ADOPTION PREAMBLE

The Texas Health and Human Services Commission (HHSC) adopts amended §711.415, concerning What are the requirements for face-to-face contact with the alleged victim?; §711.419, concerning What if the investigator cannot complete the investigation on time?; §711.901, concerning What is an appeal of the investigation?; §711.905, concerning Who may request an appeal of the investigation?; §711.907, concerning How does a qualified party request an appeal?; §711.913, concerning What if the administrator of a state-operated facility disagrees with the second level appeal decision?; and §711.915, concerning Is a finding ever changed without an appeal? , without changes to the proposed text as published in the December 8, 2017 issue of the *Texas Register* (42 TexReg 6913). HHSC adopts amended §711.7, concerning What does APS not investigate under this chapter?; §711.17, concerning How is verbal/emotional abuse defined?; §711.19, concerning How is neglect defined?; §711.21, concerning How is exploitation defined?; §711.405, concerning What action does the investigator take if the alleged perpetrator is a licensed professional?; §711.603, concerning What is included in the investigation report?; §711.903, concerning How is an appeal affected by a determination that the perpetrator's confirmed act of abuse, neglect, or exploitation may rise to the level of reportable conduct?; §711.909, concerning What is the timeline for requesting an appeal?; and §711.911, concerning How and when is the appeal conducted?, with changes to the proposed text as published in the December 8, 2017 issue of the *Texas Register* (42 TexReg 6913). HHSC adopts the repeal of §711.425, concerning How are allegations classified?

BACKGROUND AND JUSTIFICATION

The amendments and repeal are intended to streamline administrative processes and address specific challenges experienced through the expanded scope and jurisdiction of Adult Protective Services (APS), while providing quality investigations to vulnerable individuals receiving services.

Senate Bills (SBs) 760 and 1880, 84(R), 2015, expanded the scope and jurisdiction of the APS Provider Investigations (PI) program to resolve gaps, inconsistencies, and ambiguities in the investigation of abuse, neglect and exploitation of individuals receiving Medicaid home and community-based services. The expansion ensured Texas was in compliance with revised Centers for Medicare and Medicaid Services requirements to ensure the health and welfare of consumers. SBs 760 and 1880 also brought the APS statutory framework up to date regarding the transition to managed care from the 83rd Legislature.

With the expanded scope and jurisdiction, APS PI intakes increased 73% overall from Fiscal Year (FY) 15 to FY 16, but completed investigations increased by only 5%. Intakes increased most notably for neglect and exploitation allegation categories. For allegations of exploitation, intakes increased 374% from FY 15 to FY 16, then another 56% from FY 16 to FY 17.

APS has applied different strategies to manage the workload which includes; procedural efficiencies, working overtime, and temporarily reassigning caseworkers from across the state to crisis areas. Despite these strategies, APS PI has not been able to remain current with the increased case load. HHSC requests adoption of rule changes to increase efficiencies associated with PI workload, while aligning PI responsibilities with the scope and jurisdiction provided in statute.

COMMENTS

The 30-day comment period ended January 7, 2018.

During this period, HHSC received comments regarding the proposed amendments and repeal from 7 commenters, including HHSC State Operated Facilities division, Disability Rights Texas, the HHS Office of the Inspector General, the Texas Council for Developmental Disabilities, PRO International, the National Alliance on Mental Illness, Twin Visions Corporation HCS, and Daybreak HCS. A summary of comments relating to the rules and HHSC's responses follows.

Comment: Regarding proposed amendments to §711.7 (What does APS not investigate under this chapter?), all commenters recommended APS PI continue to investigate allegations of abuse, neglect, and exploitation committed by a licensed professional. Multiple commenters had concerns regarding APS PI eliminating investigation of allegations of exploitation less than $25.00 and theft.

Response: HHSC acknowledges the comments and concerns raised during the public comment period regarding licensed professionals. HHSC will engage in further discussion with internal and external stakeholders prior to adopting any changes related to licensed professionals. This rule will retain the original language related to licensed professionals. However, HHSC disagrees with recommendations regarding exploitation as any amount less than $25.00 is ineligible for the Employee Misconduct Registry. Eliminating theft and low dollar exploitation allows APS PI to focus on allegations of physical abuse, sexual abuse, serious neglect, and exploitation eligible for

reportable conduct. As a result of language changes, HHSC made a non-substantive edit to the sequence of the items listed in the rule.

Comment: Regarding proposed amendments to §711.17 (How is verbal/emotional abuse defined?), multiple commenters proposed reinserting language to include a “reasonable person standard” or a “witness” to the alleged abuse when determining whether verbal/emotional abuse occurred.

Response: HHSC acknowledges that a reasonable person standard would add clarity to this rule and has revised the language to retain that standard as currently included in rule. However, HHSC disagrees with the recommendation to add a witness as an alleged victim because APS PI already identifies additional allegations and address them appropriately. HHSC identified a minor non-substantive edit and corrected the spelling of the word “health.” As a result of language changes, HHSC made a non-substantive edit to the numbering of this rule.

Comment: Regarding proposed amendment to §711.19 (How is neglect defined?), multiple commenters requested reinserting language related to possible risk of injury to the individual receiving services in a community provider setting, citing institutional settings as the core concern.

Response: HHSC disagrees with the recommendation as the definition change does not impact individuals receiving services in an institutional setting. HHSC identified a minor non-substantive edit and made a correction to §711.19(c) to read “any other service provider.”

Comment: Regarding proposed amendment to §711.21 (How is exploitation defined?), one commenter recommended adding a definition for a “loan” to rule language. One commenter recommended reinserting language regarding allegations of theft in an HCS setting. Multiple commenters recommended APS PI investigate all allegations of exploitation regardless of amount.

Response: HHSC disagrees with the recommendation regarding theft. HHSC APS PI has never and does not currently investigate theft in an HCS provider setting. However, HHSC acknowledges the comments regarding loans and rule language has been amended to reflect recommendations.

Comment: Regarding proposed amendments to §711.405 (What action does the investigator take if the alleged perpetrator is a licensed professional?), all commenters recommended APS PI continue to investigate allegations of abuse, neglect, and exploitation of a licensed professional.

Response: HHSC acknowledges the comments and concerns received during the public comment period. HHSC will engage in further discussion with internal and external stakeholders and will publish this rule with its original unedited language.

Comment: Regarding proposed amendment to §711.415 (What are the requirements for face-to-face contact with the alleged victim?), all commenters recommended making a face-to-face contact mandatory in all investigations and requested requirements for contact time frames outlined in rule.

Response: HHSC disagrees with recommendations because a mandatory face-to-face contact is not reasonable, timely, or efficient in all circumstances when alternate and effective means of communications are available, such as telephone interviews.

Comment: Regarding proposed amendment to §711.419 (What if the investigator cannot complete the investigation on time?), most commenters requested more specific information included in the rule language regarding "good cause" and time frames for extensions.

Response: HHSC disagrees with recommendations because time-frames for continuing an investigation vary by investigation need and "good cause" varies by investigation and it is not reasonable and could limit investigatory flexibility to include every circumstance in which investigation would continue for good cause or for how long in rule language.

Comment: Regarding proposed repeal of §711.425 (How are allegations classified?), two commenters were concerned the state-operated facility would not be able to identify the correct class of allegation if APS PI did not provide it with the final report and requested HHSC not repeal this rule.

Response: HHSC disagrees with the recommendation as allegation classifications are under the purview of HHSC/DADS and HHSC/DSHS, respectively 40 TAC 4.562, 25 TAC 414.562 and outlined in CANRS.

Comment: Regarding proposed amendment to §711.603 (What is included in the investigative report?), several commenters were concerned with edits to the analysis of the evidence requirement. Comments suggest removing specific examples of what to include in the analysis would decrease the quality of the report and recommend returning the rule to its original language.

Response: HHSC disagrees with the recommendation in that the proposed amendment is the result of extensive stakeholder conversations and input and aligns with the report format that will be implemented with upcoming technology modifications. HHSC identified a minor non-substantive edit and made a correction to §711.603(1) to read “a statement of the allegation or allegations.”

HHS did not receive comments regarding proposed amendments to §§711.901, 711.903, 711.905, 711.907, 711.909, 711.911, 711.913 and 711.915 (Appealing the investigation finding).

Minor editorial changes were made to §711.903(a) to change “act(s)” to “act or acts”; §711.909(a)(1) and §711.909(a)(2) to change the capitalization to indicate continuation of sentences; and §711.911(a)(2), §711.911(a)(4), and §711.911(b)(4) to delete extraneous words and re-organize the sentences for clarity.

STATUTORY AUTHORITY

The rule amendments and repeal are authorized by Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies.

The rule amendments and repeal implements HRC §42.042.
This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency’s legal authority.

For further information, please call: (512) 834-3483.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 19 DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
CHAPTER 711 INVESTIGATIONS OF INDIVIDUALS RECEIVING SERVICES FROM CERTAIN PROVIDERS
SUBCHAPTER A INTRODUCTION

**§711.7. What does APS not investigate under this chapter?**

APS does not investigate:

(1) if another branch of HHSC or another state agency is responsible under state law for the investigation;

(2) general complaints such as:

(A) rights violations;

(B) daily administrative operations;

(3) operational issues related to the business of managed care or consumer directed services ;

(4) if the allegation involves only the clinical practice of a licensed professional ;

(5) theft, as defined in Chapter 31 of the Texas Penal Code;

(6) allegations of exploitation less than $25.00 ; or

(7) loans made by an individual receiving services to a provider.

**§711.17. How is verbal/emotional abuse defined?**

(a) In this chapter, when the alleged perpetrator is a direct provider, verbal/emotional abuse is defined as:

(1) the willful infliction of an act or repeated acts of verbal or other communication, including gestures, to harass, intimidate, humiliate, or degrade an individual receiving services; or

(2) threats of physical or emotional harm against an individual receiving services.

(b) In order for the definition of verbal/emotional abuse to be met, the act or communication must:

(1) result in an individual receiving services experiencing:

(A) significant impairment to his or her physical, mental, or emotional health;

(B) substantial physical, mental, or emotional distress as identified by an appropriate medical professional; or

(2) be of such a serious nature that a reasonable person would consider it causing significant impairment to the physical, mental, or emotional health of the victim.

**§711.19. How is neglect defined?**

(a) In this chapter, when the alleged perpetrator is a direct provider to an individual receiving services in or from a facility, local authority, community center, or HCS waiver program or TxHmL waiver program provider, neglect is defined as a negligent act or omission which caused or may have caused physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death.

(b) Examples of neglect may include, but are not limited to, the failure to:

(1) establish or carry out an appropriate individual program plan or treatment plan for a specific individual receiving services, if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death;

(2) provide adequate nutrition, clothing, or health care to a specific individual receiving services in a residential or inpatient program if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death; or

(3) provide a safe environment for a specific individual receiving services, including the failure to maintain adequate numbers of appropriately trained staff, if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death.

(c) In this chapter, when the alleged perpetrator is a direct provider to an individual receiving services from any other service provider, neglect is defined as a negligent act or omission which caused physical or emotional injury or death to an individual receiving services.

**§711.21. How is exploitation defined?**

In this chapter, when the alleged perpetrator is a direct provider to an individual receiving services, exploitation is defined as the illegal or improper act or process of using an individual receiving services or the resources of an individual receiving services for monetary or personal benefit, profit, or gain, and excludes:

(1) theft as defined in Chapter 31 of the Texas Penal Code;

(2) allegations of exploitation less than $25.00; and

(3) a loan, which includes money or property given to someone to use for a period of time with an understanding that it will be paid back or returned, made by an individual receiving services to a direct provider in a community provider setting.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 19 DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
CHAPTER 711 INVESTIGATIONS OF INDIVIDUALS RECEIVING SERVICES FROM CERTAIN PROVIDERS
SUBCHAPTER E CONDUCTING THE INVESTIGATION

## §711.405. What action does the investigator take if the alleged perpetrator is a licensed professional?

(a) The investigator determines whether the allegation involves clinical practice by consultation with an appropriate professional, and in state hospitals, in accordance with 25 TAC §417.509 (relating to Peer Review).

(b) If the allegation is determined to involve clinical practice, the investigator refers the allegation to the service provider for peer or professional review. If the service provider does not have a peer or professional review process, the investigator refers the allegation to the service provider as well as the appropriate professional licensing board.

(c) If the allegation is determined to not involve clinical practice, the investigator investigates the allegation.

(d) If there are multiple allegations, the investigator refers any allegation involving clinical practice to the service provider for peer/professional review and investigates any allegation not involving clinical practice.

## §711.415. What are the requirements for face-to-face contact with the alleged victim?

(a) The investigator makes a face-to-face contact with the alleged victim except when the intake alleges any allegation type when there is no physical or emotional injury to the alleged victim and no risk of physical or emotional injury or death to the alleged victim.

(b) If during the course of an investigation the investigator determines a face-to-face contact with the alleged victim is necessary, the investigator conducts such contact.

**§711.419. What if the investigator cannot complete the investigation on time?**

(a) If additional time is required to complete the investigation, the investigator must request an extension by submitting an extension request to the appropriate program administrator or designee.

(b) The program administrator or designee may grant an extension for good cause.

(c) The investigator notifies the service provider of the extension.

**§711.425. How are allegations classified?** - REPEAL

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 19 DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
CHAPTER 711 INVESTIGATIONS OF INDIVIDUALS RECEIVING SERVICES FROM CERTAIN PROVIDERS
SUBCHAPTER G RELEASE OF REPORT AND FINDINGS

## §711.603. What is included in the investigative report?

The investigative report includes the following:

(1) a statement of the allegation or allegations;

(2) a summary of the investigation;

(3) an analysis of the evidence;

(4) a finding that the allegation is confirmed, unconfirmed, inconclusive, or unfounded;

(5) concerns and recommendations, if any, resulting from the investigation;

(6) the name of the perpetrator or alleged perpetrator;

(7) photographs relevant to the investigation, including photographs showing the existence of injuries or the non-existence of injuries, when appropriate; and

(8) all witness statements and supporting documents.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 19 DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
CHAPTER 711 INVESTIGATIONS OF INDIVIDUALS RECEIVING SERVICES FROM CERTAIN PROVIDERS
SUBCHAPTER J APPEALING THE INVESTIGATION FINDING

## §711.901. What is an appeal of the investigation?

(a) An appeal is a challenge of the findings of the investigation, as described in §711.421 of this chapter (relating to What are the possible findings of an investigation?) by a qualified party, as described by §711.905 of this chapter (relating to Who may request an appeal of the investigation?) that results in a review of the investigation.

(b) An appeal may not challenge the determination of whether a confirmation rises to the level of reportable conduct for purposes of the Employee Misconduct Registry.

(c) There are two levels of appeal:

(1) The first level appeal is conducted by the Director of Provider Investigations or his or her designee, or a reviewer designated by the Director of Provider Investigations.

(2) If a qualified party disagrees with the decision of the first appeal, the qualified party may further appeal. This second level appeal is conducted by a reviewer designated by the Director of Provider Investigations.

(d) The determination resulting from the second appeal is final and cannot be appealed by any qualified party except Disability Rights Texas or as described in §711.913 (relating to What if the administrator of a state-operated facility disagrees with the second level appeal decision?).

## §711.903. How is an appeal affected by a determination that the perpetrator's confirmed act of abuse, neglect, or exploitation may rise to the level of reportable conduct?

(a) An appeal that is described in this subchapter is not affected by a determination that the confirmed act or acts of abuse, neglect, or exploitation may rise to the level of reportable conduct.

(b) The designated perpetrator will not receive notice about his or her right to request an EMR hearing until:

(1) the timeframe for all appeals described in this subchapter have expired; or

(2) until the second appeal is completed and a confirmed finding that rises to the level of reportable conduct is upheld.

### §711.905. Who may request an appeal of the investigation?

(a) In order to be a qualified party to request an appeal, you must be:

(1) the administrator of the service provider or their attorney;

(2) the CDS employer or their legal representative;

(3) the reporter;

(4) the victim or alleged victim, or the legal guardian or parent (if the victim or alleged victim is a child); or

(5) Disability Rights Texas, only if Disability Rights Texas represents the victim or alleged victim or is authorized by law to represent the victim or alleged victim.

(b) An alleged or designated perpetrator may not request an appeal even if they are otherwise a qualified party. An alleged or designated perpetrator may not coerce a provider into requesting an appeal on the alleged perpetrator's behalf.

### §711.907. How does a qualified party request an appeal?

(a) To request an appeal, the qualified party must:

(1) complete the required form; and

(2) send the completed form either via email to the email address or via mail to the mailing address designated on the form.

(b) The victim, alleged victim, legal guardian, parent (if the victim or alleged victim is a child), and reporter may request an appeal by calling the designated phone number.

**§711.909. What is the timeline for requesting an appeal?**

(a) To request a first level appeal:

(1) service providers may request an appeal no later than the 30th calendar day following the date the investigative report was signed and dated by the investigator; and

(2) reporters, alleged victims, legal guardians, and Disability Rights Texas may request an appeal no later than the 60th calendar day following the date the investigative report was signed and dated by the investigator.

(b) A qualified party has 30 calendar days following the date the first level appeal decision letter is signed to request a second level appeal.

(c) APS Provider Investigations may accept a request for appeal after the deadline for good cause as determined by APS Provider Investigations.

**§711.911. How and when is the appeal conducted?**

(a) A first level appeal is conducted by the Director of Provider Investigations or his or her designee, or a reviewer designated by the Director or Provider Investigations, who:

(1) analyzes the investigative report and the methodology used to conduct the investigation and makes a decision to sustain, alter, or reverse the original finding;

(2) completes the review within 14 calendar days after receipt of the complete appeal request;

(3) notifies the appeal requestor of the appeal decision; and

(4) notifies the service provider, victim, or reporter, as appropriate, if the finding changed.

(b) A second level appeal is conducted by a reviewer designated by the Director of Provider Investigations, who:

(1) analyzes the investigative report and makes a decision to sustain, alter, or reverse the original finding;

(2) completes the review within 14 calendar days after receipt of the request; and

(3) notifies the appeal requestor of the appeal decision; and

(4) notifies the service provider, victim, or reporter, as appropriate, if the finding changed.

### §711.913. What if the administrator of a state-operated facility disagrees with the second level appeal decision?

If the administrator of a state-operated facility disagrees with the second level appeal decision, as referenced in §711.911(b) of this chapter (relating to How and when is the appeal conducted?), then the administrator may contest the decision in accordance with 25 TAC §417.510(g)(2) (relating to Completion of the Investigation) and 40 TAC §3.305(b) (relating to Completion of an Investigation).

### §711.915. Is a finding ever changed without an appeal?

Provider Investigations, in its sole discretion, may designate a person to conduct a review of the investigation records or reopen an investigation to collect additional evidence. If a review of the records and any additional investigation results in a change of the finding, the reviewer or his or her designee will notify the appropriate parties in writing.