# SPH, Section 8000, Service Delivery Options

Revision 18-2; Effective September 3, 2018

## 8100 Selection of a Service Delivery Option

Revision 18-2; Effective September 3, 2018

All service coordinators must present delivery options to the applicant, member or legally authorized representative (LAR) at the initial assessment and each subsequent annual reassessment. Use [Appendix XVII](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xvii-sph-its-your-choice-deciding-how-manage-your-personal-assistance-services), It's Your Choice: Deciding How to Manage Your Personal Assistance Services, or a document created by the managed care organization (MCO) and with Health and Human Services Commission (HHSC) approval, to assist the applicant, member or LAR in making the service delivery decision.

MCOs must obtain a signature on [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice, indicating the member's choice of options. 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.

## 8110 Member Decision

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The managed care organization (MCO) must keep [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice, in the member's case record and ensure the member understands he or she may request a service delivery option change at any time by contacting the MCO.

## 8200 Consumer Directed Services

Revision 18-2; Effective September 3, 2018

## 8210 Overview

Revision 18-2; Effective September 3, 2018

Consumer Directed Services (CDS) allows members to hire and manage the people who provide their services within their current home and community-based 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.

A member or legally authorized representative (LAR) may elect 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 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 service plan for delivery through the CDS option; and
* recruits, screens, hires, trains, manages and terminates service providers.

A member or LAR, as the employer, may appoint in writing a willing adult as the DR to assist in performing employer responsibilities.

CDS is a service delivery option in which a member or LAR employs and retains service providers and directs the delivery of STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program services. A member participating in the CDS option is required to select and use an FMSA to provide FMS. FMS is assistance to members to manage funds associated with services elected for self-direction. This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. FMSA conducts a payroll function and pays employer federal and state taxes on behalf of CDS employers, and provides ongoing support for members who choose the CDS option. If requested, the FMSA may also assist with recruiting, screening, hiring, training, managing and terminating service providers.

**8211 Definitions**

Revision 18-2; Effective September 3, 2018

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 interdisciplinary 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.

**Designated representative (DR)** — An actively involved, willing adult appointed by the employer of record to assist with or perform the employer's required responsibilities to the extent approved by the employer. The DR is not the employer of record.

**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 of record** — The member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining service providers to deliver program services.

**Employer support services** — Services and items the member or LAR needs to perform employer and employment responsibilities, such as office equipment and supplies, support consultation, recruitment and payment of Hepatitis B vaccinations for employees.

**Financial management services (FMS)** —Services delivered by the FMSA to the member or LAR, such as 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 the managed care organization (MCO) to provide FMS.

**Legally authorized representative (LAR)** — A person authorized by law to act on behalf of a STAR+PLUS member, including a parent, guardian, 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.

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

**Support consultation** — An optional service that is provided by a support advisor and provides a level of assistance and training beyond that provided by the FMSA through FMS or Community First Choice support management. Support consultation helps an employer to meet the required employer responsibilities of the CDS option and to successfully manage the delivery of program services.

## 8212 STAR+PLUS Services Available Under the CDS Option

Revision 18-2; Effective September 3, 2018

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

* Personal assistance services (PAS);
* Community First Choice (CFC) PAS or Habilitation (PAS/HAB);
* In-home respite services;
* Skilled nursing;
* Employment assistance;
* Supported employment;
* Physical therapy;
* Occupational therapy;
* Cognitive rehabilitation therapy; and
* Speech language therapy.

STAR+PLUS members may choose to self-direct any or all services available through the CDS option. The CDS option is available to STAR+PLUS HCBS program members for one or more of their STAR+PLUS HCBS program services.

All applicants and ongoing members will be assessed for financial and functional eligibility under the STAR+PLUS HCBS program. Choosing the CDS option in no way impacts a member's eligibility for services. Members have the option of having the above services delivered through the service delivery option of their choice.

Financial management services (FMS), a required service under the CDS option, 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 the responsibilities of being an employer and adhering to legal requirements for employers. If requested, an FMSA can provide support consultation, which is extra help training, working with, and if necessary, dismissing an employee provided by a support advisor. FMSAs also conduct payroll and pay employer taxes on behalf of the employer. A monthly administrative fee is authorized on the individual service plan (ISP) and paid by the MCO to the FMSA for FMS.

## 8213 Advantages and Risks of the CDS Option

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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 a decision, information is presented by the service coordinator. Refer to [Section 8221](https://hhs.texas.gov/#8213), Presentation of the CDS Option.

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* pay raises, direct service providers, using funds from the CDS budget and in consultation with the financial management service agency (FMSA)
* direct service providersestablished by the managed care organization (MCO) or the wage floor established by the Texas Legislature
* may be able to recruit eligible service providers, including family members, friends and other persons they know;
* can appoint an eligible person as a designated representative (DR) to assist with or perform employer responsibilities; andservice providers and supervising the services delivered by the service providers

## 8213.2 Risks and Liability Associated with the CDS Option

Revision 18-2; Effective September 3, 2018

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 employer in the CDS option, and therefore assumes all liability related to employment. The member or LAR retains control over hiring, managing, and firing employees. The persons providing services are not the employees of the FMSA, the managed care organization (MCO), any state or federal agency, or other contracted provider agency. The member or LAR is solely responsible and liable for any negligent acts or omissions as the employer or by the employee, other employees, service providers, or the designated representative (DR);
* responsible for handling all conflicts with their employees. The FMSA and HCSSA are not involved;
* 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 member or LAR 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; and
* responsible for meeting all requirements as an employer and can be held liable for failure to meet those requirements.

## 8214 Member and Financial Management Services Agency Responsibilities

Revision 18-2; Effective September 3, 2018

## 8214.1 Member Responsibilities

Revision 18-2; Effective September 3, 2018

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

An employer or designated representative (DR) hires and is responsible and liable for a person, contractor or vendor hired to deliver program services.

An employer is responsible for:

* service planning with the individual's service planning team (SPT);
* budgeting allocated program funds in the individual's service plan (ISP) for services delivered through the Consumer Directed Services (CDS) option;
* determining compensation for service providers within the service rate and spending limits established by the Texas Health and Human Services Commission (HHSC);
* ensuring that employees and contractors are paid for services delivered based on an hourly rate;
* recruiting, screening, hiring and training qualified employees in accordance with qualifications and other requirements of the member's program;
* recruiting, screening and retaining qualified contractors;
* managing and terminating service providers;
* following state and federal employment 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 employee and service provider concerns and complaints;
* maintaining a personnel file on each service provider;
* developing and implementing backup service plans for services determined by the person-centered service planning team to be critical to the member's health and welfare; and
* ensuring protection of the member receiving services and preserving evidence in the event of a Department of Family and Protective Services (DFPS) Adult Protective Services (APS) investigation of an allegation of abuse, neglect or exploitation (ANE) against a CDS employee, DR, 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 18-2; Effective September 3, 2018

A financial management services agency (FMSA) must provide financial management services (FMS) to an employer or designated representative (DR), including:

* providing initial orientation as described in this section;
* providing ongoing training, assistance and support for employer-related responsibilities;
* conducting criminal history checks and registry checks of applicants;
* verifying eligibility and qualifications of applicants before services are delivered;
* monitoring continued eligibility of service providers;
* approving and monitoring budgets for services delivered through the Consumer Directed Services (CDS) option;
* managing payroll, including calculations of employee withholdings and employer contributions and depositing these funds with appropriate agencies;
* complying with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings and benefits;
* preparing and filing required tax forms and reports;
* paying allowable expenses incurred by the employer;
* providing status reports concerning the member's budget, expenditures, and compliance with CDS option requirements to the employer and service coordinator at least quarterly; and
* responding to the employer or DR as soon as possible, but at least within **two business days** after receipt of information requiring a response from the FMSA.

The FMSA must obtain employer-agent status 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 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

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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 service coordinator at all initial and annual planning meetings or at any time requested by the member. The service coordinator should provide written and oral information about the benefits and requirements of the CDS option.

## 8221 Presentation of the CDS Option

Revision 18-2; Effective September 3, 2018

At the time of a member's enrollment in a STAR+PLUS or a STAR+PLUS HCBS program that offers the Consumer Directed Services (CDS) option, and at least annually thereafter, a case manager, service coordinator or other 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 an oral explanation of the CDS option specific to the member's program;
* present or make available to the member, the Health and Human Services Commission (HHSC) video, The Consumer Directed Services Option, which can be accessed by visiting <https://hhs.texas.gov/cds>; and
* complete Form 1581, Consumer Directed Services Option Overview.

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

A member or LAR declining participation in the CDS option may at any time elect to participate in the CDS option while receiving services through STAR+PLUS.

The 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 service coordinator:

* shares an overview of the benefits and responsibilities of the CDS option by reviewing Form 1581;
* provides a copy of Form 1581 to the applicant or member; and
* informs the applicant or member of the right to choose service delivery through the agency option or the CDS option.

For initial applications, the service coordinator obtains the applicant's signature on Form 1581 at the initial contact. The 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 service coordinator provides the member with a copy of Form 1581 and clearly documents in the case record that Form 1581 was shared with the member.

When members request information about the CDS option at other times, the service coordinator must provide CDS information to the member within **five business days** after receipt of the request. The service coordinator may provide the information by making a home visit or contacting the member by telephone. If a home visit is not made, the service coordinator obtains the member's signature by mailing Form 1581 to the member with a postage-paid and return envelope. The 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 service coordinator must discuss the CDS option, as well as differences in service delivery and payment options, and allow the member the opportunity to choose between delivery of services through the agency option or the CDS option.

If the member is interested in participating in the CDS option once the information on Form 1581 is shared, the 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 service coordinator:

* reviews with the member or legally authorized representative (LAR) the responsibilities, risks, and advantages of the CDS option;
* assists the member as needed in completing the member self-assessment on Page 4 of Form 1582;
* records the member's or LAR's choice if he or she is willing and able to participate in the CDS option to designate a representative (DR), or records choice not to participate in the CDS option;
* assists the member or LAR in selecting and designating the DR, or his or her choice not to participate;
* obtains the DR's dated signature if the member or LAR chooses to designate a DR;
* obtains the member's or LAR's dated signature on Form 1582; and
* signs and dates Form 1582.

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

If an employer would like to use a DR, the financial management services agency (FMSA) assists the employer in appointing a DR.

Refer to [Section 8223](#8223), Designated Representative, for procedures related to a member appointing a DR.

## 8222 Member Choice and Enrollment in the CDS Option

Revision 18-2; Effective September 3, 2018

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

(1) Form 1582, Consumer Directed Services Responsibilities

(2) Form 1583, Employee Qualification Requirements;

(3) Form 1584, Consumer Participation Choice;

(4) Form 1585, Acknowledgement of Responsibility for Exemption from Nursing Licensure for Certain Services through Consumer Directed Services, or Form 1733, 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, 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) in order to participate in the CDS option. 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, and any assessment required by the member's program.

The 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).

## 8222.1 Choosing an FMSA and the CDS Option

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The service coordinator presents a list of contracted financial management services agencies (FMSAs) and home and community support services (HCSS) providers. The member must select:

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

If the member or legally authorized representative (LAR) chooses and is able to participate in the Consumer Directed Services (CDS) option, the 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 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; and
* signs and dates the forms.

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

## 8222.2 Declining the CDS Option

Revision 18-2; Effective September 3, 2018

If the member or legally authorized representative (LAR) declines or is not ready to select 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 service coordinator:

* obtains the applicant's, member's or LAR's signature on Form 1584, Consumer Participation Choice, indicating his or her selection of service delivery options; and
* signs and dates Form 1584.

The service coordinator must ensure the member understands the CDS option is always available and that the member may call the 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 18-2; Effective September 3, 2018

The member or legally authorized representative (LAR) has the option of designating a representative to assist with the responsibilities of being an employer in the Consumer Directed Services (CDS) option. An employer may appoint a willing adult as a designated representative (DR) to assist or to perform employer responsibilities. The employer maintains responsibility and accountability for decisions and actions taken by the DR. If the employer chooses to appoint or change a DR, the employer must complete Form 1720, Appointment of Designated Representative. The employer must notify the financial management services agency (FMSA) by fax or telephone within **two business days** after the appointment or change of a DR.

* If the employer notifies the FMSA by telephone, the 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 an employer decides to revoke the appointment of a DR, the employer must:

* complete Form 1721, Revocation of Appointment of Designated Representative; and
* provide a copy of the completed form to the FMSA within two days after the effective date of the revocation.

Based on documentation provided by the FMSA of an employer's inability to meet employer responsibilities, the person-centered service planning team may recommend that the employer designate a DR to assist with or to perform employer responsibilities. A DR must not:

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

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

Revision 18-2; Effective September 3, 2018

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 ceilings;
  + reviewing services; and
  + obtaining approval for planned services.

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

All 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 different service; it is a service delivery option. The 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 system to assure the provision of all authorized personal assistance services (PAS) without a service break, even if there are unexpected changes in personnel. The member or legally authorized representative (LAR) must develop and receive approval from the service coordinator for each required service back-up plan in order to participate in the CDS option. Refer to [Section 8245](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-8000-sph-service-delivery-options#8245), Service Back-Up Plans.

If the member 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), 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.

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

In CDS or the Service Responsibility Option (SRO), 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 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 Employer Support Services in the CDS Option

Revision 18-2; Effective September 3, 2018

An employer or designated representative (DR) may budget 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. Employer support services include employment-related expenses, employer-related expenses and support consultation services. Employer support services exclude non-allowable expenditures listed in Appendix XI, 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.

An 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;
* purchased 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.

An employer or DR may budget employer-related services, goods or items required to meet 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*.*

An employer or DR may budget up to 10 percent of the amount available, after the FMSA portion is calculated, in those services delivered by one or more employees. An 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 employer support services.

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 an employer, an employer's DR, or a member receiving services through the CDS option if that member will be the 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 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, 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 employer responsibilities in the CDS option;
  + developing, revising and implementing service back-up plans;
  + performing employer responsibilities;
  + complying with the member's program and this section; and
  + developing ongoing decision making skills for employer-related and employment-related situations.

An 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 employer or DR must:

* identify the person or persons (the employer, the DR, or the member within six months after becoming the 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, employer or DR); and
* terminate the service when goals are met.

## 8240 Initiation of and Transition to the CDS Option

Revision 18-2; Effective September 3, 2018

Within **five business days** after receipt of a completed Form 1584, 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 service coordinator or service coordinator must provide the following documentation to the financial management services agency (FMSA):

* Form 1584;
* the individual service plan (ISP);
* date the employer may begin incurring expenses to initiate start-up activities and to incur recruitment and hiring expenses;
* date the employer may begin delivery of program services through the 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.

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

The 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 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 service coordinator must emphasize that the applicant assumes all responsibility for arranging their self-directed services.

Members who participate in the CDS option and choose to transfer back to the Agency Option (AO) will not have the choice of returning to the CDS option for at least 90 days.

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 18-2; Effective September 3, 2018

Upon choosing to participate in the Consumer Directed Services (CDS) option, an 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;
* complete and maintain a copy of Form 1736, Documentation of Employer Orientation by Financial Management Services Agency, upon completion of the orientation;
* complete Form 1735, Employer and Financial Management Services Agency Service Agreement, with the program addendums, if applicable;
* complete Form 1726, Relationship Definitions in Consumer Directed Services;
* as required by the member's program, complete Form 1733, Employer and Employee Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, or Form 1585, Acknowledgement of Responsibility for Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services;
* complete Form 1728, 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 service coordinator, the FMSA completes the initial employer orientation with the member, legally authorized representative (LAR) or designated representative (DR) (if one is appointed) in the member's residence. The FMSA provides an overview of the CDS option, including the rules and requirements of applicable government agencies, and the roles of the 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, managed care organization (MCO) and state agencies, including:
  + the 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 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 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 employer's records; and
  + if applicable, nursing requirements as described on Form 1747, Acknowledgement of Nursing Requirements; and
* review and leave with the employer and DR, if applicable, printed information on how to report allegations of abuse, neglect and exploitation.

The FMSA must provide to the employer or DR a printed or electronic copy of the HHSC *CDS Option Employer Manual*.

Upon conclusion of the orientation, the FMSA and employer must complete Form 1736, 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 employer before initiation of the CDS option.

The member, LAR 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 member and FMSA notify the 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 18-2; Effective September 3, 2018

The financial management services agency (FMSA) assists the member, legally authorized representative (LAR) or designated representative (DR) in completing the employer and employee acknowledgment. The employee acknowledges that, as the person who delivers the service, he or she has 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 assists the member, LAR or DR in hiring or retaining service providers in accordance with qualifications and other requirements of the STAR+PLUS Home and Community Based Services (HCBS) program.

## 8243 Authorizing CDS

Revision 18-2; Effective September 3, 2018

When the member or legally authorized representative (LAR) and financial management services agency (FMSA) notify the service coordinator that CDS services are ready to begin, the service coordinator negotiates a start date for services. The service coordinator revises [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-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 member, LAR and the FMSA to ensure that the expenditures for the year remain within the authorized amount. The managed care organization (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 their services.

## 8244 CDS Service Planning

Revision 18-2; Effective September 3, 2018

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

An employer or designated representative (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 service coordinator.

An 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 with documentation of circumstances that require a revision to the ISP.

The MCO and STAR+PLUS Home and Community Based Services (HCBS) program interdisciplinary team (IDT) members make up the person-centered service planning team for the member who selects the CDS option. The MCO convenes the IDT as required by STAR+PLUS HCBS program policy and obtains approvals as appropriate from IDT members. The MCO and IDT 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 employer and service coordinator (SC) and document and notify the managed care organization (MCO) of issues or concerns, including:

* allegations of abuse, neglect, exploitation or fraud;
* concerns about the member's health, safety or welfare;
* non-delivery or extended breaks in services;
* noncompliance with 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 HCBS program.

The member 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, LAR or DR and if agreed to by the FMSA. Within three days after receiving a request from the member, LAR, DR, MCO or other involved parties, the FMSA must provide information related to the member's participation in the CDS option.

The MCO and IDT 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 8245 below and [Section 8246](#8246), Corrective Action Plans.

## 8245 Service Back-Up Plans

Revision 18-2; Effective September 3, 2018

An employer or designated representative (DR) must develop and document a service back-up plan for each service to be delivered through the Consumer Directed Services (CDS) option that the person-centered service planning team has determined to be critical to the health and welfare of the member.

The person-centered service planning team must describe which services are critical and the length of time that constitutes a service interruption or an emergency for the member. An employer or DR must develop a service back-up plan that:

* ensures the provision of services when the employer's regular service provider is not available to deliver the service or in an emergency; and
* 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 individual service plan (ISP).

The managed care organization (MCO) must discuss with the member, legally authorized representative (LAR) or DR the services delivered through CDS that are critical to the member's health and welfare. The MCO must inform the member, LAR 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 member, LAR or DR must develop a back-up system to assure the provision of all authorized personal assistance services without a service break.

The member, LAR or DR, with the assistance of the MCO (if needed), completes [Form 1740](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1740-service-backup-plan), Service Backup Plan. The service back-up plan must list the steps the member, LAR or DR implements in the absence of the 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 member, LAR 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. The MCO and interdisciplinary team (IDT), as appropriate, approve the plans as being viable in the event a service provider is absent. The MCO or IDT must approve each service back-up plan and any revision before implementation by the member, LAR or DR. The MCO approves the service back-up plan by signing, dating and returning a copy of the plan to the member, LAR or DR.

The member, LAR 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 IDT.

The FMSA must assist a member, LAR or DR as requested to revise budgets to:

* meet service back-up plan strategies approved by the member's IDT;
* 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 member, LAR or DR.

## 8246 Corrective Action Plans

Revision 18-2; Effective September 3, 2018

A written corrective action plan may be required from an employer or designated representative (DR) if the 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 Consumer Directed Services (CDS) option;
* does not meet other employer responsibilities.

The member, legally authorized representative (LAR) or DR must provide written corrective action plans (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), Health and Human Services Commission (HHSC) staff or interdisciplinary team 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 member, LAR or DR may request assistance in the development or implementation of a CAP from the:

* FMSA or others, if the plan is related to employer responsibilities; and
* MCO, if the CAP is related to the 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.

## 8246.1 Terminating the CDS Option

Revision 18-2; Effective September 3, 2018

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. Termination from the CDS option must last at least 90 days.

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

* the member's health or welfare 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); or
* HHSC or another government agency with applicable regulatory authority recommends that participation in the CDS option be immediately terminated.

If a member, LAR or DR does not implement and successfully complete the following steps and interventions, a member's service planning team may recommend termination of participation in the CDS option in accordance with the member's program requirements:

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

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

* provide documentation to the member's service coordinator of additional and ongoing training and supports provided by the FMSA when an employer or DR demonstrates noncompliance with employer responsibilities;
* provide assistance requested by the employer or DR to develop and implement a corrective action plan;
* provide documentation of any corrective action plan required of the employer or DR by the FMSA in accordance with this section; and
* notify the 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 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 member, employer or DR to eliminate noncompliance with program requirements for delivery of program services through the CDS option; and
* convene the service planning team 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 welfare for continued participation in the CDS option; and
  + make revisions to the member's service plan if needed.

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

* the reasons for the recommendation;
* the conditions and time frame established by the member's service planning team 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 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.

## 8246.2 Re-enrollment in the CDS Option

Revision 18-2; Effective September 3, 2018

Following termination of participation in the Consumer Directed Services (CDS) option, a member or LAR must request re-enrollment in the CDS option by notifying the member's service coordinator. If a member or LAR wishes to re-enroll in the CDS option, the 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 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 service planning team 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 employer or DR has not received initial orientation; and
* notify the employer, DR, and the member's 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.

## 8247 Budgets

Revision 18-2; Effective September 3, 2018

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

* develop a budget for each program 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 HHSC at <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/consumer-directed-services-cds/cds-forms-handbooks>;

* request assistance from the FMSA as needed;
* submit each budget to the FMSA for review; and
* obtain written approval for each budget from the FMSA before initiating services or making purchases for payment.

The member, legally authorized representative (LAR) or DR develops a budget for each STAR+PLUS Home and Community Based Services (HCBS) program service to be delivered through the CDS option based on the projected expenditures allocated in the ISP period.

The member, LAR or DR develops an initial and annual budget and receives written approval from the FMSA before implementation of the budget and initiation of service delivery through the CDS option.

The FMSA must provide assistance as requested or needed by the member, LAR or DR to develop a budget. The FMSA reviews the member's budgeted payroll spending decisions, verifies the applicable budget workbooks are within the approved budget, and notifies the member in writing of budget approval or disapproval. The FMSA must work with the member, LAR or DR to resolve issues that prevent the approval of budget plans.

### **Budget Revisions and Approval**

An 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;
* strategies are added or 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 service coordinator, the person-centered service planning team, or an HHSC representative require a revision.

The member, LAR 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 member, LAR or DR with budget revisions as requested or needed by the member, validate the budget, and provide written approval to the member, LAR or DR.

The managed care organization (MCO) evaluates ISP changes requested by the member and participates in the interdisciplinary team meetings to resolve issues when the member does not follow the budget or comply with CDS option budget requirements.

## 8300 Service Responsibility Option (SRO) Description

Revision 18-2; Effective September 3, 2018

SRO is a service delivery option that empowers the member to manage most day-to-day activities. This includes supervision of the employee providing personal assistance services and respite services.

The member decides how services are provided. SRO leaves the business details to the member's managed care organization’s contracted provider. See [Appendix XVII](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xvii-sph-its-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 18-2; Effective September 3, 2018

[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, provider and managed care organization (MCO). The member, provider and MCO receive and sign Form 1582-SRO indicating their agreement to accept the service responsibility option (SRO) responsibilities.

## 8311 MCO Responsibilities in the SRO

Revision 18-2; Effective September 3, 2018

The intake, referral and assessment procedures for members 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 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 about all options for managing eligible services; and
* review [Appendix XVII](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xvii-sph-its-your-choice-deciding-how-manage-your-personal-assistance-services), It's Your Choice: Deciding How to Manage Your Personal Assistance Services, with the member 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 choice on [Form 1584](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1584-consumer-participation-choice), Consumer Participation Choice;
* explaining SRO rights, responsibilities and resources to the member;
* presenting the MCO-contracted provider list and the support consultation provider to the member;
* making a referral to the provider(s) selected by the member;
* processing the member'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 an interdisciplinary 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/starplus-handbook/section-8000-sph-service-delivery-options#8322), Monitoring.

## 8312 Agency Responsibilities

Revision 18-2; Effective September 3, 2018

The agency contracted with the managed care organization (MCO) is the attendant's 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 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 request; and
* orients the member to the agency's attendant evaluation process, including forms and the schedule for evaluating attendants.

## 8313 Member Responsibilities

Revision 18-2; Effective September 3, 2018

The member or designated representative (DR) 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 DR to assist or perform those management tasks on the member's behalf.

The member is responsible for:

* choosing the SRO service delivery option;
* 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 are not able to resolve the concerns/issues, the member should contact the managed care organization (MCO).
  + If concerns and issues are still not resolved, the member may select another agency. The member 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 may, at any time, request an interdisciplinary team (IDT) meeting); and
* notifying the MCO and agency supervisor if a change to either the Agency Option (AO) or Consumer Directed Services (CDS) is desired. An IDT meeting will be held to plan for the change.

## 8320 Managed Care Organization (MCO) Procedures

Revision 18-2; Effective September 3, 2018

The service responsibility option (SRO) is not a different 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 18-2; Effective September 3, 2018

The member'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/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3300), Administrative Procedures, for specific information.

## 8322 Monitoring

Revision 11-2; Effective June 1, 2011

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 to determine if the issues can be resolved; and
* convene an interdisciplinary team meeting if the issue cannot be resolved.

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

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

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

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

## 8323 Presentation of the SRO

Revision 18-2; Effective September 3, 2018

Members 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 at each annual reassessment or upon request. If the member is interested in transferring to the SRO, the member 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 understands the responsibility he or she is assuming. 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 it of the member's selection. Notify the agency the member will be contacting it for training. Request the agency to advise the MCO, using Form H2067-MC, when the transition planning is complete. Negotiate a start date with the member and the agency.

## 8400 Agency Option

Revision 18-2; Effective September 3, 2018

## 8410 Description

Revision 18-2; Effective September 3, 2018

Under the Agency Option (AO), the managed care organization contracted provider is responsible for managing the day-to-day activities of the attendant and all business details. Most members select the AO model because of the simplicity and convenience of receiving services. For example, under AO, the agency, not the member, 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).