**8000 Service Delivery Options**

Revision 20-1; Effective March 16, 2020

**8100 Selection of a Service Delivery Option**

Revision 20-1; Effective March 16, 2020

All managed care organization (MCO) service coordinators (SCs) must present service delivery options to the applicant, member or legally authorized representative (LAR) at the initial assessment and each subsequent annual reassessment. The service coordinator may use [Appendix XVII](https://hhs.texas.gov/laws-regulations/handbooks/sph/appendices/appendix-xvii-your-choice-deciding-how-manage-your-personal-assistance-services), It's Your Choice: Deciding How to Manage Your Personal Assistance Services, [Form 1581](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1581-consumer-directed-services-cds-option-overview), Consumer Directed Services (CDS) Option Overview, and [Form 1582](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1582-consumer-directed-services-responsibilities), Consumer Directed Services Responsibilities, or a document created by the MCO and with Texas Health and Human Services Commission (HHSC) approval, to assist the applicant, member or LAR in making the service delivery decision.

**8110 Member Decision**

Revision 20-1; Effective March 16, 2020

Managed care organizations (MCOs) must obtain a signature on [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice" \o "Form 1584), Consumer Participation Choice, indicating the member's service delivery option choice. If, at any time during the year, a current member contacts the MCO requesting information on service delivery options, the MCO must present the information to the member.

The MCO must keep Form 1584 in the member's case record and ensure the member or legally authorized representative (LAR) understands they may request a service delivery option change at any time by contacting the MCO.

**8200 Consumer Directed Services**

Revision 20-1; Effective March 16, 2020

**8210 Overview**

Revision 20-1; Effective March 16, 2020

Consumer Directed Services (CDS) allows a member or their legally authorized representative (LAR) to hire and manage the people who provide their services within their current STAR+PLUS and STAR+PLUS Home and Community Based Services (HCBS) program. The philosophy behind CDS is that people are the best judges of the type and level of assistance they may need and how that assistance should be delivered.

The CDS option was codified in Section 531.051 of the Government Code and expanded by the 79th Texas Legislature to provide more options for members to direct their long-term services and supports (LTSS). The rules for the CDS option are found in [Texas Administrative Code, Title 40, Chapter 41](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=41).

A member or LAR who chooses to participate in the CDS option becomes the CDS employer of their service providers, and is referred to as the CDS employer. The CDS employer is required to select and use a financial management services agency (FMSA) to provide financial management services (FMS). FMS includes assistance to members to manage funds associated with services elected for self-direction. This includes initial CDS employer orientation and ongoing training related to the responsibilities of being a CDS employer. The FMSA conducts payroll files and pays employer federal and state taxes on behalf of CDS employers, screens potential service providers for employment eligibility and provides ongoing support for members who choose the CDS option.

A member or LAR may choose the CDS option if:

* the member's program offers the CDS option;
* one or more program services in the member's authorized service plan are available for delivery through the CDS option;
* the member or LAR agrees to perform, or to appoint a designated representative (DR) to perform, the CDS employer responsibilities required for participation in the CDS option;
* the member or LAR selects a financial management services agency (FMSA) to provide financial management services (FMS); and
* the member or LAR has developed and received approval from the service planning team for each required service back-up plan.

If a member or LAR elects to participate in the CDS option, the member or LAR:

* selects one FMSA to provide FMS;
* with the assistance of the FMSA, budgets funds allocated in the member's authorized service plan for delivery through the CDS option; and
* recruits, screens, hires, trains, manages and terminates service providers.

As the CDS employer, a member or LAR may appoint in writing a willing adult as the designated representative (DR) to assist in performing employer responsibilities.

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**8211 Consumer Directed Services Option Definitions**

Revision 20-1; Effective March 16, 2020

The following words and terms, when used in reference to the Consumer Directed Services (CDS) option, have the following meanings.

**Actively involved** — Involvement with a member that the member's service planning team deems to be of a quality nature based on the following:

* observed interactions of the person with the member;
* a history of advocating for the best interests of the member;
* knowledge and sensitivity to the member's preferences, values, and beliefs;
* ability to communicate with the member; and
* availability to the member for assistance or support when needed.

**Budget** — A written projection of expenditures for each program service delivered through the CDS option.

**CDS employer** — The member or LAR who chooses to participate in the CDS option and is responsible for recruiting, hiring, training, managing, retaining and terminating service providers to deliver program services.

**Designated representative (DR)** — A willing adult appointed by the CDS employer to assist with or perform the employer's required responsibilities to the extent approved by the CDS employer. The DR is not the CDS employer. The DR must be a volunteer and cannot be a paid service provider.

**Employee** — A person employed by the member or legally authorized representative (LAR) through a service agreement to deliver program services and is paid an hourly wage for those services.

**Employer support services** — Services and items the CDS employer needs to perform. These are employer and employment responsibilities, such as office equipment and supplies, support consultation, expenses related to recruiting employees, and other items approved in Texas Administrative Code, Title 40, Part 1, Chapter 41, §41.507 and the *Consumer Directed Services Handbook*, Appendix XI, Allowable and Non-Allowable Expenditure.

**Financial management services (FMS)** — Services delivered by the financial management services agency (FMSA) to the member or LAR, as described in Section 8214.2, FMSA Responsibilities. These services include orientation, training, support, assistance with and approval of budgets, and processing payroll and payables on behalf of the member or LAR.

**Financial management services agency (FMSA)** — An agency that contracts with a managed care organization (MCO) to provide FMS.

**Legally authorized representative (LAR)** — A person authorized or required by law to act on behalf of a STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) member with regard to CDS, including a parent of a minor, guardian of a minor, managing conservator of a minor or the guardian of an adult.

**Service backup plan** — A documented plan to ensure that critical program services delivered through the CDS option are provided to a member when normal service delivery is interrupted or there is an emergency.

**Service Planning Team (SPT)** — A group of people who meet to discuss the member’s needs, which consists of the member or LAR, the service coordinator and any other person invited by the member or LAR.

**Support advisor** — An employee who provides support consultation to a CDS employer, a DR or a member receiving services through the CDS option.

**Support consultation** — A service that provides skills training and assistance for performing CDS employer-related responsibilities.

**8212 Services Available in the CDS Option**

Revision 20-1; Effective March 16, 2020

STAR+PLUS services available in the Consumer Directed Services (CDS) option are:

* Personal Assistance Services (PAS); and
* Community First Choice (CFC) PAS or Habilitation.

STAR+PLUS Home and Community Based Services (HCBS) program services available in the CDS option are: ~~The STAR+PLUS Home and Community Based Services (HCBS) program services available in the Consumer Directed Services (CDS) option are:~~

* In-home respite services;
* Skilled nursing;
* Employment assistance;
* Supported employment;
* Physical therapy (PT);
* Occupational therapy (OT); and
* Cognitive rehabilitation therapy (CRT); and
* Speech language therapy.

A member or their legally authorized representative (LAR) may choose to self-direct any or all services available through the CDS option. The CDS option is available to members living in their own homes or the homes of family members. The CDS option is not available to members living in adult foster care (AFC) homes or assisted living facilities (ALFs).

Choosing the CDS option does not impact a member's eligibility for services. Members can choose to have the above services delivered through the service delivery option of their choice.

Financial management services (FMS) is a required service in the CDS option. FMS provides assistance to CDS employers to manage funds associated with services elected for self-direction, and is provided by a financial management services agency (FMSA) contracted with the member’s managed care organization (MCO). This includes initial orientation and ongoing training related to CDS employer responsibilities and assisting with and approving the CDS employer’s budget. The FMSA also conducts payroll and pays employer taxes on behalf of the CDS employer. A monthly administrative fee is authorized on the individual service plan (ISP) and paid by the MCO to the FMSA for FMS.

If requested, an FMSA can provide support consultation, which includes additional training and support for the CDS employer related to their employer responsibilities beyond the ongoing support provided by the FMSA.

**8213 Advantages and Risks of the CDS Option**

Revision 20-1; Effective March 16, 2020

The member or legally authorized representative (LAR) should be informed of and consider the advantages and risks associated with the Consumer Directed Services (CDS) option before choosing to enroll. To assist the member in making an informed decision, the managed care organization (MCO) service coordinator must present information about service delivery options to the member or LAR. Refer to [Section 8221](https://hhs.texas.gov/laws-regulations/handbooks/sph/section-8000-service-delivery-options#8221), Presentation of the CDS Option.

**8213.1 Advantages of the CDS Option**

Revision 20-1; Effective March 16, 2020

Below are some of the advantages of using the Consumer Directed Services (CDS) option. The member or legally authorized representative (LAR):

* has more control over who provides services and the days and times the services are delivered;
* can offer benefits, such as bonuses, overtime pay, pay raises, vacation pay, sick pay and insurance to direct service providers, using funds from the CDS budget and in consultation with the financial management services agency (FMSA);
* can control the final rate of pay for service providers within allowable limits;
* may hire eligible service providers, such as family members, friends and other persons they know, in compliance with program and CDS rules;
* ;
* can appoint an eligible person as a designated representative (DR) to assist with or perform employer responsibilities; and
* may use budgeted funds to hire a support advisor, if they need assistance beyond the support provided by the FMSA.

**8213.2 Risks and Liability Associated with the CDS Option**

Revision 20-1; Effective March 16, 2020

Below are some of the member responsibilities and potential risks associated with the Consumer Directed Services (CDS) option. The member or legally authorized representative (LAR) is:

* responsible for locating attendants, back-up attendants and other direct service providers since there is no home and community support services agency (HCSSA) provider to fall back on to provide services. The member or LAR may contract with an HCSSA that agrees to provide back-up services, but the HCSSA is not required to contract with the member or LAR;
* the CDS employer in the CDS option, and therefore assumes all liability related to employment. The member or LAR retains control over recruiting, hiring, training, managing and terminating employees. The persons providing services are not the employees of the financial management services agency (FMSA), the managed care organization (MCO), any state or federal agency, or other contracted provider agency. As the CDS employer, the member or LAR is solely responsible and liable for any negligent acts or omissions made by the employee(s), service providers or the designated representative (DR);
* responsible for handling all conflicts with their employees. The CDS employer can request support consultation services be added to their service plan and budget to provide training and assistance with this employer responsibility, as necessary;
* not able to decrease or increase the MCO-authorized service hours by adjusting the employee’s hourly wage;
* required to keep certain paperwork to be specified by the FMSA for a required time period. The CDS employer must safely store the documentation for five years or longer;
* ultimately responsible for payroll taxes owed to the Internal Revenue Service (IRS) and Texas Workforce Commission (TWC), and is liable if the FMSA fails to pay. The FMSA assumes full responsibility for payment of payroll taxes owed to the IRS; and
* responsible for meeting all state and federal requirements as an employer and can be held liable for failure to meet those requirements.

**8214 Member and Financial Management Services Agency Responsibilities**

Revision 20-1; Effective March 16, 2020

**8214.1 Member Responsibilities**

Revision 20-1; Effective March 16, 2020

The member or legally authorized representative (LAR) assumes responsibility as the employer of record.

The member or LAR is responsible for:

* recruiting, hiring, training, managing and terminating direct service providers;
* setting wages and benefits for direct service providers within funds allocated for services elected for delivery through the Consumer Directed Services (CDS) option;
* following state and federal laws including the payment of overtime;
* evaluating each service provider's job performance;
* approving, signing and submitting time sheets, invoices and receipts to the financial management services agency (FMSA) for payment to direct service providers;
* providing the FMSA with necessary information to register as the member’s agent with the Internal Revenue Service (IRS) and the Texas Workforce Commission (TWC);
* having the FMSA verify eligibility of each applicant before hiring or retaining for employment or service delivery;
* resolving service provider concerns and complaints;
* maintaining a personnel file on each service provider;
* developing and implementing back-up service plans for services determined by the individual's planning team to be critical to the individual's health and safety; and
* ensuring protection of the individual receiving services and preserving evidence in the event of a Department of Family and Protective Services Adult Protective Services investigation of an allegation of abuse, neglect, or exploitation against a CDS employee, designated representative, FMSA representative or service coordinator.

The member or LAR must agree to accept financial management services (FMS) from the selected FMSA. The member or LAR must obtain an employer identification number from applicable government agencies and may request assistance from the FMSA to meet the requirements. The member or LAR must provide the information needed for the FMSA to register as the member's agent with the IRS and other appropriate government agencies.

**8214.2 FMSA Responsibilities**

Revision 20-1; Effective March 16, 2020

A financial management services agency (FMSA) must provide financial management services (FMS) to a Consumer Directed Services (CDS) employer or designated representative (DR), including:

* orienting and training the CDS employer or DR about CDS employer responsibilities for the Consumer Directed Services (CDS) option, including legal requirements of various governmental agencies;
* assisting with and approving budgets for each service to be delivered through CDS;
* with the CDS employer, completing forms required to obtain an employer identification number (EIN) from federal and state agencies;
* conducting criminal history checks and registry checks of applicants;
* verifying each applicant's eligibility with program requirements, including Medicaid fraud exclusions, before an applicant is employed or retained by the CDS employer;
* registering as the employer-agent with the Internal Revenue Service (IRS) and assuming full liability for filing reports;
* paying employer taxes on the CDS employer's behalf, to the IRS and Texas Workforce Commission (TWC);
* receiving and processing employee time sheets, computing and paying all federal and state employment-related taxes and withholdings, and distributing payroll at least twice a month;
* receiving and processing invoices and receipts for payment;
* maintaining records of all expenses and reimbursements and monitoring budget;
* submitting claims to the member's managed care organization (MCO);
* providing written summaries and budgeting balances of payroll and other expenses at least quarterly;
* preparing and filing employer-related tax and withholding forms and reports (this does not include filing personal income tax returns for employees); and
* providing ongoing training and assistance, as needed or requested.

The FMSA must obtain employer-agent status, as defined by [IRS Rev. Proc., 2013-39](https://www.irs.gov/pub/irs-drop/rp-13-39.pdf),  and perform all responsibilities as required by the IRS and other appropriate government agencies. The FMSA enters into service agreements with each of the member's direct service providers before issuing payment.

An FMSA may not provide financial management services (FMS) and case management services to the same member.

The FMSA must participate in all mandatory training provided or authorized by the Texas Health and Human Services Commission.

The MCO must monitor the FMSA’s performance and must ensure the FMSA performs all FMSA responsibilities, including participation in mandatory training.

**8220 Member Choice in the CDS Option**

Revision 20-1; Effective March 16, 2020

Information about the Consumer Directed Services (CDS) option must be presented to the STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program member by the managed care organization (MCO) service coordinator at all initial and annual planning meetings or at any time requested by the member. The MCO service coordinator should provide written and verbal information about the benefits and requirements of the CDS option. The member chooses which services will be delivered through the CDS option and which will be through the agency or service responsibility option.

**8221 Presentation of the CDS Option**

Revision 20-1; Effective March 16, 2020

At the time of a member's enrollment in a STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program that offers the Consumer Directed Services (CDS) option, and at least annually thereafter, the managed care organization (MCO) service coordinator or another person designated by the member's program must:

* provide written materials on the CDS option to the member or legally authorized representative (LAR);
* meet with and provide the member or LAR with a verbal explanation of the CDS option specific to the member's program;
* present or make available to the member, the Texas Health and Human Services Commission (HHSC) video, The Consumer Directed Services Option, which can be accessed by visiting [https://hhs.texas.gov/cds](https://hhs.texas.gov/services/disability/consumer-directed-services); and
* complete [Form 1581](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1581-consumer-directed-services-cds-option-overview), Consumer Directed Services Option Overview.

A member or LAR may request that an MCO service coordinator provide additional verbal and written information to the member or LAR regarding the CDS option or assist with enrollment in the CDS option at any time. The MCO service coordinator must comply within **five business days** after receipt of the request.

A member or LAR who initially declines to participate in the CDS option when it is presented by their service coordinator may request information about CDS and elect to participate in the CDS option at any time while receiving services through STAR+PLUS or STAR+PLUS HCBS.

The MCO service coordinator is responsible for presenting the CDS option annually to all new applicants and ongoing members who are not enrolled in the CDS option and whenever information is requested. The MCO service coordinator:

* shares an overview of the benefits and responsibilities of the CDS option by reviewing [Form 1581](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1581-consumer-directed-services-cds-option-overview);
* provides a copy of Form 1581 to the applicant or member or LAR; and
* informs the applicant or member of the right to choose service delivery through the CDS option, the agency option or the service responsibility option (SRO).

For initial applications, the MCO service coordinator obtains the applicant's signature on Form 1581 at the initial contact. The MCO service coordinator signs and dates the form verifying the information was presented to the applicant. A copy of Form 1581 is placed in the case record to document that CDS information was shared.

For annual redeterminations, the MCO service coordinator provides the member or LAR with a copy of Form 1581 and clearly documents in the case record that Form 1581 was shared with the member.

When members or LARs request information about the CDS option at other times, the MCO service coordinator must provide CDS information to the member within **five business days** after receipt of the request. The MCO service coordinator may provide the information by making a home visit or contacting the member or LAR by telephone. If a home visit is not made, the MCO service coordinator obtains the member's or LAR’s signature by mailing Form 1581 to the member with a postage-paid and return envelope. The MCO service coordinator signs and dates Form 1581 indicating the information was presented. A copy of Form 1581 is placed in the member's case record to document Form 1581 was shared.

The MCO service coordinator must discuss the CDS option, as well as differences in service delivery and payment options, and allow the member or LAR the opportunity to choose between delivery of services through the agency option or the CDS option.

If the member or LAR is interested in participating in the CDS option once the information on Form 1581 is shared, the MCO service coordinator reviews [Form 1582](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1582-consumer-directed-services-responsibilities), Consumer Directed Services Responsibilities. The MCO service coordinator:

* reviews with the member or LAR the responsibilities, risks and advantages of the CDS option;
* assists the member or LAR as needed in completing the member self-assessment on Page 4 of Form 1582;
* records the member's or LAR's choice to participate in the CDS option, and assists the member in selecting and appointing a designated representative (DR), if needed, or records the choice not to participate in the CDS option;
* obtains the DR's dated signature if the member or LAR chooses to appoint a DR; and
* signs and dates Form 1582.

If a member or LAR (the CDS employer) is not able to complete the Consumer Self-Assessment, a person appointed by the CDS employer to be the CDS employer's DR must be able to complete the Consumer Self-Assessment for the member receiving services to participate in the CDS option.

**8222 Member Choice and Enrollment in the CDS Option**

Revision 20-1; Effective March 16, 2020

A member or legally authorized representative (LAR) who decides to participate in the Consumer Directed Services (CDS) option must, with assistance from the managed care organization (MCO) service coordinator, complete the following forms:

(1) [Form 1582](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1582-consumer-directed-services-responsibilities), Consumer Directed Services Responsibilities

(2) [Form 1583](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1583-employee-qualification-requirements), Employee Qualification Requirements;

(3) [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice;

(4) [Form 1585](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1585-acknowledgement-responsibility-exemption-nursing-licensure-certain-services-delivered), Acknowledgement of Responsibility for Exemption from Nursing Licensure for Certain Services through Consumer Directed Services, or [Form 1733](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1733-employer-employee-acknowledgement-exemption-nursing-licensure-certain-services-delivered), Employer and Employee Acknowledgement of Exemption from Nursing License for Certain Services Delivered through Consumer Directed Services, if required by the policies of the member's program; and

(5) [Form 1586](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1586-acknowledgement-information-regarding-support-consultation-services-consumer-directed), Acknowledgement of Information Regarding Support Consultation Services in the Consumer Directed Services (CDS) Option, if the service is available in the member's program.

A member or LAR who elects to participate in the CDS option must complete the self-assessment in Form 1582 and, if applicable, complete any assessment required by the member's program.

A member or LAR who is not able to complete the self-assessment must appoint a designated representative (DR) to participate in the CDS option.

The MCO service coordinator presents the information on Form 1582 and allows the member or LAR to choose between the CDS option or the Agency Option (AO). The MCO service coordinator develops the member’s service plan according to policy and CDS option rules.

**8222.1 Choosing the CDS Option and an FMSA**

Revision 20-1; Effective March 16, 2020

If the member or legally authorized representative (LAR) chooses and is able to participate in the Consumer Directed Services (CDS) option, the MCO service coordinator proceeds to [Form 1583](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1583-employee-qualification-requirements), Employee Qualification Requirements, and [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice. The MCO service coordinator:

* provides Form 1583 information on the additional responsibilities of being an employer in the CDS option and who may or may not be hired in the CDS option;
* shares Form 1584 indicating the applicant's, member's or LAR's selection of the CDS option;
* obtains the applicant's, member's or LAR's dated signature on Form 1583 and Form 1584, if applicable;
* signs and dates the forms; and
* assists the member or LAR in choosing a financial management services agency (FMSA).

The MCO service coordinator presents a list of MCO-contracted FMSAs and home and community support services agencies (HCSSA) providers. The member or LAR must select:

* an FMSA to provide CDS financial management services (FMS); and
* an HCSSA provider to deliver all other STAR+PLUS Home and Community Based Services (HCBS) program services that are not delivered under the CDS option.

The MCO service coordinator develops the individual service plan (ISP) according to STAR+PLUS and STAR+PLUS HCBS program policy and CDS option rules.

**8222.2 Declining the CDS Option**

Revision 20-1; Effective March 16, 2020

If the member or legally authorized representative (LAR) declines the Consumer Directed Services (CDS) option after reviewing the self-assessment tool on [Form 1582](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1582-consumer-directed-services-responsibilities), Consumer Directed Services Responsibilities, the managed care organization (MCO) service coordinator:

* obtains the applicant's, member's or LAR's signature on [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice, indicating his or her selection of service delivery options; and
* signs and dates Form 1584.

The MCO service coordinator must ensure the member understands the CDS option is always available and that the member may call the MCO service coordinator to request a change to the CDS option at any time.

Form 1584 is signed by the member any time a different service delivery option is chosen.

**8223 Designated Representative**

Revision 20-1; Effective March 16, 2020

The member or legally authorized representative (LAR) has the option to appoint a designated representative (DR) to assist with the responsibilities of being a CDS employer in the Consumer Directed Services (CDS) option. If a CDS employer decides to appoint a DR, after the financial management services agency (FMSA) has been selected, then the FMSA assists the CDS employer in appointing a DR. A CDS employer may appoint a willing adult as a DR to assist or to perform CDS employer responsibilities. The CDS employer maintains responsibility and accountability for decisions and actions taken by the DR. If the CDS employer chooses to appoint or change a DR, the CDS employer must complete [Form 1720](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1720-appointment-a-designated-representative), Appointment of Designated Representative.

The person appointed as the DR by the member or LAR must:

* be willing to serve as the member's or LAR's DR for participation in the CDS option;
* be or become actively involved with the member; and
* complete the self-assessment in Form 1582, Consumer Directed Services Responsibilities, and any assessment required by the member's program.

A DR must not:

* sign or represent themselves as the CDS employer;
* be paid to perform employer responsibilities;
* be an employee of the CDS employer;
* have a spouse employed by the CDS employer; or
* provide a program service to the member.

The CDS employer must notify the FMSA by fax or telephone within **two business days** after the appointment or change of a DR.

* If the CDS employer notifies the FMSA by telephone, the CDS employer must fax or mail a copy of Form 1720 to the FMSA within **five business** **days** after the appointment or change of a DR.

If a CDS Employer decides to revoke the appointment of a DR, the CDS employer must:

* complete [Form 1721](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1721-revocation-appointment-designated-representative), Revocation of Appointment of Designated Representative; and
* provide a copy of the completed form to the DR, the FMSA and the individual’s case manager/service coordinator within two days after the effective date of the revocation.

Based on documentation provided by the FMSA of a CDS employer's inability to meet employer responsibilities, the person-centered service planning team may recommend that the CDS employer designate a DR to assist with or to perform CDS employer responsibilities.

**8230 Developing the Individual Service Plan in the CDS Option**

Revision 20-1; Effective March 16, 2020

Service planning for a member who chooses to participate in the Consumer Directed Services (CDS) option is completed in accordance with the rules and requirements of the member's program in the same manner as if services are delivered through a program provider. Service planning includes:

* determining the member's needs;
* determining service levels;
* justifying changes to the service plan;
* maintaining costs and cost limits;
* reviewing services; and
* obtaining approval for planned services.

The managed care organization (MCO) service coordinator must adhere to rules and requirements of the member's program if the member's services or a request for services is recommended for:

* denial;
* reduction;
* suspension; or
* termination.

The MCO service coordinator must provide a written or verbal explanation of an action recommended by a service planning team. The procedure for requesting a fair hearing must be provided verbally and in accordance with the member's program requirements.

All STAR+PLUS and STAR+PLUS Home and Community Based Services (HCBS) program financial and non-financial eligibility requirements apply. All existing Medicaid eligibility requirements apply in the CDS option. CDS is not a service; it is a service delivery option. The MCO service coordinator completes all forms currently required for STAR+PLUS HCBS program services, including [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060, and [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum, as applicable.

The member using the CDS option must have a back-up plan to assure the provision of all authorized services critical to the member’s health and safety without a service break, even if there are unexpected changes in personnel. The CDS employer or designated representative (DR) must develop and receive approval from the MCO service coordinator for each required service back-up plan in order to participate in the CDS option. Refer to [Section](https://hhs.texas.gov/laws-regulations/handbooks/sph/section-7000-starplus-hcbs-program-services" \l "8245" \o "8245) 8231, Service Back-Up Plans.

The MCO service coordinator follows program policy when completing denials or terminations, reductions in services and suspensions. The MCO service coordinator must ensure the CDS employer fully understands the reasons for actions taken relating to the individual service plan (ISP) and STAR+PLUS or STAR+PLUS HCBS program services, as well as actions that could affect the member's participation in the CDS option.

If the CDS employer or DR hires a nurse to provide services, nurses must operate within their license requirements outlined in the Texas Board of Nursing regulations ([Texas Administrative Code, Title 22, Part 11](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=22&pt=11" \t "_blank)), including registered nurse (RN) or physician oversight, plan of care development for nurses depending on the level of nurse hired, and RN or physician delegation, as indicated.

In the CDS option, an RN must develop the nursing plan of care that determines hours of nursing needed and how many, if any, of the nursing hours can be provided by a licensed vocational nurse (LVN) and the same RN responsibilities listed in the paragraphs above. The RN and LVN must acknowledge nursing rules, including that an LVN must practice under the supervision of an RN, by completing [Form 1747](https://hhs.texas.gov/sites/default/files/documents/laws-regulations/forms/1747/1747.pdf), Acknowledgement of Nursing Requirements.

The RN may be employed through contract with a home health agency or private arrangement. The same expectation of collaboration exists between the MCO RN service coordinator and the RN that develops the plan of care in the CDS option.

**8231 Service Back-up Plans**

Revision 20-1; Effective March 16, 2020

The managed care organization (MCO) must discuss with the CDS employer or designated representative (DR) the services delivered through Consumer Directed Services (CDS) that are critical to the member's health and safety. The MCO must require the CDS employer or DR to develop a service back-up plan to ensure the health and safety of the member when regular service providers are not available to deliver services or in an emergency. The CDS employer or DR must develop a back-up plan and document the plan on [Form 1740](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1740-service-backup-plan), Service Backup Plan, to assure the provision of all authorized personal assistance services without a service break.

The CDS employer or DR, with the assistance of the MCO service coordinator (if needed), completes Form 1740. The service back-up plan must list the steps the CDS employer or DR will implement in the absence of the regular service provider. The service back-up plan may include the use of paid service providers, unpaid service providers, such as family members, friends or non-program services, or respite (if included in the ISP). The CDS employer or DR is responsible for implementation of the service back-up plan in the absence of the employee.

Service back-up plans are submitted by the member, LAR or DR to the MCO service coordinator. The MCO service coordinator /service planning team (SPT), as appropriate, approve the plans as being viable in the event a service provider is absent. The MCO or SPT must approve each service back-up plan and any revision(s) before implementation by the CDS employer or DR. The MCO approves the service back-up plan by signing, dating and returning a copy of the plan to the CDS employer and DR, if applicable.

The CDS employer or DR is required to:

* budget sufficient funds in the CDS option budget to implement a service back-up plan;
* review and revise each service back-up plan annually;
* revise a service back-up plan if:
  + the member experiences a problem in the implementation; or
  + there are changes in availability of resources;
* redistribute funds that are not used in carrying out a service back-up plan; and
* provide a copy of the initial and revised service back-up plans and budgets to the financial management services agency (FMSA) within **five business days** after a plan's approval by the SPT.

The FMSA must:

* assist a CDS employer or DR, as requested, to revise budgets to meet service back-up plan strategies approved by the member's SPT;
* review, validate and approve revised budgets in accordance with [§41.511](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=1&ch=41&rl=511" \t "_blank), Texas Administrative Code, relating to Budget Revisions and Approval;
* reimburse documented, budgeted allowable expenses incurred related to implementing service back-up plan strategies; and
* retain a copy of service back-up plans received from the CDS employer or DR.

**8232 Service Planning Team Responsibilities**

Revision 20-1; Effective March 16, 2020

A member’s person-centered service planning team consists of persons required or allowed by the member's program. A CDS employer must attend and participate in the member's service planning meetings. A CDS employer's designated representative (DR) may also attend the meeting with approval of the CDS employer.

A CDS employer or DR must provide documentation related to services, service delivery, and participation in the Consumer Directed Services (CDS) option when requested by a managed care organization (MCO) or MCO service coordinator.

A CDS employer or DR must, when requesting a change in a service or the addition of a service for delivery through the CDS option, provide the person-centered service planning team (SPT) with documentation of circumstances that require a revision to the individual service plan (ISP).

The MCO and STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program SPT members make up the person-centered SPT for the member who selects the CDS option. The MCO convenes the SPT, as required by STAR+PLUS or STAR+PLUS HCBS program policy and obtains approvals, as appropriate, from SPT members. The MCO and SPT also assist in resolving issues and concerns related to the member's participation in the CDS option.

The financial management services agency (FMSA) must send a quarterly expenditure report to the CDS employer and MCO service coordinator and document and notify the MCO of issues or concerns, including:

* allegations of abuse, neglect, exploitation or fraud;
* concerns about the member's health or safety;
* non-delivery or extended breaks in services;
* noncompliance with CDS employer responsibilities;
* noncompliance with service back-up plans; or
* over- or under-utilization of services or funds allocated in the ISP for delivery of services to the member through the CDS option and in accordance with the requirements of the STAR+PLUS or STAR+PLUS HCBS program.

The member or legally authorized representative (LAR) is required to participate in the service planning meetings and provide requested documentation related to services and service delivery. The member or LAR must provide documentation to support any requests for a revision to the ISP.

The FMSA may also participate in the member's service planning if requested by the member or LAR, and if agreed to by the FMSA.

The FMSA must provide information related to the member's participation in the CDS option within three days of receiving a request for information from the member or LAR, DR, MCO or other involved parties,.

The MCO and SPT members, as appropriate, participate in approving back-up plans, developing corrective action plans, if necessary, and recommending suspension or termination of the CDS option. Refer to Section 8244, Service Back-Up Plans, and Section 8245, Corrective Action Plans.

**8233 CDS Employer Support Services in the CDS Option**

Revision 20-1; Effective March 16, 2020

A CDS employer or designated representative (DR) may budget CDS employer support services and start-up expenses, through the services that are delivered by one or more employees in the Consumer Directed Services (CDS) option. CDS employer support services include employment-related expenses, employer-related expenses and support consultation services. CDS employer support services exclude non-allowable expenditures listed in [Appendix XI](https://hhs.texas.gov/laws-regulations/handbooks/cds/appendices/appendix-xi-allowable-non-allowable-expenditure), Allowable and Non-Allowable Expenditures, in the *Consumer Directed Services Handbook*.

Start-up expenses must be:

* budgeted for purchases projected before the delivery of services through the CDS option; and
* accrued from the budgeted unit rate for services scheduled for delivery through the CDS option within the first three months of initiation of the CDS option.

A CDS employer or DR may budget allowable, necessary, and reasonable employment-related services, goods or items, including:

* recruiting expenses;
* obtaining a criminal history report from the Texas Department of Public Safety;
* purchasing employee job-specific training;
* cardio-pulmonary resuscitation training;
* first-aid training;
* supplies required for an employee or provider of the service to perform a task, if not available through the member's program or other source and the purchase is allowable through the member's program;
* non-taxable employee benefits; and
* services, goods, and items specifically approved by the member's program as an employer support service or included as allowable expenditures in [Appendix XI](https://hhs.texas.gov/laws-regulations/handbooks/cds/appendices/appendix-xi-allowable-non-allowable-expenditure).

A CDS employer or DR may budget employer-related services, goods or items required to meet CDS employer responsibilities, including:

* basic office equipment, which may include a basic fax machine for the purpose of submitting documents to the financial management services agency (FMSA);
* mailing costs;
* expenses related to making copies;
* file folders and envelopes; and
* services, goods, and items specifically approved by the member's program as an employer support service or included as allowable expenditures in [Appendix XI](https://hhs.texas.gov/laws-regulations/handbooks/cds/appendices/appendix-xi-allowable-non-allowable-expenditure).

~~An employer or DR may budget up to 10 percent of their CDS budget for employer support services. An employer or DR must not budget more than $600 annually or more than $50 per month for employer support services if less than 12 months remain in the service plan.~~Support consultation, if available through the member's program, is an optional service available to a member participating in the CDS option. Support consultation is delivered to a CDS employer, DR, or a member receiving services through the CDS option if that member will be the CDS employer within six months of the initiation of support consultation services to the member.

Support consultation is provided by a person who meets the qualifications of a support advisor. A support advisor may be a contractor of the CDS employer or an employee or contractor of an FMSA.

Support consultation must provide a level of training, assistance and support that does not duplicate or replace the services delivered by the FMSA, managed care organization (MCO) service coordinator, or other available program or non-program services or resources.

Support consultation provides practical skills training and assistance to successfully manage service providers for authorized program services delivered through the CDS option. This includes skills training and assistance for:

* recruiting, screening and hiring workers;
* developing and documenting job descriptions;
* verifying employment eligibility and qualifications;
* completing documents required to:
  + employ an individual;
  + retain a contractor or vendor; and
  + manage service providers;
* communicating effectively, solving problems and documenting CDS employer responsibilities in the CDS option;
* developing, revising and implementing service back-up plans;
* performing CDS employer responsibilities;
* complying with the member's program and this section; and
* developing ongoing decision-making skills for employer-related and employment-related situations.

A CDS employer or DR may budget and initiate support consultation services while the member is participating in the CDS option. Before initiation of the service, the CDS employer or DR must:

* identify the person or persons (the CDS employer, the DR or the member within six months after becoming the CDS employer) to receive the service and establish goals specific to the service;
* obtain approval of the goals established for the service from the member's service planning team;
* develop a budget for support consultation; and
* obtain approval of the budget from the FMSA.

If the member's service planning team authorizes support consultation, the team must:

* approve the funds, the duration and the frequency of the service;
* assist with development of goals and ensure that the activities required to meet the goals through support consultation comply with this section;
* approve the goals for support consultation and the person or persons who will receive the service (the member, CDS employer or DR); and
* terminate the service when goals are met.

A CDS employer or DR may budget up to 10 percent of their CDS budget for CDS employer support services. ~~the amount available, after the FMSA portion is calculated, in those services delivered by one or more employees.~~ CDS employer or DR must not budget more than $600 annually or more than $50 per month ~~if less than 12 months remain in the service plan~~ for CDS employer support services if less than 12 months remain in the service plan.

**8240 Initiation of and Transition to the CDS Option**

Revision 20-1~~19-1~~; March 16, 2020

Within **five business days** after receipt of a completed [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice, by an eligible member or legally authorized representative (LAR), or upon receipt of Form 1584 and within **five business days** after eligibility determination for an applicant applying for program services, a managed care organization (MCO) service coordinator must provide the following documentation to the financial management services agency (FMSA):

* Form 1584;
* the individual service plan (ISP);
* date the CDS employer may begin incurring expenses to initiate start-up activities and to incur recruitment and hiring expenses;
* date the CDS employer may begin delivery of program services through the CDS employer's service providers;
* the number of units, the approved rate, or the amount authorized in the ISP for each service to be delivered through the CDS option;
* total funds authorized for each program service to be delivered through the CDS option; and
* the authorized schedule of service delivery per day, week, month or other time frame specific to the service if not listed on the above forms.

Within **five business days** after eligibility determination for the STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program, new applicants who choose the CDS option are referred to the FMSA they select to begin the initiation process.

Within **five business days** of receipt of the completed [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), ongoing STAR+PLUS and STAR+PLUS HCBS program members who choose the CDS option are referred to the FMSA they selected to begin the CDS initiation process.

The MCO service coordinator provides the FMSA the following documentation:

* Form 1584;
* [Form 1582](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1582-consumer-directed-services-responsibilities), Consumer Directed Services Responsibilities; and
* the ISP.

The MCO service coordinator must provide the FMSA with the authorized schedule of service delivery per day, week, month or other time frame specific to the service if not listed on the above forms.

Some applicants may have been anticipating the availability of the CDS option and may elect to go directly to the CDS option. The MCO service coordinator must emphasize that the applicant assumes all responsibility for arranging their self-directed services.

MCO service coordinators must carefully coordinate transition activities when transitioning applicants or members to and from the CDS option.

**8241 Initiation and Orientation of the Member as Employer**

Revision 20-1; Effective March 16, 2020

Upon choosing to participate in the Consumer Directed Services (CDS) option, a CDS employer, and the designated representative (DR), if applicable, must:

* complete the initial face-to-face orientation provided by the financial management services agency (FMSA) in the residence of the member or setting of the member's or legally authorized representative’s (LAR’s) choosing;
* complete and maintain a copy of [Form 1736](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1736-documentation-employer-orientation-financial-management-services-agency), Documentation of Employer Orientation by Financial Management Services Agency, upon completion of the orientation;
* complete [Form 1735](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1735-employer-financial-management-services-agency-service-agreement), Employer and Financial Management Services Agency Service Agreement, with the program addendums, if applicable;
* complete [Form 1726](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1726-relationship-definitions-consumer-directed-services), Relationship Definitions in Consumer Directed Services;
* as required by the member's program, complete [Form 1733](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1733-employer-employee-acknowledgement-exemption-nursing-licensure-certain-services-delivered), Employer and Employee Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, or [Form 1585](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1585-acknowledgement-responsibility-exemption-nursing-licensure-certain-services-delivered), Acknowledgement of Responsibility for Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services;
* complete [Form 1728](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1728-liability-acknowledgement), Liability Acknowledgment;
* submit completed original forms specified in this section to the FMSA within **five business days** after the date of the initial orientation; and
* retain copies of completed documentation required by this section.

Upon receipt of the CDS referral from the managed care organization (MCO) service coordinator, the FMSA completes the initial CDS employer orientation with the member, LAR or DR, if applicable, in the member's residence or setting of the member’s or LAR’s choosing. The FMSA provides an overview of the CDS option, including the rules and requirements of applicable government agencies, and the roles of the CDS employer and the FMSA.

During the initial face-to-face orientation, the FMSA must also:

* explain the roles, rules and responsibilities that apply to a CDS employer, provider, FMSA, MCO and state agencies, including:
  + the CDS employer budget based on the authorized service plan;
  + the hiring process, including documents and forms to be completed for new employees; and
  + managing paper and electronic timesheets, due dates, payday schedules, and disbursing employee payroll checks;
* review and leave with the CDS employer and DR, if applicable, a printed document that clearly states the FMSA's:
  + normal hours of operation;
  + key persons to contact with issues or questions and how to contact these persons; and
  + the complaint process, including how to file a complaint with the FMSA or about the FMSA;
* review [Form 1735](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1735-employer-financial-management-services-agency-service-agreement) and required addendums, emphasizing rule and policy requirements of the member's program, including:
  + service definitions;
  + provider qualifications;
  + required documentation to be kept in the home;
  + training requirements for service providers;
  + program staff who will be reviewing the CDS employer's records; and
  + if applicable, nursing requirements as described on [Form 1747](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1747-acknowledgement-nursing-requirements), Acknowledgement of Nursing Requirements; and
* review and leave with the CDS employer and DR, if applicable, printed information on how to report allegations of abuse, neglect and exploitation.

The FMSA must provide to the CDS employer or DR a printed or electronic copy of the [HHSC CDS Option Employer Manual](https://hhs.texas.gov/services/disability/consumer-directed-services/cds-employer-resources/cds-option-employer-manual).

Upon conclusion of the orientation, the FMSA and CDS employer must complete [Form 1736](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1736-documentation-employer-orientation-financial-management-services-agency), Documentation of Employer Orientation by Financial Management Services Agency.

The FMSA must receive a completed Form 1735 with required attachments signed and dated by the CDS employer or DR before initiation of the CDS option.

The CDS employer or DR signs and submits all required forms for participation in the CDS option and returns the forms to the FMSA within **five business days** after the date of initial orientation.

The CDS employer and FMSA notify the MCO service coordinator when all initiation activities are complete. The MCO must ensure the FMSA performs all FMSA responsibilities, including providing orientation to CDS Employers.

**8242 Employer and Employee Acknowledgment of Exemption from Nursing Licensure for Certain Services Delivered through CDS**

Revision 20-1; Effective March 16, 2020

The financial management services agency (FMSA) assists the Consumer Directed Services (CDS) employer or designated representative (DR) in completing the CDS employer and employee acknowledgment of exemption from nursing licensure requirements for certain services delivered through CDS. Tasks prohibited from delegation are described in the Texas Administrative Code §225.13, Tasks Prohibited From Delegation. The employee acknowledges that, as the person who delivers the service, they have not been:

* denied a license under Chapter 301 or 302, Occupations Code; or
* issued a license under Chapter 301, Occupation Code, that is revoked or suspended.

The FMSA verifies potential service providers selected by the CDS employer or DR meet provider qualifications and other requirements of STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) before the CDS employer or DR hires the service provider.

**8243 Authorizing CDS**

Revision 20-1; Effective March 16, 2020

When the CDS employer and financial management services agency (FMSA) notify the managed care organization (MCO) service coordinator that CDS services are ready to begin, the MCO service coordinator negotiates a start date for services. The MCO service coordinator revises [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg. 1), and changes the applicable authorizations to the FMSA. For ongoing members, the individual service plan (ISP) year remains the same. The same procedures are followed for any other transfer of agencies.

It is the responsibility of the CDS employer and the FMSA to ensure that the expenditures for the year remain within the authorized amount. The MCO is responsible for timely payment of FMSA claims, submitted on behalf of the CDS employer, as well as for payment of the monthly service fee, which pays the FMSA for its services.

**8245 Corrective Action Plans**

Revision 20-1; Effective March16, 2020

A written corrective action plan (CAP) may be required from a Consumer Directed Services (CDS) employer or designated representative (DR) if the CDS employer or DR:

* hires an ineligible service provider;
* submits incomplete, inaccurate, or late documentation of service delivery;
* does not follow the budget;
* does not comply with program requirements related to the CDS option;
* does not meet other CDS employer responsibilities.

The CDS employer or DR must provide a written CAP to the person requiring the plan within **10 business days** after receiving a CAP request. CAPs may be requested in writing by the financial management services agency (FMSA), managed care organization (MCO), Texas Health and Human Services Commission (HHSC) staff or service planning team (SPT) member.

The written CAP must include the:

* reason the CAP is required;
* action to be taken;
* person responsible for each action; and
* date the action must be completed.

The CDS employer or DR may request assistance in the development or implementation of a CAP from the:

* FMSA or others, if the plan is related to CDS employer responsibilities; and
* MCO, if the CAP is related to the STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program rules or requirements.

[Form 1741](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1741-corrective-action-plan), Corrective Action Plan, is used to document the CAP.

**8245.1 Terminating the CDS Option**

Revision 20-1; Effective March 16, 2020

A Consumer Directed Services (CDS) employer may request voluntary termination of participation in the CDS option and receive services through a program agency provider at any time. A member may also be involuntarily terminated from participation in the CDS option in accordance with the requirements of the member's program and Texas Administrative Code [§41.407](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=1&ch=41&rl=407), Termination of Participation in the CDS Option. After terminating the CDS option, t

A member’s managed care organization (MCO) service coordinator convenes the member's service planning team (SPT) concerning issues that may warrant immediate termination of the member's participation in the CDS option. On review of the information, the SPT may recommend immediate termination of participation in the CDS option when:

* the member's health or safety is immediately jeopardized by the member's participation in the CDS option;
* the designated representative (DR) has been convicted of an offense under Chapter 32 of the Penal Code or an offense barring employment as listed in the [Texas Health and Safety Code, §250.006(a) and (b)](https://statutes.capitol.texas.gov/Docs/HS/htm/HS.250.htm); or
* HHSC or another government agency with applicable regulatory authority recommends that participation in the CDS option be immediately terminated.

If a CDS employer or designated representative (DR) does not implement and successfully complete the following steps and interventions, a member's SPT may recommend termination of participation in the CDS option in accordance with the member's program requirements:

* eliminate jeopardy to the member's health and safety;
* successfully direct the delivery of program services through CDS;
* meet CDS employer responsibilities;
* successfully implement corrective action plans; or
* appoint a DR or access other available supports to assist the CDS employer in meeting CDS employer responsibilities.

Before a financial management services agency (FMSA) recommends involuntary termination of participation in the CDS option to a member's MCO service coordinator, the FMSA must:

* provide documentation to the member's MCO service coordinator of additional and ongoing training and supports provided by the FMSA when a CDS employer or DR demonstrates noncompliance with CDS employer responsibilities;
* provide assistance requested by the CDS employer or DR to develop and implement a corrective action plan;
* provide documentation of any corrective action plan required of the CDS employer or DR by the FMSA in accordance with this section; and
* notify the MCO service coordinator in writing in accordance with the requirements of the member's program when recommending termination of a member's participation in the CDS option.

On receipt of a recommendation for involuntary termination from the FMSA or other party, the member's MCO service coordinator must:

* provide assistance with accessing supports and developing and implementing a corrective action plan related to noncompliance with program and CDS requirements;
* document interventions utilized by the CDS employer or DR to eliminate noncompliance with program requirements for delivery of program services through the CDS option; and
* convene theSPT to:
  + consider recommendations related to the member's participation in the CDS option;
  + recommend additional interventions to be implemented to protect the member's health and safety for continued participation in the CDS option; and
  + make revisions to the member's service plan if needed.

If the SPT recommends terminating participation in the CDS option, the member's MCO service coordinator must document:

* the reasons for the recommendation;
* the conditions and time frame established by the member's SPT that the member must meet prior to re-enrollment in the CDS option;
* justification for any time period for a termination in excess of the minimum 90-day requirement; and
* if applicable, the conditions and time frame specified by a hearing officer as the result of a fair hearing that upholds the termination.

When a member's participation in the CDS option is terminated, the MCO service coordinator must take steps and interventions in accordance with the requirements of the member's program to:

* ensure continuity of delivery of program services that were being delivered through the CDS option; and
* document arrangements made for delivery of program services that were being delivered through the CDS option to be delivered by the member's program provider or other resources.

**8245.2 Re-enrollment in the CDS Option**

Revision 20-1; Effective March 16, 2020

Following termination of participation in the Consumer Directed Services (CDS) option, a member or legally authorized representative (LAR) must request re-enrollment in the CDS option by notifying the member's managed care organization (MCO) service coordinator. If a member or LAR wishes to re-enroll in the CDS option, the MCO service coordinator must:

* review the reason that the member was suspended or terminated from the CDS option;
* verify that the member has fulfilled the minimum 90-day period and any conditions specified by the member's service planning team (SPT) or a hearing officer, if applicable;
* verify how each issue that contributed to the suspension or termination has been resolved; and
* refer the request for re-enrollment in the CDS option to the member's SPT and follow requirements of the member's program, including:
  + revising the member's service plan and re-enrolling the member in the CDS option upon approval; and
  + issuing a denial and providing information related to requesting a fair hearing if the request is not approved.

If approved for re-enrollment, the FMSA must:

* provide an initial orientation in accordance with this section, following the member's re-enrollment in the CDS option if the current CDS employer or DR has not received initial orientation; and
* notify the CDS employer, DR, and the member's MCO service coordinator in writing within **two business days** after any repeat of prior noncompliance or additional noncompliance with requirements of the member's program or this section during the member's participation in the CDS option.

**8246 Budgets**

Revision 20-1; Effective March 16, 2020

The CDS employer or designated representative (DR), with assistance obtained from the financial management services agency (FMSA) or others, must:

* develop an initial and annual budget for each STAR+PLUS service and STAR+PLUS Home and Community Based Services (HCBS) service to be delivered through the CDS option;
* project expenditures of funds allocated in the individual service plan (ISP) for the effective period of the ISP;
* use a workbook approved by the managed care organization (MCO) or applicable budget workbooks available through Texas Health and Human Services Commission (HHSC) at [https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/consumer-directed-services-cds/cds-forms-handbooks](https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/consumer-directed-services/cds-forms-handbooks);
* budget to pay employees in accordance with minimum wage laws and any other applicable base wage requirements;
* request assistance from the FMSA as needed;
* submit each budget to the FMSA for review of the member's budgeted payroll spending decisions and verification that the applicable budget workbooks are within the approved budget. The FMSA must work with the CDS employer or DR to resolve issues that prevent the approval of budget plans; and
* obtain written approval for each budget from the FMSA before implementation of the budget and initiation of service delivery through the CDS option.

An FMSA must:

* review the CDS employer’s budgeted payroll spending decisions;
* verify that each applicable budget workbook is within the approved budget; and
* notify the CDS employer, in writing, of the approval or disapproval of the CDS employer’s budget and work with the CDS employer or DR to resolve issues that prevent budget approval.

**Budget Revisions and Approval**

A CDS employer or DR must make budget revisions if:

* a change to the individual service plan (ISP) affects funding for a program service delivered through the CDS option;
* a budget has been or will be exceeded before the end date of the ISP;
* authorized units, unit rate or amount of funds allocated have changed;
* an amount paid for one or more services, goods or items affects the approved budget;
* revisions are made to a service back-up plan;
* funds budgeted for a service back-up plan are not used or needed; or
* the FMSA, the MCO service coordinator, the person-centered service planning team (SPT) or an HHSC representative requires a revision.

The CDS employer or DR must submit budget revisions to the FMSA for approval. Revised budgets cannot be implemented until written approval is received from the FMSA.

The FMSA must provide assistance to the CDS employer or DR with budget revisions as requested or needed by the member, validate the budget, and provide written approval to the CDS employer or DR.

The MCO evaluates ISP changes requested by the CDS employer and participates in the SPT meetings to resolve issues when the CDS employer or DR does not follow the budget or comply with CDS option budget requirements.

**8300 Service Responsibility Option (SRO) Description**

Revision 20-1; Effective March 16, 2020

The Service Responsibility Option (SRO) is a service delivery option that empowers the member or legally authorized representative (LAR) to manage most day-to-day activities. This includes supervision of the employee providing personal assistance services and respite services.

The member or LAR decides how services are provided. SRO leaves the business details to the member's managed care organization's contracted provider. The rules for the SRO are found in [Texas Administrative Code, Title 40, Chapter 43](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=43).

See [Appendix XVII](https://hhs.texas.gov/laws-regulations/handbooks/sph/appendices/appendix-xvii-your-choice-deciding-how-manage-your-personal-assistance-services), It's Your Choice: Deciding How to Manage Your Personal Assistance Services, for a comparison of all available service delivery option features.

**8310 SRO Roles and Responsibilities**

Revision 20-1; Effective March 16, 2020

[Form 1582-SRO](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1582-sro-service-responsibility-option-roles-responsibilities), Service Responsibility Option Roles and Responsibilities, specifies the roles and responsibilities assigned to the member or legally authorized representative (LAR), provider and managed care organization (MCO). The member or LAR, provider and MCO receive and sign Form 1582-SRO indicating their agreement to accept the service responsibility option (SRO) responsibilities.

**8311 Managed Care Organization Responsibilities**

Revision 20-1; Effective March 16, 2020

The intake, referral and assessment procedures for members or legally authorized representatives (LARs) requesting service delivery through the service responsibility option (SRO) are handled in the usual way. The managed care organizations (MCOs) are responsible for:

* ensuring the member or LAR has an opportunity to make an informed choice by providing an objective and balanced review of the options; and
* monitoring the quality of services and service delivery.

Once the assessment is complete, the MCO is required to:

* inform the member or LAR about all options for managing eligible services; and
* review [Appendix XVII](https://hhs.texas.gov/laws-regulations/handbooks/sph/appendices/appendix-xvii-your-choice-deciding-how-manage-your-personal-assistance-services), It's Your Choice: Deciding How to Manage Your Personal Assistance Services, with the member or LAR to determine if the SRO is an appropriate choice.

In addition, the MCO's responsibilities include:

* presenting all service delivery options;
* documenting the member's or LAR’s choice on [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice;
* providing a list of contracted SRO agencies;
* explaining SRO rights, responsibilities and resources to the member or LAR;
* presenting the MCO-contracted provider list and the support consultation provider to the member or LAR;
* making a referral to the provider(s) selected by the member, LAR or representative;
* processing the member's or LAR’s request to change service delivery options;
* redeveloping the individual service plan (ISP) when a member's needs change;
* serving as a resource if the member has health or safety concerns, issues involving the attendant or other service-related concerns;
* convening a service planning team meeting in instances where the member:
  + has health and safety concerns;
  + is having difficulty selecting or keeping an attendant; or
  + has other issues relating to services that cannot otherwise be resolved; and
  + monitoring services in accordance with [Section 8322](https://hhs.texas.gov/laws-regulations/handbooks/sph/section-8000-service-delivery-options#8322), Monitoring.

**8312 Agency Responsibilities**

Revision 20-1; Effective March 16, 2020

The agency contracted with the managed care organization (MCO) is the attendant's Consumer Directed Services (CDS) employer and handles the business details (**for example**, paying taxes and doing the payroll). The agency also orients attendants to policies and standards before sending the attendants to members' homes.

The agency:

* discusses and negotiates potential back-up plans for those times when the attendant is absent from work;
* sends a maximum of three attendants, including any individuals recommended by the member, for the member to review;
* explains to the selected attendants that the agency is the CDS employer of record and the member is the day-to-day manager;
* provides agency time sheets to the member and orients the member to the time sheet submission process, including how frequently time sheets must be completed;
* receives and processes attendant time sheets;
* sends new attendants within the required time frame to interview at the member's or legally authorized representative’s (LAR’s) request; and
* orients the member or LAR to the agency's attendant evaluation process, including forms and the schedule for evaluating attendants.

**8313 Member Responsibilities**

Revision 20-1; Effective March 16, 2020

The member, legally authorized representative (LAR) or representative is responsible for most of the day-to-day management of the attendant's activities, beginning with interviewing and selecting the person who will be the attendant. To participate in the service responsibility option (SRO), the member must be capable of performing all management tasks as described below, or may identify a representative to assist or perform those management tasks on the member's behalf.

The member is responsible for:

* choosing the SRO;
* choosing the SRO service and support provider(s);
* meeting with the SRO support provider within 14 days of selecting the SRO;
* coordinating with the agency supervisor as part of the service planning process by:
  + negotiating the type, frequency and schedule of quality assurance contacts;
  + discussing any concerns about care management;
  + requesting on-site assistance while orienting a new attendant, if desired; and
  + negotiating to develop a back-up plan for when the attendant cannot come to work;
* selecting personal attendant(s) from candidates sent by the agency (including someone the person recommends to the agency supervisor or someone who has completed the agency pre-employment screening);
* informing the agency supervisor within 24 hours:
  + of the personal attendant selected;
  + if the attendant gives notice of his intention to quit;
  + if the attendant quits; or
  + if the member wants to dismiss the attendant;
* training the personal attendant on how to safely perform the approved tasks in the manner desired;
* supervising the personal attendant;
* ensuring the attendant only does the tasks authorized in the individual service plan (ISP) and works only the number of hours authorized in the ISP;
* complying with agency payroll and attendance policies;
* evaluating the attendant's job performance at the time designated by the agency;
* reviewing, approving and signing agency employee time sheets after the attendant completes them;
* ensuring employee time sheets are submitted to the agency within the time frames designated by the agency;
* notifying the agency as soon as possible if the personal attendant will be absent and a substitute is needed;
* taking responsibility for liability risk if the member or attendant is injured while doing tasks under the member's training and supervision;
* using the following complaint procedures:
  + If the agency is not fulfilling the expected responsibilities, address those issues directly with the agency. If the agency and the member or LAR are not able to resolve the concerns/issues, the member or LAR should contact the managed care organization (MCO).
  + If concerns and issues are still not resolved, the member or LAR may select another agency. The member or LAR must contact the MCO to transfer from one agency to another. The MCO will make all necessary arrangements for the transfer.
* notifying the MCO and/or agency supervisor of any health or safety concerns or issues with the attendant (the member or LAR may, at any time, request a service planning team (SPT) meeting); and
* notifying the MCO and agency supervisor if a change to either the agency option or Consumer Directed Services (CDS) is desired. An SPT meeting will be held to plan for the change.

**8320 Managed Care Organization (MCO) Procedures**

Revision 20-1; Effective March 16, 2020

The service responsibility option (SRO) is not a service; it is a service delivery option. All financial and non-financial eligibility criteria, including unmet need and "do not hire" policy, continue to apply for each program area. Unless otherwise stated in this section, MCO procedures are not impacted by the member's choice of SRO.

Complete all forms currently required, including the assessment of functional needs on [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060, and [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum. Continue to identify any caregivers who are currently providing for the member's needs.

**8321 Initial Authorization of Services**

Revision 20-1; Effective March 16, 2020

The member's or legally authorized representative’s (LAR’s) decision to receive services using the service responsibility option (SRO) does not change the manner in which initial services are authorized. See [Section 3300](https://hhs.texas.gov/laws-regulations/handbooks/sph/section-3000-starplus-hcbs-program-eligibility-services#3300), Administrative Procedures, for specific information.

**8322 Monitoring**

Revision 20-1; Effective March 16, 2020

All monitoring for service responsibility option (SRO) members is done by the managed care organization (MCO) according to the mandated schedule for its specific services. When health and safety issues arise, the MCO staff:

* discuss the issues with the agency staff;
* talk to the member or legally authorized representative (LAR) to determine if the issues can be resolved; and
* convene a service planning team meeting if the issue cannot be resolved.

Because the member or LAR now shares responsibility for service delivery, the MCO, in addition to other monitoring requirements, must monitor the member's or LAR’s:

* satisfaction with the SRO; and
* ability to comply with SRO requirements.

If it is evident that the member or LAR is having difficulty in the management of SRO responsibilities, the MCO staff must:

* consult the agency staff; and
* advise the member or LAR of the option to transfer back to the agency option.

**8323 Presentation of the SRO**

Revision 20-1; Effective March 16, 2020

Members or legally authorized representatives (LARs) must be offered the service responsibility option (SRO) by the managed care organization (MCO) annually, and may request a transfer to the SRO at any time. Additionally, the SRO must be presented to ongoing members or LARs at each annual reassessment or upon request. If the member or LAR is interested in transferring to the SRO, the member or LAR must sign [Form 1582-SRO](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1582-sro-service-responsibility-option-roles-responsibilities), Service Responsibility Option Roles and Responsibilities.

The MCO must ensure the member or LAR understands the responsibility they are assuming. The MCO must:

* send [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, to the agency to advise the agency of the member's or LAR’s selection;
* notify the agency the member or LAR will be contacting the agency for training;
* request the agency to advise the MCO, using Form H2067-MC, when the transition planning is complete; and
* negotiate a start date with the member and the agency.

**8400 Agency Option**

Revision 20-1; Effective March 16, 2020

**8410 Description**

Revision 20-1; Effective March 16, 2020

Under the agency option, the managed care organization (MCO) contracted provider is responsible for managing the day-to-day activities of the attendant and all business details. Most members or legally authorized representatives (LARs) select the agency option model because of the simplicity and convenience of receiving services. For example, under this option, the agency, not the member or LAR, is responsible for:

* locating qualified attendant(s) to provide services;
* any negligent acts or omissions by the attendant(s), and assumes liability for those acts;
* handling all conflicts with the attendant(s);
* any business details related to service delivery; and
* providing basic training for the attendant(s).