer--A life, health, and accident insurance company; health insurance company; or other company operating under: Insurance Code Chapters 841 (concerning Life, Health, or Accident Insurance Companies); 842 (concerning Group Hospital Service Corporations); 884 (concerning Stipulated Premium Insurance Companies); 885 (concerning Fraternal Benefit Societies); 982 (concerning Foreign and Alien Insurance Companies); or 1501 (concerning Health Insurance Portability and Availability Act), that is authorized to issue,

deliver, or issue for delivery in this state a preferred provider benefit plan under Insurance Code Chapter 1301.

(8) Mediation--A process in which an impartial mediator facilitates and promotes agreement between the insurer offering a preferred provider benefit plan, or the administrator, and a hospital-based physician or the physician's representative to settle a qualified claim of an enrollee.

(9) Mediator--An impartial person who is appointed to conduct mediation under Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution).

(10) Out-of-network claim--A claim for payment for medical or health care services or supplies or both furnished by a hospital-based physician that is not contracted as a preferred provider with a preferred provider benefit plan or contracted with an administrator.

(11) Preferred provider--A hospital or hospital-based physician that contracts on a preferred-benefit basis with an insurer issuing a preferred provider benefit plan under Insurance Code Chapter 1301 to provide medical care or health care to enrollees covered by a health insurance policy.

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 October 14, 2016.

TRD-201605290

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Texas Department of Insurance

Effective date: November 3, 2016

Proposal publication date: May 27, 2016

For further information, please call: (512) 676-6584



## DIVISION 2. MEDIATION PROCESS

### 28 TAC §§21.5010 - 21.5013

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1467.001, 1467.003, 1467.051, 1467.054, and 36.001.

Section 1467.001 contains definitions, including a definition for the facility-based physicians to whose billings Chapter 1467 applies.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Section 1467.054 sets out the procedure for requesting mediation and preliminary procedures for that mediation, and provides that a request for mandatory mediation must be provided to the department on a form prescribed by the commissioner.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

§21.5010. *Qualified Claim Criteria.*

(a) Required criteria. An enrollee may request mandatory mediation of an out-of-network claim under §21.5011 of this title (relating to Mediation Request Form and Procedure) if the claim complies with the criteria specified in this subsection. An out-of-network claim that complies with those criteria is referred to as a "qualified claim" in this subchapter.

(1) The out-of-network claim must be for medical services or supplies, or both, provided by a hospital-based physician in a hospital that is a preferred provider with the insurer or that has a contract with the administrator.

(2) For services provided before September 1, 2015, the aggregate amount for which the enrollee is responsible to the hospital-based physician for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than \$1,000.

(3) For services provided on or after September 1, 2015, the aggregate amount for which the enrollee is responsible to the hospital-based physician for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than \$500.

(b) Submission of multiple claim forms. The use of more than one form in the submission of a claim, as defined in §21.5003(3) of this title (relating to Definitions), does not prevent eligibility of a claim for mandatory mediation under this subchapter if the claim otherwise meets the requirements of this section.

(c) Ineligible claims.

(1) An out-of-network claim is not eligible for mandatory mediation under this subchapter if:

(A) the hospital-based physician has provided a complete disclosure to an enrollee under Insurance Code §1467.051 (concerning Availability of Mandatory Mediation; Exception), and this subsection before providing the medical service or supply or both and has obtained the enrollee's written acknowledgment of that disclosure; and

(B) the amount billed by the hospital-based physician is less than or equal to the maximum amount specified in the disclosure.

(2) A complete disclosure under paragraph (1) of this subsection must:

(A) explain that the hospital-based physician does not have, as applicable, either a contract with the enrollee's health benefit plan as a preferred provider or a contract with the administrator of the plan, other than an HMO plan, provided under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act);

(B) disclose projected amounts for which the enrollee may be responsible; and

(C) disclose the circumstances under which the enrollee would be responsible for those amounts.

(d) Qualification continues. A claim that meets the criteria for a qualified claim after claim adjudication by the insurer or administrator does not lose that status by virtue of the aggregate amount for which the enrollee is responsible being reduced below the thresholds set out in this section without the consent of the enrollee.

§21.5011. *Mediation Request Form and Procedure.*

(a) Mediation request form. The commissioner adopts by reference Form No. CP029 (Health Insurance Mediation Request Form), which is available at [www.tdi.texas.gov/consumer/cpmmmediation.html](http://www.tdi.texas.gov/consumer/cpmmmediation.html). Form No. CP029 (Health Insurance Mediation Request

Form) requires information necessary for the department to properly identify the qualified claim, including:

- (1) the name and contact information, including a telephone number, of the enrollee requesting mediation;
- (2) a brief description of the qualified claim to be mediated;
- (3) the name and contact information, including a telephone number, of the requesting enrollee's counsel, if the enrollee retains counsel;
- (4) the name of the hospital-based physician;
- (5) the name of the insurer or administrator;
- (6) the name and address of the hospital where services were rendered; and
- (7) an authorization allowing the department to disclose the enrollee's protected health information or other confidential information to the hospital-based physician and the hospital-based physician's representative, the enrollee's health benefit plan's insurer or administrator, the appointed mediator, and the State Office of Administrative Hearings.

(b) **Submission of request.** An enrollee may submit a request for mediation by completing and submitting Form No. CP029 (Health Insurance Mediation Request Form) as provided in paragraphs (1) - (4) of this subsection. The request may be submitted:

- (1) by mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;
- (2) by fax to 512-490-1007;
- (3) by email to [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov); or
- (4) online, when the department makes Form No. CP029 (Health Insurance Mediation Request Form) available to be completed and submitted online.

(c) **Assistance.** Assistance with submitting a request for mediation is available at the department's toll-free telephone number, 1-800-252-3439.

*§21.5012. Informal Settlement Teleconference.*

An insurer or administrator subject to mandatory mediation requested by an enrollee under §21.5011 of this title (relating to Mediation Request Form and Procedure) must use best efforts to coordinate the informal settlement teleconference required by Insurance Code §1467.054 (concerning Request and Preliminary Procedures for Mandatory Mediation) by:

- (1) arranging a date and time when the insurer or administrator; the enrollee or the enrollee's representative, if the enrollee or the enrollee's representative, chooses to participate; and the hospital-based physician or the hospital-based physician's representative can participate in the informal settlement teleconference, which must occur not later than the 30th day after the date on which the enrollee submitted a request for mediation; and
- (2) providing a toll-free telephone number for participation in the informal settlement teleconference.

*§21.5013. Mediation Participation.*

(a) An insurer or administrator subject to mediation under this subchapter must participate in mediation in good faith and is subject to any rules adopted by the chief administrative law judge in accordance with Insurance Code §1467.003 (concerning Rules).

(b) Under Insurance Code §1467.101 (concerning Bad Faith), conduct that constitutes bad faith mediation includes failing to:

- (1) participate in the mediation;
- (2) provide information that the mediator believes is necessary to facilitate an agreement; or
- (3) designate a representative participating in the mediation with full authority to enter into any mediated agreement.

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 October 14, 2016.

TRD-201605291

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General Counsel

Texas Department of Insurance

Effective date: November 3, 2016

Proposal publication date: May 27, 2016

For further information, please call: (512) 676-6584



### DIVISION 3. PLAN ADMINISTRATOR'S REQUIRED NOTICE OF CLAIMS DISPUTE RESOLUTION

#### **28 TAC §21.5020**

**STATUTORY AUTHORITY.** The amendments are adopted under Insurance Code §§1467.003, 1467.151, and 36.001.

Section 1467.001 contains definitions, including a definition for the facility-based physicians to whose billings Chapter 1467 applies.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Section 1467.151 provides, in pertinent part, that the commissioner adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467, and requires that the rules require plan administrators to include a notice of the claims dispute resolution process available under Chapter 1467 with the explanation of benefits sent to an enrollee.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

*§21.5020. Required Notice of Claims Dispute Resolution.*

An administrator of a plan under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act), must include a notice of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for an out-of-network claim for services, supplies, or both, furnished in a hospital that has a contract with the administrator.

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 October 14, 2016.

TRD-201605292

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Effective date: November 3, 2016

Proposal publication date: May 27, 2016

For further information, please call: (512) 676-6584



## DIVISION 4. COMPLAINT RESOLUTION AND OUTREACH

### 28 TAC §21.5030, §21.5031

STATUTORY AUTHORITY. The amendments are adopted pursuant to Insurance Code §§1467.003, 1467.151, and 36.001.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Section 1467.151 provides, in pertinent part, that the commissioner adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

#### §21.5030. *Complaint Resolution.*

##### (a) Written complaint.

(1) An individual may submit a written complaint to the department regarding a qualified claim or a mediation that has been requested under §21.5010 of this title (relating to Qualified Claim Criteria). A recommended form for filing a complaint under this subsection is available online at [www.tdi.texas.gov/consumer/cpmmediation.html](http://www.tdi.texas.gov/consumer/cpmmediation.html). The complaint may be submitted by:

(A) mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;

(B) fax to 512-490-1007;

(C) email to [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov); or

(D) online submission.

(2) Assistance with filing a complaint is available at the department's toll-free telephone number, 1-800-252-3439.

(b) Complaint form. The recommended form for filing a complaint under subsection (a) of this section requests information concerning the complaint, including:

(1) whether the complaint is within the scope of Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution);

(2) whether medical care has been delayed or has not been given;

(3) whether the medical service, supply, or combination thereof that is the subject of the complaint was for emergency care; and

(4) specific information about the qualified claim, including:

(A) the type and specialty of the hospital-based physician;

(B) the type of service performed or supplies provided;

(C) the city and county where service was performed; and

(D) the dollar amount of the disputed claim.

(c) Department Processing. The department will maintain procedures to ensure that a written complaint made under this section is not dismissed without appropriate consideration, including:

(1) review of all of the information submitted in the written complaint;

(2) contact with the parties that are the subject of the complaint;

(3) review of the responses received from the subjects of the complaint to determine if and what further action is required, as appropriate; and

(4) notification to the enrollee of the mediation process, as described in Insurance Code Chapter 1467, Subchapter B (concerning Mandatory Mediation).

#### §21.5031. *Department Outreach.*

In addition to the notice provided to consumers regarding the availability of mandatory mediation described in §21.5030(c) of this title (relating to Complaint Resolution), the department will provide outreach as required by Insurance Code §1467.151(a)(2) (concerning Consumer Protection; Rules), by making information concerning the availability of this mandatory mediation process available:

(1) on the department's website; and

(2) in consumer publications.

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 October 14, 2016.

TRD-201605293

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Effective date: November 3, 2016

Proposal publication date: May 27, 2016

For further information, please call: (512) 676-6584



## TITLE 37. PUBLIC SAFETY AND CORRECTIONS

### PART 1. TEXAS DEPARTMENT OF PUBLIC SAFETY

#### CHAPTER 13. CONTROLLED SUBSTANCES SUBCHAPTER A. GENERAL PROVISIONS

##### 37 TAC §13.1

The Texas Department of Public Safety (the department) adopts the repeal of §13.1, concerning Definitions. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6946) and will not be republished.

The repeal of §13.1 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605338  
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General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



### 37 TAC §13.1

The Texas Department of Public Safety (the department) adopts new §13.1, concerning Definitions. The new rule is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6947) and will not be republished.

New §13.1 is filed simultaneously with the repeal of current §13.1. The new rule and the repeal of current §13.1 is necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13, and provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this proposal.

The new rule is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605334  
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Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
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## SUBCHAPTER B. PRECURSOR CHEMICAL LABORATORY APPARATUS (PCLA)

### 37 TAC §§13.11 - 13.25

The Texas Department of Public Safety (the department) adopts new §§13.11 - 13.25, concerning Precursor Chemical Laboratory Apparatus (PCLA). The new rules are adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6948) and will not be republished.

New §§13.11 - 13.25 is filed simultaneously with the repeal of current Subchapter B, concerning Registration. The new rules, and the repeal of current Subchapter B, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13, and provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of the proposal.

The new rules are adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605335

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Effective date: November 6, 2016

Proposal publication date: September 9, 2016

For further information, please call: (512) 424-5848



## SUBCHAPTER B. REGISTRATION

### 37 TAC §§13.21 - 13.27

The Texas Department of Public Safety (the department) adopts the repeal of §§13.21 - 13.27, concerning Registration. The repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6951) and will not be republished.

The repeal of §§13.21 - 13.27 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605339

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Effective date: November 6, 2016

Proposal publication date: September 9, 2016

For further information, please call: (512) 424-5848



## SUBCHAPTER C. PEYOTE DISTRIBUTORS

### 37 TAC §§13.31 - 13.44

The Texas Department of Public Safety (the department) adopts new §§13.31 - 13.44, concerning Peyote Distributors. The new rules are adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6952) and will not be republished.

New §§13.31 - 13.44 is filed simultaneously with the repeal of current Subchapter C, concerning Peyote. The new rules, and the repeal of current Subchapter C, are necessary in part to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13, and provides an opportunity to consolidate and update the administrative rules of the Peyote Distributor Registration program. Specifically, proposed §13.43, relating to Exemption from Penalty for Failure to Renew in Timely Manner, and proposed §13.44, relating to Extension of License Renewal Deadlines for Military Members, are necessary to implement the requirements of Occupations Code, Chapter 55 as amended by Senate Bill 1307, 84th Legislative Session. This bill requires the creation of exemptions and extensions for occupational license applications and renewals for military service members, military veterans, and military spouses.

No comments were received regarding the adoption of the proposal.

The new rules are adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code, and Occupations Code, §55.02 which authorizes a state agency that issues a license to adopt rules to exempt an individual who holds a license issued by the agency from an increased fee or other penalty imposed by the agency for failing to renew the license in a timely manner if the individual establishes to the satisfaction of the agency that the individual failed to renew the license in a timely manner because the individual was serving as a military service member.

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 October 17, 2016.

TRD-201605336

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Effective date: November 6, 2016

Proposal publication date: September 9, 2016

For further information, please call: (512) 424-5848



## SUBCHAPTER C. PEYOTE

### 37 TAC §§13.41 - 13.58

The Texas Department of Public Safety (the department) adopts the repeal of §§13.41 - 13.58, concerning Peyote. This repeal

is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6955) and will not be republished.

The repeal of §§13.41 - 13.58 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605340

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Effective date: November 6, 2016

Proposal publication date: September 9, 2016

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## SUBCHAPTER D. MISCELLANEOUS PROVISIONS

### 37 TAC §13.51

The Texas Department of Public Safety (the department) adopts new §13.51, concerning Ephedrine, Pseudoephedrine, and Norpseudoephedrine. The new rule is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6956) and will not be republished.

New §13.51 is filed simultaneously with the repeal of current Subchapter E, concerning Precursors and Apparatus, within which current §13.112, concerning Ephedrine, Pseudoephedrine, and Norpseudoephedrine, appears. The new rule, and the repeal of current Subchapter E, is being adopted in conjunction with the repeal and amendment of significant portions of Chapter 13 necessitated by the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription

Drug Monitoring program to the Texas Board of Pharmacy. The need to amend significant portions of Chapter 13 provides an opportunity to update the administrative rule relating to Ephedrine, Pseudoephedrine, and Norpseudoephedrine.

No comments were received regarding the adoption of the proposal.

The new rule is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605337

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Effective date: November 6, 2016

Proposal publication date: September 9, 2016

For further information, please call: (512) 424-5848



## SUBCHAPTER D. TEXAS PRESCRIPTION PROGRAM

### 37 TAC §§13.71 - 13.83

The Texas Department of Public Safety (the department) adopts the repeal of §§13.71 - 13.83, concerning Texas Prescription Program. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6957) and will not be republished.

The repeal of §§13.71 - 13.83 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016

TRD-201605341

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Texas Department of Public Safety

Effective date: November 6, 2016

Proposal publication date: September 9, 2016

For further information, please call: (512) 424-5848

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**SUBCHAPTER E. PRECURSORS AND APPARATUS**

**37 TAC §§13.101 - 13.117**

The Texas Department of Public Safety (the department) adopts the repeal of §§13.101 - 13.117, concerning Precursors and Apparatus. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6957) and will not be republished.

The repeal of §§13.101 - 13.117 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605342

D. Phillip Adkins  
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Texas Department of Public Safety

Effective date: November 6, 2016

Proposal publication date: September 9, 2016

For further information, please call: (512) 424-5848

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**SUBCHAPTER H. SECURITY**

**37 TAC §§13.181 - 13.187**

The Texas Department of Public Safety (the department) adopts the repeal of §§13.181 - 13.187, concerning Security. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6958) and will not be republished.

The repeal of §§13.181 - 13.187 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605343

D. Phillip Adkins  
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Texas Department of Public Safety

Effective date: November 6, 2016

Proposal publication date: September 9, 2016

For further information, please call: (512) 424-5848

◆ ◆ ◆  
**SUBCHAPTER I. RECORD KEEPING**

**37 TAC §§13.201 - 13.209**

The Texas Department of Public Safety (the department) adopts the repeal of §§13.201 - 13.209, concerning Record Keeping. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6959) and will not be republished.

The repeal of §§13.201 - 13.209 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy.

toring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605344  
D. Phillip Adkins  
General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



## SUBCHAPTER J. INVENTORY

### 37 TAC §§13.221 - 13.224

The Texas Department of Public Safety (the department) adopts the repeal of §§13.221 - 13.224, concerning Inventory. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6960) and will not be republished.

The repeal of §§13.221 - 13.224 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605345  
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General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



## SUBCHAPTER K. INSPECTION

### 37 TAC §§13.231 - 13.237

The Texas Department of Public Safety (the department) adopts the repeal of §§13.231 - 13.237, concerning Inspection. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6960) and will not be republished.

The repeal of §§13.231 - 13.237 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605346  
D. Phillip Adkins  
General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



## SUBCHAPTER L. REPORTING DISCREPANCY, LOSS, THEFT, OR DIVERSION

### 37 TAC §§13.251 - 13.254

The Texas Department of Public Safety (the department) adopts the repeal of §§13.251 - 13.254, concerning Reporting Discrepancy, Loss, Theft, or Diversion. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6961) and will not be republished.

The repeal of §§13.251 - 13.254 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605348  
D. Phillip Adkins  
General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



## SUBCHAPTER M. DENIAL, REVOCATION, AND RELATED DISCIPLINARY ACTION

### 37 TAC §§13.271 - 13.278

The Texas Department of Public Safety (the department) adopts the repeal of §§13.271 - 13.278, concerning Denial, Revocation, and Related Disciplinary Action. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6962) and will not be republished.

The repeal of §§13.271 - 13.278 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are neces-

sary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605350  
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General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



## SUBCHAPTER N. ADMINISTRATIVE PENALTIES AND HEARINGS

### 37 TAC §§13.301 - 13.305

The Texas Department of Public Safety (the department) adopts the repeal of §§13.301 - 13.305, concerning Administrative Penalties and Hearings. This repeal is adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6962) and will not be republished.

The repeal of §§13.301 - 13.305 is filed simultaneously with new Chapter 13. This repeal, and the new Chapter 13, are necessary to implement the requirements of Texas Health and Safety Code, Chapter 481 as amended by Senate Bill 195, 84th Legislative Session. The bill eliminates the Controlled Substance Registration program and transfers the Prescription Drug Monitoring program to the Texas Board of Pharmacy. The bill thus necessitates the repeal of significant portions of Chapter 13. This also provides an opportunity to consolidate and update the administrative rules of the two remaining programs, the Precursor Chemical and Laboratory Apparatus permitting program and the Peyote Distributor Registration program.

No comments were received regarding the adoption of this repeal.

This repeal is adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Health and Safety Code, §481.003, which authorizes the Public Safety Commission to adopt rules to administer and enforce Chapter 481 of the Health and Safety Code.

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

Filed with the Office of the Secretary of State on October 17, 2016.

TRD-201605351  
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General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



## CHAPTER 23. VEHICLE INSPECTION SUBCHAPTER D. VEHICLE INSPECTION ITEMS, PROCEDURES, AND REQUIREMENTS

### 37 TAC §§23.41, §23.42

The Texas Department of Public Safety (the department) adopts amendments to §23.41 and §23.42, concerning Vehicle Inspection Items, Procedures, and Requirements. The department initially published proposed amendments to §23.41 and §23.42 in the July 1, 2016, issue of the *Texas Register* (41 TexReg 4785). In response to errors noted by department staff, the department withdrew the July 1st proposal and republished proposed amendments to §23.41 and §23.42 in the August 12, 2016, issue of the *Texas Register* (41 TexReg 5964). These amendments are adopted without changes to the proposed text as published in the August 12, 2016, issue of the *Texas Register* (41 TexReg 5964) and will not be republished.

The amendments reflect changes to the attached graphics, including the addition of the center mounted brake light as a required component of the vehicle inspection procedure for stop lamps, along with general updates relating to the vehicle inspection program required by Transportations Code, Chapter 548.

No comments were received regarding the adoption of the proposal.

These amendments are adopted pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work, and Texas Transportation Code, §548.002, which authorizes the department to adopt rules to administer and enforce Chapter 548.

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 October 17, 2016.

TRD-201605352  
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General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: August 12, 2016  
For further information, please call: (512) 424-5848



## CHAPTER 27. CRIME RECORDS SUBCHAPTER M. CRIMINAL HISTORY CLEARINGHOUSE

### 37 TAC §§27.171 - 27.174

The Texas Department of Public Safety (the department) adopts new §§27.171 - 27.174, concerning Criminal History Clearinghouse. The new rules are adopted without changes to the proposed text as published in the September 9, 2016, issue of the *Texas Register* (41 TexReg 6963) and will not be republished.

The department is responsible for establishing and maintaining an electronic clearinghouse and subscription service to provide Texas and Federal Bureau of Investigation (FBI) criminal history record information to authorized entities. The department is the record creation point for the computerized criminal history system maintained by the state and is the control terminal for entry of records, in accordance with federal law, rule and policy, into the federal records systems maintained by the FBI. Due to changes in the FBI subscription service, the department is required to have rules to clarify the process for obtaining criminal history record information from the department and the FBI. The department has authority under Texas Government Code, §411.042(g)(6) to establish rules as necessary to establish guidelines for the department's criminal history clearinghouse established under Texas Government Code, §411.0845.

No comments were received regarding the adoption of the proposal.

The new rules are adopted pursuant to Texas Government Code, §411.004(3) which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work; §411.042(g)(6), which authorizes the department to adopt reasonable rules relating to a system for providing criminal history record information through the criminal history clearinghouse under §411.0845.

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 October 17, 2016.

TRD-201605353  
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General Counsel  
Texas Department of Public Safety  
Effective date: November 6, 2016  
Proposal publication date: September 9, 2016  
For further information, please call: (512) 424-5848



# PART 11. TEXAS JUVENILE JUSTICE DEPARTMENT

## CHAPTER 380. RULES FOR STATE-OPERATED PROGRAMS AND FACILITIES

### SUBCHAPTER A. ADMISSION, PLACEMENT, RELEASE, AND DISCHARGE

#### DIVISION 5. PROGRAM COMPLETION AND RELEASE

##### 37 TAC §§380.8559, 380.8565, 380.8569

The Texas Juvenile Justice Department (TJJD) adopts amendments to §380.8569, concerning Transfer of Sentenced Offenders Adjudicated for Capital Murder, without changes to the proposed text as published in the April 15, 2016, issue of the *Texas Register* (41 TexReg 2689).

Due to a *Texas Register* editing error, the rule text for §380.8569(h) published in the April 15, 2016, issue of the *Texas Register* on page 2695 was incorrect. The words "the you that least" should be "the youth at least". This adoption incorporates the correct version of the text as proposed by TJJD.

TJJD also adopts amendments to §380.8559, concerning Program Completion for Sentenced Offenders, and §380.8565, concerning Discharge of Sentenced Offenders upon Transfer to TDCJ or Expiration of Sentence, with changes to the proposed text as published in the April 15, 2016, issue of the *Texas Register* (41 TexReg 2689).

Changes to the proposed text of §380.8559 consist of minor grammatical corrections and clarifications.

Changes to the proposed text of §380.8565 consist of minor grammatical corrections.

##### JUSTIFICATION FOR CHANGES

The public benefit anticipated as a result of administering the sections will be promoting the safety of youth, staff, and the public by being more specific about the circumstances under which TJJD staff members review sentenced offenders for the appropriateness of recommending transfer to the Texas Department of Criminal Justice - Correctional Institutions Division (TDCJ-CID). The amended rules will also promote safety of youth, staff, and the public by allowing all time spent in TJJD secure facilities (including time on an indeterminate commitment) to count toward the minimum length of stay required before TJJD may recommend transfer of a sentenced offender to TDCJ-CID.

##### SUMMARY OF CHANGES

The following changes are made to each of the three rules: 1) clarify that the confirmation of a major rule violation is an appropriate time for TJJD to review a sentenced offender's progress to determine whether the youth is appropriate for a recommendation for transfer to the Texas Department of Criminal Justice (TDCJ); 2) add age 16 as a time when TJJD will review each sentenced offender's progress to determine whether the youth is appropriate for a recommendation for transfer to TDCJ; 3) remove references to youth who were committed before June 9, 2007, as TJJD no longer has any such youth in its custody; 4) clarify that the notice provided to the parent/guardian, any designated advocate, and any identified victims before TJJD conducts an exit review will include the date by which written com-

ments must be received; 5) clarify that the notice provided to the parent/guardian and any identified victim will include the date by which a request to present in-person information must be received; and 6) remove references that indicated Level I hearings may be used to confirm major rule violations, as Level I hearings are no longer used for this purpose.

In addition to the changes listed above, the amended §380.8565 and §380.8569: 1) clarify that when a youth receives a determinate sentence for conduct occurring in a TJJD or contract facility, time spent in high-restriction facilities on an indeterminate commitment before receiving the determinate sentence will count toward the six-month minimum stay required before TJJD is able to recommend transfer to TDCJ-CID; 2) clarify that it is a youth's *unwillingness* (rather than inability) to progress in the rehabilitation program that may contribute to TJJD's recommendation to transfer the youth to TDCJ-CID; and 3) clarify that when a hearing has been held to determine whether a youth will be transferred to adult parole or prison, TJJD is not required to send the 10-day notice of a youth's pending discharge to parties who are typically present at these hearings.

In addition to the changes listed above, the amended §380.8565 also: 1) clarifies that the rule applies to any determinate sentence, not just a youth's original determinate sentence; 2) clarifies that youth in *any residential facility* (rather than just high-restriction facilities) who have not met program completion criteria and have not received court approval for transfer to TDCJ-CID must be transferred to adult parole; 3) clarifies that when a youth cannot complete the minimum period of confinement by his/her 19th birthday and TJJD requests a court hearing to determine transfer to adult parole or prison, TJJD is not bound by the criteria specified earlier in the rule regarding who is appropriate for a recommendation for prison; and 4) removes the reference to TJJD's requirement to send a progress report and reentry plan to the committing court at least 30 days before the youth's release or discharge. The statute requiring TJJD to send this information does not apply to the types of discharges described in this rule. For some of the youth covered by this rule, these reports are provided in connection with events that occur earlier than the events described in this rule.

##### SUMMARY OF PUBLIC COMMENTS

TJJD did not receive any public comments on the proposed rule-making actions.

##### STATUTORY AUTHORITY

The amendments are adopted under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJD schools, facilities, and programs.

§380.8559. *Program Completion for Sentenced Offenders.*

(a) Purpose. This rule establishes criteria and the approval process for sentenced offenders to qualify for release or transfer to parole by completing required programming.

(b) Applicability.

(1) This rule applies only to sentenced offenders.

(2) This rule does not apply to sentenced offenders who

are:

(A) discharged due to expiration of the sentence or transferred to the Texas Department of Criminal Justice (TDCJ) by court order or by aging out of the Texas Juvenile Justice Department (TJJD). See §380.8565 of this title; or

(B) adjudicated for capital murder. See §380.8569 of this title.

(c) General Requirements.

(1) A detainer or bench warrant is not an automatic bar to earned release. TJJD releases youth to authorities pursuant to a warrant.

(2) To determine eligibility for release or transfer, TJJD reviews each youth's progress:

(A) six months after admission to TJJD;

(B) when the minimum period of confinement is complete;

(C) when the youth becomes 16 years of age;

(D) when the youth becomes 18 years of age and again at 18 years and six months of age to determine eligibility or make a recommendation for transfer to TDCJ-Correctional Institutions Division (TDCJ-CID) or TDCJ-Parole Division (TDCJ-PD);

(E) within 45 days after revocation of parole, if applicable; and

(F) at other times as appropriate, such as after a major rule violation has been confirmed through a Level II hearing.

(3) TJJD notifies the youth, the youth's parent/guardian, any designated advocate for the youth, and any identified victim(s) of a pending exit review at least 30 days before the date of the review. The notification informs the recipients that they have the opportunity to submit written comments to TJJD and specifies the date by which the comments must be received. The notification also informs the parent/guardian and any identified victim(s) that they may present information in person during the youth's exit review process and specifies the date by which a request to present in-person information must be received. Any information received from a youth's family members, victims, local officials, staff, or the general public is considered by TJJD and included in the release/transfer packet.

(4) A youth must serve the entire minimum period of confinement applicable to the committing offense in a high-restriction facility unless:

(A) the youth is transferred to TDCJ-CID by the committing court. See §380.8565 of this title;

(B) the youth is approved by the committing court to attain parole status before completing the minimum period of confinement;

(C) the youth's sentence expires before the minimum period of confinement expires; or

(D) the executive director waives such placement.

(d) Program Completion Criteria.

(1) A youth may be considered for release or transfer to parole when the following criteria have been met:

(A) no major rule violations confirmed through a Level II due process hearing within 90 days prior to the exit interview or during the approval process;

(B) participation in or completion of assigned specialized treatment programs or curriculum as required under §380.8751 of this title;

(C) assignment by the Multi-disciplinary Team to the highest stage in the rehabilitation program as described in §380.8703 of this title, which reflects that the youth:

(i) is consistently participating in academic and workforce development programs commensurate with abilities as reflected in the youth's educational plan;

(ii) is consistently participating in skills development groups, as reflected in the youth's individual case plan;

(iii) is consistently demonstrating learned skills, as reflected in the documentation of the youth's behavior; and

(iv) has completed a community reintegration plan, approved by the Multi-disciplinary Team, that demonstrates the youth's:

(I) understanding of his/her risk and protective factors;

(II) development of skills, abilities, and knowledge to reduce risk factors and increase protective factors;

(III) identification of goals and a plan of action to achieve those goals; and

(IV) identification of obstacles that may hinder successful re-entry and plans to deal with those obstacles;

(D) participation in or completion of any statutorily required rehabilitation programming, including but not limited to:

(i) participation in a reading improvement program for identified youth to the extent required under §380.9155 of this title;

(ii) participation in a positive behavioral interventions and supports system to the extent required under §380.9155 of this title; and

(iii) completion of at least 12 hours of a gang intervention education program, if required by court order; and

(E) completion of:

(i) all but nine months of the sentence if the sentence expires before or simultaneously with the minimum period of confinement; or

(ii) the entire minimum period of confinement if the sentence expires after the minimum period of confinement.

(2) Youth are released to TJJD parole unless the youth meets program completion criteria within two months before his/her 19th birthday, in which case the youth will be transferred to TDCJ-PD.

(e) Release or Transfer Approval. For sentenced offenders, the executive director or his/her designee is the final decision authority for release or transfer. The final decision authority ensures that the youth meets all program completion criteria and that the community re-entry/transition plan adequately addresses risk before approving the release or transfer.

(f) Loss of Release or Transfer Eligibility.

(1) Eligibility for release or transfer is lost when either of the following occurs after the exit interview:

(A) youth commits a major rule violation that is confirmed through a Level II due process hearing; or

(B) the youth's Multi-disciplinary Team determines that the youth no longer meets the required rehabilitation program criteria.

(2) Except as described in paragraph (3) of this subsection, a youth who loses release or transfer eligibility will not be eligible for release or transfer until such time as the youth again meets program completion criteria and a subsequent exit review/interview confirms eligibility.

(3) If a youth is being considered for release or transfer nine months before completion of his/her sentence and he/she loses eligibility for release or transfer, the youth must remain in high restriction until the sentence has expired.

(g) Release or Transfer Date.

(1) TJJD holds the exit interview within 14 calendar days after the date a youth meets program completion criteria as set forth in this rule.

(2) If the youth meets program completion criteria, the youth is:

(A) released to TJJD parole within 60 calendar days after the date the youth met program completion criteria unless the youth loses release eligibility, in which case the release process is re-initiated when the youth again meets program completion criteria; or

(B) transferred to TDCJ-PD on or before the youth's 19th birthday.

(h) Notification.

(1) TJJD provides the committing juvenile court a copy of the youth's community re-entry/transition plan and a report concerning the youth's progress while committed to TJJD no later than 30 days before the date of the youth's release or transfer. Additionally, if on release the youth is placed in another state or a county other than a county served by the committing juvenile court, TJJD provides the community re-entry/transition plan and progress report to a juvenile court having jurisdiction over the county of the youth's residence.

(2) TJJD notifies the following at least ten calendar days before the youth's release:

(A) the committing juvenile court;

(B) the prosecuting attorney;

(C) the youth's parole officer;

(D) the chief juvenile probation officer in the county to which the youth is being moved; and

(E) any entity that has issued an active warrant for the youth.

*§380.8565. Discharge of Sentenced Offenders upon Transfer to TDCJ or Expiration of Sentence.*

(a) Purpose. This rule establishes criteria and an approval process for:

(1) requesting court approval to transfer sentenced offenders to adult prison; and

(2) discharging sentenced offenders:

(A) whose sentences have expired; or

(B) who did not previously qualify for release or transfer by completing required programming.

(b) Applicability.

(1) This rule applies only to the disposition of a youth's determinate sentence(s).

(2) This rule applies only to sentenced offenders.

(3) This rule does not apply to:

(A) sentenced offenders who qualify for release or transfer to parole by completing required programming. See §380.8559 of this title; or

(B) sentenced offenders adjudicated for capital murder. See §380.8569 of this title.

(c) General Requirements.

(1) By law, a sentenced offender is transferred from the custody of the Texas Juvenile Justice Department (TJJD) no later than the youth's 19th birthday.

(2) A youth must serve the entire minimum period of confinement that applies to the committing offense in a high-restriction facility unless:

(A) the youth is transferred by the committing court to the Texas Department of Criminal Justice- Correctional Institutions Division (TDCJ-CID);

(B) the youth is approved by the committing court to attain parole status before completing the minimum period of confinement;

(C) the youth's sentence expires before the minimum period of confinement expires; or

(D) the executive director waives such placement.

(3) TJJD reviews each youth's progress:

(A) six months after admission to TJJD;

(B) when the minimum period of confinement is complete;

(C) when the youth becomes 16 years of age;

(D) when the youth becomes 18 years of age and again at 18 years and six months of age to determine eligibility or make a recommendation for transfer to TDCJ-CID or to the Texas Department of Criminal Justice - Parole Division (TDCJ-PD);

(E) within 45 days after revocation of parole, if applicable; and

(F) at other times as appropriate, such as after a major rule violation has been confirmed through a Level II hearing.

(4) TJJD notifies the youth, the youth's parent/guardian, any designated advocate for the youth, and any identified victim(s) of a pending exit review at least 30 days before the date of the review. The notification informs the recipients that they have the opportunity to submit written comments to TJJD and specifies the date by which the comments must be received. The notification also informs the parent/guardian and any identified victim(s) that they may present information in person during the youth's exit review process and specifies the date by which a request to present in-person information must be received. Any information received from a youth's family members, victims, local officials, staff, or the general public is considered by TJJD and included in the release packet.

(5) TJJD jurisdiction is terminated and a youth is discharged when:

(A) the youth is transferred to TDCJ; or

(B) the youth's sentence has expired, except when the youth is committed to TJJD under concurrent determinate and indeterminate commitment orders as described in §380.8525 of this title.

(d) Transfer Criteria.

(1) Transfer to TDCJ-CID for Youth Whose Conduct Occurs While on Parole Status. TJJD may request a juvenile court hearing to recommend transfer of a youth to TDCJ-CID if all of the following criteria are met:

(A) the youth's parole has been revoked or the youth has been adjudicated or convicted of a felony offense occurring while on parole status;

(B) the youth is at least age 16;

(C) the youth has not completed his/her sentence; and

(D) the youth's conduct indicates that the welfare of the community requires the transfer.

(2) Transfer to TDCJ-CID for Youth Whose Conduct Occurs While in a High-Restriction Facility. TJJJ may request a juvenile court hearing to recommend transfer of a youth in a high-restriction facility to TDCJ-CID if the following criteria are met:

(A) the youth is at least age 16; and

(B) the youth has spent at least six months in high-restriction facilities, which is counted as follows:

(i) if the youth received a determinate sentence for conduct that occurred in the community, the six months begins upon admission to TJJJ; or

(ii) if the youth received a determinate sentence for conduct that occurred in a TJJJ or contract facility, the six months begins upon the youth's initial admission to TJJJ, regardless of whether the initial admission resulted from a determinate or indeterminate commitment; and

(C) the youth has not completed his/her sentence; and

(D) the youth meets at least one of the following behavior criteria:

(i) the youth has committed a felony or Class A misdemeanor while assigned to a residential facility; or

(ii) the youth has committed major rule violations as confirmed through a Level II due process hearing on three or more occasions; or

(iii) the youth has engaged in conduct that has resulted in at least five Security Program admissions or extensions in one month or ten in three months (see §380.9740 of this title for information on the Security Program); or

(iv) the youth has demonstrated an unwillingness to progress in his/her rehabilitation program due to persistent non-compliance with objectives; and

(E) alternative interventions have been tried without success; and

(F) the youth's conduct indicates that the welfare of the community requires the transfer.

(3) Transfer to TDCJ-PD for Youth in Residential Facilities. A youth in a residential facility who has not met program completion criteria in §380.8559 of this title and who has not received court approval for transfer to TDCJ-CID must be transferred to TDCJ-PD to complete his/her sentence no later than the youth's 19th birthday.

(4) Transfer to TDCJ-PD for Youth on TJJJ Parole. A youth on TJJJ parole who has not completed his/her sentence must be transferred to TDCJ-PD no later than the youth's 19th birthday.

(e) Transfer Recommendation for Youth Who Will Not Complete the Minimum Period of Confinement before Age 19. TJJJ requests a court hearing for any youth who cannot complete his/her minimum period of confinement by his/her 19th birthday. The purpose of the hearing is to determine whether the youth will be transferred to TDCJ-CID or to TDCJ-PD. Notwithstanding the criteria in subsection

(d)(2) of this section, TJJJ considers the following factors in forming a recommendation for the committing court:

(1) length of stay in TJJJ;

(2) youth's progress in the rehabilitation program;

(3) youth's behavior while in TJJJ;

(4) youth's offense/delinquent history; and

(5) any other relevant factors, such as:

(A) risk factors and protective factors the youth possesses as identified in his/her psychological evaluation; and

(B) the welfare of the community.

(f) Discharge Criteria. TJJJ discharges youth from its jurisdiction when one of the following occurs:

(1) expiration of the sentence imposed by the juvenile court, unless the youth is under concurrent commitment orders as described in §380.8525 of this title; or

(2) the youth has been transferred to TDCJ-CID under court order or transferred to TDCJ-PD.

(g) Decision Authority for Approval to Transfer.

(1) TJJJ does not transfer youth from a high-restriction facility to TDCJ-PD until the executive director or his/her designee determines the youth's community re-entry/transition plan adequately addresses risk factors.

(2) When a determination has been made that the youth meets criteria for requesting a hearing for transfer to TDCJ-CID or cannot complete his/her minimum period of confinement before age 19, the executive director or his/her designee approves the staff request for a hearing by the committing juvenile court.

(3) The committing juvenile court is the final decision authority for transferring a youth to TDCJ-CID.

(h) Notification.

(1) TJJJ notifies the following at least ten calendar days before the youth's discharge due to expiration of sentence or transfer to TDCJ-PD without a transfer/release hearing:

(A) the committing juvenile court;

(B) the prosecuting attorney;

(C) the youth's TJJJ parole officer;

(D) the chief juvenile probation officer in the county to which the youth is being moved; and

(E) any entity that has issued an active warrant for the youth.

(2) TJJJ notifies any entity that has issued an active warrant for the youth at least ten calendar days before:

(A) the youth's transfer to TDCJ-PD resulting from a transfer/release hearing; or

(B) the youth's transfer to TDCJ-CID.

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 October 13, 2016.

TRD-201605267  
Jill Mata  
General Counsel  
Texas Juvenile Justice Department  
Effective date: December 1, 2016  
Proposal publication date: April 15, 2016  
For further information, please call: (512) 490-7278



## SUBCHAPTER B. TREATMENT DIVISION 1. PROGRAM PLANNING

### 37 TAC §380.8707

The Texas Juvenile Justice Department (TJJD) adopts amendments to §380.8707, concerning Furloughs, and §380.9161, concerning Youth Employment and Work, without changes to the proposed text as published in the April 15, 2016, issue of the *Texas Register* (41 TexReg 2696). The amended rules will not be republished.

#### JUSTIFICATION FOR CHANGES

The public benefit anticipated as a result of administering the sections will be the promotion of successful community reentry by allowing youth with high school diplomas or GEDs to spend more time developing job skills and social skills and obtaining employment experience while in a secure TJJD facility.

#### SUMMARY OF CHANGES

The amended §380.8707 adds off-campus employment to the list of reasons an administrative furlough may be granted. The amended rule also clarifies that youth may be granted an administrative furlough for *health care* services (rather than medical services). Additionally, the rule no longer includes a prohibition on granting furloughs to youth assigned to emergency shelters.

The amended §380.9161 adds individualized skills development programs to the types of uncompensated work listed in the rule. These programs may include tasks incidental to facility operations and/or assignments related to developing job skills or obtaining industry certifications. Youth who demonstrate sustained improvement may be eligible for incentives, which may include minimal monetary awards. The amended rule also clarifies that a youth must meet established criteria and apply for a specific work assignment in order to participate in the paid on-campus work program. Additionally, the rule clarifies that the requirement for each facility to maintain and implement written procedures is not limited to the paid on-campus work program. Each facility must have written procedures for all types of compensated work programs, including on-campus work and off-campus work.

#### SUMMARY OF PUBLIC COMMENTS

TJJD did not receive any public comments on the proposed rule-making actions.

#### STATUTORY AUTHORITY

The amended section is adopted under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJD schools, facilities, and programs. The amended section is also adopted under Texas Human Resources Code §244.005, which authorizes TJJD to permit a committed child liberty under supervision on conditions TJJD believes are conducive to acceptable behavior and to order the

child's confinement under conditions TJJD believes are best designed for the child's welfare and the interests of the public.

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 October 13, 2016.

TRD-201605268  
Jill Mata  
General Counsel  
Texas Juvenile Justice Department  
Effective date: December 1, 2016  
Proposal publication date: April 15, 2016  
For further information, please call: (512) 490-7278



## SUBCHAPTER C. PROGRAM SERVICES DIVISION 3. YOUTH EMPLOYMENT AND WORK

### 37 TAC §380.9161

#### STATUTORY AUTHORITY

The amended section is adopted under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJD schools, facilities, and programs. The amended section is also adopted under Texas Human Resources Code §244.005, which authorizes TJJD to permit a committed child liberty under supervision on conditions TJJD believes are conducive to acceptable behavior and to order the child's confinement under conditions TJJD believes are best designed for the child's welfare and the interests of the public.

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 October 13, 2016.

TRD-201605269  
Jill Mata  
General Counsel  
Texas Juvenile Justice Department  
Effective date: December 1, 2016  
Proposal publication date: April 15, 2016  
For further information, please call: (512) 490-7278



## DIVISION 4. HEALTH CARE SERVICES

### 37 TAC §380.9197

The Texas Juvenile Justice Department (TJJD) adopts amendments to §380.9197, concerning HIV/AIDS, with changes to the proposed text as published in the April 15, 2016, issue of the *Texas Register* (41 TexReg 2697).

Changes to the proposed text of §380.9197 consist of: 1) clarifying that *TJJD-employed health care staff* (in addition to contract

health care staff) are authorized to disclose HIV test results or a youth's HIV/AIDS status in certain limited circumstances, and 2) clarifying that *any person* (rather than just medical professionals) who is designated on a signed release form may release a youth's HIV test results.

#### JUSTIFICATION FOR CHANGES

The public benefit anticipated as a result of administering the section will be the availability of an up-to-date rule that reflects all statutes relating to compelling a youth to be tested for HIV following an incident of occupational exposure to blood or other potentially infectious material.

#### SUMMARY OF CHANGES

In accordance with House Bill 1595 enacted by the 84th Texas Legislature, the amended rule includes a provision stating that HIV testing may be performed on a youth when the testing is compelled by a court order following a request made by TJJJ staff in accordance with Texas Code of Criminal Procedure Article 18.22.

The amended rule also reflects that TJJJ staff who request testing of a youth under Texas Health and Safety Code §81.050 or Texas Code of Criminal Procedure Article 18.22 are entitled to receive the results of the test from the entity specified in the applicable statute.

Additionally, the rule clarifies that: 1) *only health care staff* are authorized to release or disclose HIV test results or a youth's HIV/AIDS status to the individuals specified in the rule when the testing is conducted by TJJJ; and 2) HIV testing may be performed on a youth when the testing is compelled by a Texas *Department of State Health Services (DSHS) order* following a request made by TJJJ staff in accordance with Texas Health and Safety Code §81.050. Previously, the rule referred only to testing compelled by a court order under this statute.

#### SUMMARY OF PUBLIC COMMENTS

TJJJ did not receive any public comments on the proposed rule-making action.

#### STATUTORY AUTHORITY

The amendment is adopted under Texas Human Resources Code §242.003, which authorizes TJJJ to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJJ schools, facilities, and programs.

#### §380.9197. HIV/AIDS.

(a) Purpose. This rule provides for a safe and healthy environment for youth in Texas Juvenile Justice Department (TJJJ) residential facilities by offering HIV/AIDS education, testing, and counseling/treatment and by ensuring compliance with confidentiality and reporting laws. Each youth is treated equally, and every youth's right to privacy is respected.

#### (b) Definitions.

(1) AIDS--Acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention (CDC).

(2) HIV--Human immunodeficiency virus.

(3) Test Result--Any statement indicating that an identifiable individual has or has not been tested for HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS. This includes a statement or assertion that the individual is positive, negative, at risk, or has or does not have a certain level of antigen or antibody.

#### (c) Testing.

(1) Testing for HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS is part of routine laboratory testing performed when a youth is admitted to TJJJ and does not require a specific consent form.

(2) Youth have the right to refuse HIV testing in writing, including routine HIV testing performed during admission, except as provided by law.

(3) HIV testing is not performed routinely as a result of an assault.

(4) HIV testing may be performed on a youth only when:

(A) the youth is admitted to TJJJ;

(B) the testing is requested by the youth and/or the testing is performed with the youth's consent after his/her admission to TJJJ;

(C) the testing is compelled by a Texas Department of State Health Services (DSHS) order or court order following a request made by TJJJ staff in accordance with §81.050 of the Texas Health and Safety Code;

(D) the testing is compelled by a court order following a request made by TJJJ staff in accordance with Article 18.22 of the Texas Code of Criminal Procedure; and/or

(E) the testing is directed by a warrant obtained by the TJJJ Office of Inspector General or other law enforcement entity.

(5) Blood may be collected for HIV testing only by nurses, medical providers, or DSHS or its local testing designee.

(6) Post-test counseling is provided for youth with positive HIV test results. Pre-test counseling is provided for any HIV test conducted after admission to TJJJ.

#### (d) Confidentiality.

(1) HIV test results or a youth's HIV/AIDS status are confidential and may be released or disclosed only by health care staff and only to:

(A) the TJJJ medical director;

(B) the TJJJ director of nursing;

(C) a physician, nurse, or other health care personnel who has a legitimate need to know the information to provide for the youth's health and welfare;

(D) the youth's parent/guardian if the youth is under 18 years of age or with the youth's consent if the youth is at least 18 years of age;

(E) any person designated on a signed release from the youth or the youth's parent/guardian, as appropriate. The written consent must state that HIV test results are to be released; or

(F) any person with a right pursuant to law to obtain the information.

(2) TJJJ staff who request testing in accordance with §81.050 of the Texas Health and Safety Code or Article 18.22 of the Texas Code of Criminal Procedure have a right to receive the test results from the entity specified in the applicable statute.

(e) Reporting. As required by state law, TJJJ reports any AIDS cases or the HIV-positive status of a youth diagnosed by a physician in accordance with CDC standards to the appropriate DSHS authority through the facility medical provider.

(f) Housing. HIV-positive youth are not segregated from the general population based solely on positive HIV status. Housing assignments are made in accordance with §380.8524 of this title.

(g) Treatment. HIV-positive youth are referred immediately to appropriate health care facilities or specialists for further evaluation, treatment, and counseling.

(h) Access to Services. Youth in TJJD facilities are not denied equal access to appropriate medical services because of their HIV/AIDS status.

(i) Education.

(1) TJJD provides educational information to youth regarding HIV/AIDS as follows.

(A) All youth participate in an educational session when admitted to TJJD.

(B) Education may continue as part of the academic program.

(C) Medical staff educate youth as indicated and/or as requested.

(2) HIV/AIDS education for youth is based upon current, accurate, scientific information provided by officially recognized authorities on public health. Information is communicated in a manner that youth comprehend and that is sensitive to cultural and other differences.

(3) Educational programs address topics including, but not limited to:

(A) disease and disease process;

(B) signs and symptoms;

(C) modes of HIV transmission, including high-risk and criminal behaviors that are potential risks for HIV transmission during confinement and after release;

(D) methods of preventing HIV transmission; and

(E) confidentiality of medical information and the civil and criminal penalties for failing to comply.

(j) Training.

(1) All TJJD direct-care staff members receive training initially during orientation and annually thereafter.

(2) Staff at TJJD district offices and Central Office receive educational information annually.

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 October 13, 2016.

TRD-201605271

Jill Mata

General Counsel

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Effective date: December 1, 2016

Proposal publication date: April 15, 2016

For further information, please call: (512) 490-7278



## SUBCHAPTER F. SECURITY AND CONTROL

### 37 TAC §380.9703

The Texas Juvenile Justice Department (TJJD) adopts the repeal of §380.9703, concerning Weapons and Concealed Handguns, without changes to the proposed text as published in the May 13, 2016, issue of the *Texas Register* (41 TexReg 3433).

#### JUSTIFICATION FOR REPEAL

The public benefit anticipated as a result of repealing the section will be the elimination of an unnecessary agency rule.

#### SUMMARY OF PUBLIC COMMENTS

TJJD did not receive any public comments on the proposed repeal.

#### RULE REVIEW

In the Proposed Rules section of the May 13, 2016, issue of the *Texas Register* (41 TexReg 3433), TJJD published a notice of intent to review §380.9703. TJJD did not receive any public comments regarding the rule review.

#### STATUTORY AUTHORITY

The repeal is adopted under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJD schools, facilities, and programs.

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 October 13, 2016.

TRD-201605270

Jill Mata

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Effective date: December 1, 2016

Proposal publication date: May 13, 2016

For further information, please call: (512) 490-7278



## CHAPTER 385. AGENCY MANAGEMENT AND OPERATIONS

The Texas Juvenile Justice Department (TJJD) adopts amendments to the following rules in Chapter 385, Subchapters B and C, without changes to the proposed text as published in the April 15, 2016, issue of the *Texas Register* (41 TexReg 2699): §§385.8134 (Notice of Youth Confessions of Child Abuse), 385.9959 (Transportation of Youth), and 385.9975 (State Inscription). These sections will not be republished.

TJJD also adopts amendments to the following rules with changes to the proposed text as published in the April 15, 2016, issue of the *Texas Register* (41 TexReg 2699): §§385.8117 (Private Real Property Rights Affected by Governmental Action), 385.8135 (Rights of Victims), 385.8145 (Volunteers and Community Resources Council), and 385.8183 (Advocacy, Support Group, and Social Services Provider Access).

Changes to the proposed text of §385.8117 consist of changing "section (f)(1)" to "subsection (f)(1) of this section."

Changes to the proposed text of §385.8135 consist of minor grammatical corrections and a clarification that a victim who provides in-person input at an exit review may encounter youth but will be kept from encountering the youth who victimized him/her.

Changes to the proposed text of §385.8145 consist of a minor grammatical correction.

Changes to the proposed text of §385.8183 consist of minor grammatical corrections and a clarification that security and confidentiality measures must not be designed to deny a social services provider access to youth.

#### JUSTIFICATION FOR CHANGES

The public benefit anticipated as a result of administering the sections will be the availability of rules that have been updated to conform to current laws and to more accurately reflect TJJJ's current operational practices.

Another anticipated public benefit for §385.8183 is the promotion of rehabilitation by providing social services providers with increased access to TJJJ facilities.

#### SUMMARY OF CHANGES

In addition to the change described earlier in this notice, the amended §385.8117 clarifies that the TJJJ staff member proposing a governmental action is responsible for the actions described in the rule. The rule also clarifies that the definitions of terms used in the rule can be found in the Private Real Property Rights Preservation Act. Additionally, the amendment removes unnecessary language concerning public information.

The amended §385.8134 clarifies that the rule includes confessions of child abuse made by youth who are on TJJJ parole. The rule also clarifies that the staff member or volunteer to whom the confession was made is responsible for making the report to the appropriate agency and for informing his/her supervisor that the report was made. Additionally, the amendment removes language that established separate procedures for reporting certain kinds of alleged abuse or neglect in order to clarify that all confessions of abuse or neglect under this rule must be reported in the same manner, consistent with state law.

In addition to the changes described earlier in this notice, the amended §385.8135 clarifies that a victim may receive information and notification concerning a youth's transfer to the institutions division of TDCJ, in addition to the parole division of TDCJ. The rule also adds the following to the list of items TJJJ staff may reveal to a victim who has requested information: 1) the youth's physical address if the youth is living at a TJJJ residential placement; and 2) information about and an invitation to participate in TJJJ's Special Services Committee or Release Review Panel review. Additionally, the amendment adds that staff may not reveal to the victim the name of a youth's new location if that location is only for mental health treatment.

In addition to the change described earlier in this notice, the amended §385.8145 adds that a qualified community relations coordinator oversees the volunteer program at each TJJJ-operated facility and parole office. The rule also clarifies the various steps involved in the screening and application process (i.e., criminal background check, fingerprints, personal character references, and an interview) for volunteers. Additionally, the amendment adds that every TJJJ-operated residential facility and parole office must use volunteers to enhance rehabilitation efforts for youth.

In addition to the changes described earlier in this notice, the amended §385.8183 adds social services providers to the list of organizations granted access to residential facilities. The rule also adds a definition for social services providers. Additionally, the amendment clarifies that the rule applies to all residential facilities operated by TJJJ.

The amended §385.9959: 1) adds that requests for transportation are submitted via email to the Centralized Placement Unit and the transportation unit coordinator. These requests are approved by the sending chief local administrator or designee following completion of any due process required for youth movement; 2) clarifies when the Transportation Unit is responsible for transporting a youth; 3) adds that when a youth is transported between residential facilities operated by TJJJ, staff also transport the youth's case file, if available; and 4) adds that if transportation is not provided or coordinated by the Transportation Unit, the sending facility arranges and, if necessary, pays for transportation of a youth to a placement or home.

The amended §385.9975 adds a new category to the list of TJJJ vehicles that are exempt from the requirement to bear the state inscription. The new category is for vehicles primarily used as part of the agency pool that are available for use by various personnel in support of agency operations. The rule also no longer includes the requirement that a vehicle must be used for extended travel away from staff members' home base to qualify for the state-inscription exemption.

#### SUMMARY OF PUBLIC COMMENTS

TJJJ did not receive any public comments on the proposed rule-making actions.

#### RULE REVIEW

In the Proposed Rules section of the April 15, 2016, issue of the *Texas Register* (41 TexReg 2699), TJJJ published a notice of intent to review §§385.8117, 385.8134, 385.8135, 385.8145, 385.8183, 385.9959, and 385.9975 as required by Texas Government Code §2001.039. TJJJ did not receive any public comments regarding the rule review.

TJJJ has determined that the reasons for adopting the rules continue to exist. Accordingly, these rules are readopted with amendments as described in this notice.

### SUBCHAPTER B. INTERACTION WITH THE PUBLIC

#### 37 TAC §§385.8117, 385.8134, 385.8135, 385.8145, 385.8183

#### STATUTORY AUTHORITY

Section 385.8117 is adopted under Texas Human Resources Code §242.003, which authorizes TJJJ to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJJ schools, facilities, and programs. Additionally, §385.8117 is adopted in accordance with direction from the Texas attorney general, who has established guidelines under Texas Government Code §2007.041 that direct governmental entities to institute their own specific procedures for making an analysis of whether a proposed action results in a taking under the Private Real Property Rights Preservation Act.

Section 385.8134 is adopted under Texas Family Code §261.105, which requires TJJJ to adopt rules for identifying a report made to TJJJ that is appropriate to refer to the Department of Family and Protective Services or a law enforcement agency for investigation.

Sections 385.8135 and 385.8145 are adopted under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJD schools, facilities, and programs.

Section 385.8183 is adopted under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJD schools, facilities, and programs. Section 385.8183 is also adopted under Texas Human Resources Code §242.056, which requires TJJD to allow advocacy and support groups whose primary functions are to benefit children, inmates, girls and women, the mentally ill, or victims of sexual assault to provide on-site information, support, and other services for children confined in TJJD facilities.

§385.8117. *Private Real Property Rights Affected by Governmental Action.*

(a) Purpose. This rule establishes procedures for the Texas Juvenile Justice Department (TJJD) to determine if private real property rights are affected by proposed governmental action to be taken by TJJD.

(b) Responsibility. The TJJD staff member proposing a governmental action is responsible for the actions described herein.

(c) Definitions. Definitions pertaining to this rule are in the Private Real Property Rights Preservation Act (the Act), Chapter 2007 of the Texas Government Code.

(d) Categorical Determination.

(1) Activities related to the following, and the programs, policies, rules, or regulations promulgated to implement them, do not affect private real property rights:

- (A) youth care and treatment;
- (B) facility operations, maintenance, and construction;
- (C) personnel management; and
- (D) purchase of goods and services.

(2) If the proposed governmental action falls within one of the above categories, further compliance with the Act is not required and a Takings Impact Assessment (TIA) must not be initiated.

(3) If the proposed governmental action does not fall within one of the above categories, TJJD must make a No Private Real Property Impact Determination to determine if a TIA is required.

(e) No Private Real Property Impact (No PRPI) Determination.

(1) A No PRPI Determination is made by finding the proposed governmental action does not result in a burden on private real property according to the procedures in subsection (e)(2) of this section.

(2) A No PRPI Determination is made by answering the following questions.

(A) Will the proposed governmental action involve a physical seizure or occupation of private real property?

(B) Will the proposed governmental action involve a regulation of private real property or of activities occurring on private real property?

(C) Will the proposed governmental action diminish or destroy the right of a private property owner to exclude others from the property, possess it, or dispose of it?

(D) Will the value of private real property that is the subject of the proposed governmental action be reduced by 25% or more as a result of the action?

(3) If the answer to all four questions in subsection (e)(2) of this section is "NO," there is a No PRPI Determination and no further action is required under the Act. If the answer to any of the four questions in subsection (e)(2) of this section is "YES," a TIA is required by the Act.

(f) TIA.

(1) Initiating a TIA. Before a TIA is initiated, the following must be determined to be true pursuant to the procedures in subsections (d) and (e) of this section:

(A) the contemplated governmental action does not fall within the categorical determinations for which no TIA is required; and

(B) there may be an impact on private real property interests.

(2) Elements of the TIA. If the criteria in subsection (f)(1) of this section are met, TJJD must prepare a written TIA that does the following:

(A) describes the specific purpose of the proposed governmental action;

(B) identifies:

(i) whether and how the proposed governmental action substantially advances its stated purpose;

(ii) describes the burdens imposed on private real property; and

(iii) describes the benefits to society resulting from the proposed use of private real property; and

(C) explains whether engaging in the proposed governmental action will constitute a taking under the United States Constitution, the Texas Constitution, or the Act; and

(D) describes reasonable alternative actions that could accomplish the specified purpose and compares, evaluates, and explains:

(i) how an alternative action would further the specified purpose; and

(ii) whether an alternative action would constitute a taking.

§385.8135. *Rights of Victims.*

(a) Purpose. This rule addresses the rights of victims as described in Texas Family Code Chapter 57 and Texas Code of Criminal Procedure Article 56.02 and allows victims to provide input into the release process of youth committed to the Texas Juvenile Justice Department (TJJD).

(b) Applicability. All of the rules and procedures afforded to a victim of a youth in TJJD custody, as indicated by the use of the term victim in this section, are equally afforded to the guardian of a victim or close relative of a deceased victim.

(c) Definitions.

(1) Victim--a person who as the result of the delinquent conduct of a juvenile suffers a financial loss or personal injury or harm.

(2) Close relative of a deceased victim--a person who was the spouse of a deceased victim at the time of the victim's death or who is a parent or adult brother, sister, or child of the deceased victim.

(3) Guardian of a victim--a person who is the legal guardian of the victim, whether or not the legal relationship between the guardian and victim exists because of the age of the victim or the physical or mental incompetence of the victim.

(d) Victim Confidentiality.

(1) Information in a Juvenile Victim Impact statement (JVIS) or information submitted in the preparation of a JVIS is confidential with regard to the victim's name, social security number, address, telephone number, and any other information which would identify or tend to identify the victim.

(2) Any victim involvement while the youth is in TJJD custody is confidential.

(e) Victim's Right to Information.

(1) A victim may request, in writing, any of the information listed below:

(A) information concerning the procedures for release or transfer of the youth from one program placement to another including to the custody of the Texas Department of Criminal Justice (TDCJ);

(B) notification of:

(i) release under supervision, including release to TJJD parole;

(ii) release to a non-institutional community placement;

(iii) transfer to TDCJ; and

(iv) discharge from TJJD supervision.

(2) If there is a signed request from the victim, the information is sent to the victim at his or her most current address on file.

(3) For a victim who has requested information concerning a youth, TJJD staff may reveal only the following:

(A) that the youth is under TJJD's supervision;

(B) the youth's minimum length of stay and/or the minimum period of confinement;

(C) the committing offense in which the victim was involved;

(D) the youth's conditions of parole supervision (except specialized treatment) and physical address if the youth is living at a TJJD residential placement;

(E) information about and an invitation to participate in TJJD's Special Services Committee or Release Review Panel review for the offense in which the victim was involved;

(F) that the youth has been transferred to another location and the name of that location, unless the program is only for substance abuse and/or mental health treatment;

(G) the name of the youth's caseworker and/or parole officer; and

(H) general information about the agency's rehabilitation program without revealing specific information regarding the youth's treatment.

(f) Victim's Right to Participation.

(1) A victim may provide information to be considered by TJJD before the youth is released under supervision (including release to TJJD parole), released to a non-institutional community placement, or transferred to prison or TDCJ parole.

(2) If the victim requests in writing and receives permission to provide input in person, he or she may participate in the staff meeting where release under supervision is considered. The victim is not allowed to attend the entire meeting regarding the youth.

(3) Victims who provide in-person input are provided a waiting area separate from any location where they might encounter the youth.

(g) Victim Appeal. The victim has no right of appeal in any TJJD decision.

§385.8145. *Volunteers and Community Resources Council.*

(a) Purpose. This rule establishes a volunteer program within the Texas Juvenile Justice Department (TJJD) to expand youth opportunities for educational and recreational experiences and to provide youth with increased social interactions.

(b) Community Resource Councils. Community resource councils are established to support the youth committed to TJJD. Community resource councils are organized as nonprofit corporations with tax-exempt status. The councils' role includes:

(1) informing the community about TJJD;

(2) informing TJJD of community interests and concerns;

(3) promoting volunteer/community engagement; and

(4) generating community resources to benefit youth committed to TJJD.

(c) Volunteer Program.

(1) The manager of community programs administers TJJD's volunteer program.

(2) A qualified community relations coordinator oversees the volunteer program at each TJJD-operated facility and parole office.

(3) Volunteers must successfully complete all screening and application processes, including:

(A) submitting to a criminal background check in accordance with §385.8181 of this title;

(B) providing fingerprints;

(C) providing personal character references; and

(D) participating in an interview.

(4) Volunteers are recruited and selected from various cultural and socioeconomic segments of the community.

(5) Every TJJD-operated residential facility and parole office must use volunteers to enhance rehabilitation efforts for youth.

(6) Volunteers are oriented to the TJJD program and receive training before being assigned to work with youth.

(7) Volunteers must agree in writing to abide by federal and state laws and TJJD policies and rules concerning confidentiality of youth information.

(8) Volunteers are officially registered and provided proper identification as volunteers.

(9) Volunteers may not perform professional services for TJJD unless certified or licensed to perform those services.

(d) Youth as Volunteers. Qualified youth are encouraged and provided assistance to participate in volunteer activities in the community.

(e) Employees as Volunteers. Employees may participate in volunteer activities in accordance with TJJD's policies and procedures.

§385.8183. *Advocacy, Support Group, and Social Services Provider Access.*

(a) Purpose. This rule establishes a process for allowing advocacy and support groups and social services providers to provide on-site information, support, and other services for youth confined in Texas Juvenile Justice Department (TJJD) residential facilities.

(b) Applicability.

(1) This rule applies to residential facilities operated by TJJD.

(2) This rule does not apply to a youth's access to his/her personal attorney or personal clergy member in accordance with §380.9311 of this title and §380.9317 of this title.

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

(1) Advocacy or Support Groups--organizations whose primary functions are to benefit children, inmates, girls and women, persons with mental illness, or victims of sexual assault.

(2) Social Services Providers--organizations whose primary functions are to provide psychological, social, educational, health, and other related services to juveniles and their families.

(3) Confined--placement in a residential facility.

(4) Confidential Setting--a setting that provides for private conversation but is within the line of sight of a TJJD staff member who is authorized to provide sole supervision of youth.

(d) Registration Procedures.

(1) An advocacy or support group or social services provider must register with TJJD prior to providing on-site information, support, or other services to confined youth.

(2) In order to register with TJJD, an advocacy or support group or social services provider must provide the following in a form and manner determined by TJJD:

(A) a copy of the articles of incorporation on file with the secretary of state or other official documentation showing the organization's primary purpose;

(B) contact information for the local program director(s);

(C) names of all persons employed by or otherwise officially representing the organization who would likely seek access to residential facilities under the provisions of this rule; and

(D) if 24-hour access to residential facilities is believed to be necessary to perform the organization's primary function, a written justification of the need for such access and the names of individuals representing the organization who perform the function for which 24-hour access is requested.

(3) The TJJD division director with responsibility over volunteer services or his/her designee determines whether or not an organization qualifies as an advocacy or support group or social services provider as defined in this rule, and whether or not 24-hour access, if requested, is necessary to provide the organization's primary function.

(4) A determination that an organization does not qualify as an advocacy or support group or social services provider under this rule, or a denial of a request for 24-hour access, must be in writing and may be appealed to the TJJD executive director or his/her designee. The appeal must be in writing and clearly state the reason the organization should be considered an advocacy or support group or social services provider under this rule or the reason that denial of 24-hour access would prevent the organization from effectively performing its primary function.

(5) A person representing a registered advocacy or support group or social services provider is not permitted to provide information, support, or other services to youth in a confidential setting unless and until:

(A) TJJD conducts a background check pursuant to §385.8181 of this title and clears the person for such access; and

(B) the person signs appropriate confidentiality agreements concerning youth information and/or records.

(6) A registered advocacy or support group or social services provider must provide immediate written notification to TJJD when a person who is registered with TJJD as a representative of the organization ceases to represent the organization.

(e) General Provisions.

(1) A person who has been granted 24-hour access should provide reasonable advance notice of his/her intention to visit a facility to allow for security and confidentiality arrangements to be made. Lack of advance notice does not constitute grounds for denying entry.

(2) A person who has not been granted 24-hour access may access residential facilities during youth waking hours. Such a person must provide at least 24-hour advance notice of his/her visit to the facility in order for security and confidentiality arrangements to be made. Visits with less than 24-hour advance notice will be accommodated when possible.

(3) The security and confidentiality measures arranged by TJJD must not be designed to deny a registered advocacy or support group or social services provider access to youth.

(4) A person who has been cleared for access and who has provided adequate advance notice, if required, will not be denied access to any residential facility unless, in the judgment of the facility administrator or designee, the circumstances existing at the time of the visit create an unacceptable risk to the safety of youth, staff, or visitors. If, upon arrival at a facility, a representative of an advocacy or support group or social services provider is denied entry due to unsafe conditions, the facility administrator or designee must provide written justification to the organization within three workdays. A youth's current placement in a security unit does not constitute an unacceptable safety risk that would prevent access by a registered group or provider, but may be taken into consideration with other factors in making a determination of the safety of the current circumstances.

(5) A person who has been cleared for access must present picture identification at the entry point in order to gain access to the facility.

(6) Members of advocacy or support groups or social services providers are subject to search upon entry to a residential facility in accordance with §380.9710 of this title.

(7) Under state law, any person, including a registered member of an advocacy or support group or social services provider who has cause to believe that a youth has been or may be adversely affected by abuse, neglect, or exploitation has a legal obligation to

report the matter in accordance with §380.9333 of this title. The reporting requirement applies without exception to a person whose personal communications may otherwise be privileged.

(8) Youth have the right to refuse a visit with an advocate or social services provider.

(9) Advocacy and support groups and social services providers may file complaints regarding the security and privacy procedures arranged by a facility in accordance with §385.8111 of this title.

(10) Provisions of this rule may not be used to bypass the provisions of §380.9312 of this title regarding visitation procedures for family members of youth committed to TJJD.

(f) Revocation of Access.

(1) TJJD may revoke the access of a representative of a registered advocacy or support group or social services provider, with written notice, when:

(A) the person has endangered the safety of youth or the security of the facility; or

(B) the person has violated a TJJD confidentiality agreement.

(2) Revocation of access may be appealed to the executive director or his/her designee. The appeal must be in writing and clearly state the reason the person's access should not be revoked.

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 October 13, 2016.

TRD-201605273

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Effective date: December 1, 2016  
Proposal publication date: April 15, 2016  
For further information, please call: (512) 490-7278



## SUBCHAPTER C. MISCELLANEOUS

### 37 TAC §385.9959, §385.9975

#### STATUTORY AUTHORITY

Section 385.9959 is adopted under Texas Human Resources Code §242.003, which authorizes TJJD to adopt rules appropriate to the proper accomplishment of its functions and to adopt rules for governing TJJD schools, facilities, and programs.

Section 385.9975 is adopted under Texas Transportation Code §721.003, which allows TJJD to adopt a rule that exempts TJJD from the requirement to print a state inscription on state-owned motor vehicles.

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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