Office for People With Developmental Disabilities

Liability for Services Regulations

Quick Reference Guide

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In 2009 and 2010, the Office for People With Developmental Disabilities (OPWDD) promulgated regulations concerning liability for services for certain Medicaid and OPWDD Home and Community Based Services (HCBS) Waiver funded services. This document is intended as a quick reference guide to assist you in complying with the regulations.

The processes described in this document are based on the provisions contained in 14 NYCRR §635-12. This regulation requires individuals with developmental disabilities who wish to receive specific Medicaid funded OPWDD service(s) to apply and be approved for “Full Medicaid Coverage”. “Full Medicaid Coverage” is defined as the minimum level of Medicaid coverage necessary to pay for the services being requested or received. Additionally, if an individual wants to receive an OPWDD HCBS Waiver service, the individual must take all necessary steps to enroll in the HCBS Waiver[1].

The regulations impose different requirements depending on whether a service is ‘other than preexisting’ or ‘preexisting’. Other than preexisting services are those that started on or after the date the regulations went into effect for the specific service. Preexisting

[1] If services other than those provided through the HCBS Waiver are being requested, eligibility requirements may differ. For example, individuals requesting placement in a Voluntary Operated Intermediate Care Facility (VOICF) will require an ICF Level of Care Eligibility Determination (LCED).

services are those that an individual was receiving on a regular basis at the time the regulations were implemented for the specific services. The implementation dates were:

February 15, 2009 for ICF/IDD facilities; Residential Habilitation delivered in IRAs, CRs, and Family Care; and Day Habilitation

March 15, 2010 for Care Management (formerly Medicaid Service Coordination)[2], Day Treatment Services, Community Habilitation (formerly At Home Residential Habilitation), Prevocational Services, Supported Employment Services (SEMP), Respite Services, and Blended and Comprehensive Services

What You Need to Know About Enrollment in 'Other than Preexisting' Services

The enrollment processes for services are often initiated by a service provider in response to a request for services from an individual. The request may be from an individual not yet receiving services or from an individual already receiving services who wishes to receive new or additional services.

The Service Provider

1. The service provider must verify with the DDRO that they have determined the person has a developmental disability or request initiation of the OPWDD eligibility determination process to determine whether the person has a developmental disability.[3]
2. The service provider conducts a pre-admission review. They meet with the individual, the individual's representatives (family members and/or advocates), and the individual's care manager to determine what services the individual is requesting and what services can be provided for the individual. The service provider presents the individual and/or liable party with a liability notice and the fee schedule for each service requested.
3. The service provider is responsible for verifying the Individual's Medicaid and/or HCBS Waiver status. The provider should confirm the individual's Medicaid using ePaces, contacting the Local Department of Social Services (LDSS) Medicaid unit, by documentation received from the individual, or reviewing CHOICES. If the Medicaid status cannot be confirmed using these sources or there are questions pertaining to the individual's Medicaid status, the local Revenue Support Field Office should be contacted for assistance. HCBS Waiver status can be confirmed in CHOICES or by the DDRO.

[2] This includes "Service Coordination", including non-Medicaid case management, Medicaid Service Coordination (MSC), mirrored MSC, state paid/funded MSC, or case management.

[3] If the service provider is already in possession of valid documentation verifying the individual's developmental disability status, this step may be omitted. If there is any doubt as to the validity of the documentation, the service provider must contact the responsible DDRO to verify the applicant's eligibility for OPWDD services.

For Individuals Already Enrolled in Medicaid and/or the HCBS Waiver

i. The service provider uses CHOICES or submits the Developmental Disabilities Profile 1 (DDP1) or CCO1 form to the DDRO to add the individual to the appropriate program(s) in OPWDD's Tracking and Billing System (TABS).
ii. The service provider begins services for the individual once DDRO approval is received.

b. ***For Individuals Not Enrolled in Medicaid***

i. The service provider requests that the individual or the individual's representative complete a Benefit Eligibility Questionnaire Form.
ii. The service provider works with the individual, their representatives, and the care manager to initiate the Medicaid and/or HCBS Waiver enrollment process by simultaneously submitting the Medicaid application to the LDSS Medicaid unit and contacting the HCBS Waiver Coordinator at the responsible DDRO.

c. ***For Individuals Enrolled in Medicaid, but not the HCBS Waiver***

i. The service provider works with the individual, their representatives, and the care manager to initiate the HCBS Waiver enrollment process by submitting an HCBS Waiver application to the DDRO.

d. ***For Individuals Who Appear Ineligible for Medicaid and/or the HCBS Waiver***

i. If the individual has previously been denied or terminated from Medicaid, the service provider should discuss their eligibility with the LDSS Medicaid unit, take action(s) to help the person become Medicaid eligible, and file a Medicaid application.
ii. If it is determined that the individual has previously been denied or terminated from enrollment in the HCBS Waiver, an eligibility reassessment should be discussed with the responsible DDRO. The reassessment could lead to the individual reapplying for Waiver enrollment and subsequently being found eligible.
iii. If an individual wishes to receive services but does not wish to comply with the requirements necessary to obtain funding for the services (enrolling in Medicaid and/or the HCBS Waiver), the service provider must determine if they will provide services to the individual in the absence of Medicaid and OPWDD funding. Service providers are not obligated to provide "other than preexisting services" to individuals unless subject to a court order.[4]

[4] State payments from OPWDD are not available for individuals who do not fully comply with the requirements necessary to obtain funding for the services (enrolling in Medicaid and/or the HCBS Waiver). Full compliance includes taking action(s) to obtain/maintain financial eligibility for Medicaid, such as divesting or sheltering excess resources and paying a Medicaid spenddown.

4. If the service provider received OPWDD payments for an individual who is later approved for Medicaid funding of the service(s) and enrolled in the HCBS Waiver, the service provider must submit claims to eMedNY for Medicaid reimbursement retroactive to the onset of Medicaid funding eligibility (i.e. the effective date of Medicaid eligibility or, for HCBS Waiver services, the HCBS Waiver enrollment date). OPWDD will recover any state payments made for services that are subsequently funded by Medicaid.

The service provider can opt to provide services to an individual while Medicaid and/or HCBS Waiver enrollment are pending. The individual and/or liable party are liable for the full cost of services. OPWDD payments will not be considered while eligibility for Medicaid and/or the HCBS waiver are pending. The service provider can waive or reduce fees owed by the individual or liable party at their discretion, with the understanding that OPWDD payments are not available when such concessions are granted.

The Individual and Their Representatives

1. An individual must obtain and maintain "Full Medicaid Coverage".
2. If an individual wants to receive an OPWDD HCBS Waiver service, the individual must take all necessary steps to enroll in the HCBS Waiver.
3. An individual who does not obtain Medicaid and/or HCBS Waiver enrollment to pay for services is liable for the full cost of services.

The Care Manager

1. The care manager works with the individual, their representatives, and the service provider to initiate the Medicaid and/or HCBS Waiver enrollment process by submitting a complete, fully documented Medicaid application to the LDSS Medicaid unit and providing needed documentation and paperwork to the HCBS Waiver Coordinator at the responsible DDRO.
2. The care manager works with the individual, their representatives, and the service provider to maintain Medicaid and/or HCBS Waiver eligibility, including responding in a timely fashion to requests for additional information, and appealing adverse decisions.

The Developmental Disabilities Regional Office (DDRO)

1. The DDRO determines if an individual is eligible for OPWDD Services and issues a Notice of Decision (NOD) reflecting the determination of developmental disability.
2. The DDRO adds program enrollments to TABS by responding to CHOICES entry or DDP1 and CCO1 forms received from the service provider.
3. The DDRO processes HCBS Waiver Enrollment:
    a. Processes the HCBS Waiver application.
    b. Issues a Notice of Decision (NOD) reflecting the determination made concerning the HCBS Waiver enrollment application.
    c. Enrolls the individual in the HCBS Waiver in TABS if the individual meets all HCBS Waiver eligibility requirements.

d. Notifies the service provider(s) if the individual has been determined eligible for HCBS Waiver enrollment.
e. Evaluates whether a request for state funding of the services should be submitted to the DDRO Director or Authorized Designee and OPWDD's Central Office if the individual does not qualify for HCBS Waiver enrollment.
f. Advises the service provider of the state funding decision.

4. DDRO contact information can be located on our website.

The Revenue Support Field Office (RSFO)

1. RSFO provides Medicaid technical assistance to the individual, their representatives, service providers, care managers, and the DDRO. This may include evaluating eligibility, reviewing Medicaid applications and denial notices, and providing advisement pertaining to appeals.
2. RSFO reviews requests for state funding received from the DDRO, including:
   a. Any fees to be charged to the individual or, if an individual is under the age of 21 and living in a parent's household, the individual's parents.
   b. Potential Medicaid eligibility.
   c. Approval/denial of "Fee Reduction/Waiver for Preexisting Services Request for Approval (OPWDD LIAB 04)" forms.

DDRO Director or Authorized Designee

DDRO Director or Authorized Designee responds to requests for temporary and extended state funding and informs the service provider of an authorization or denial.

Revenue Support Central Operations

1. Revenue Support Central Operations screens claims submitted by service providers, including:
   a. Date of enrollment.
   b. Eligibility for services.
   c. Authorization for state funding for the period approved by the DDRO Director or Authorized Designee.
2. Revenue Support Central Operations monitors services recorded by service providers on web-based applications.
3. Revenue Support Central Operations maintains a database of individuals authorized for state funding.
4. Revenue Support Central Operations processes service provider claims for state funding.
5. Revenue Support Central Operations issues payments for delivered services.
6. Revenue Support Central Operations can be contacted by email at central.operations@opwdd.ny.gov.

Limited Exception for Respite Services

Effective March 15, 2010, if an individual is applying for or receiving Respite services, and no other service(s) covered by the liability for services regulations, s/he qualifies for a limited exception. An individual who qualifies for the limited exception for Respite is not subject to the provisions listed under NYCRRR §635-12.2 through 635-12.10. Specifically, s/he is not required to pay for services or pursue Medicaid and HCBS Waiver enrollment. However, if an individual is receiving Medicaid funding of the service (i.e., Medicaid and Waiver enrolled), at any time on or after March 15, 2010, s/he does not qualify for the limited exception.

Agencies providing Respite services must provide a liability notice (OPWDD LIAB 07) to each individual who meets the criteria for the limited exception prior to service commencement for “other than preexisting services”.

The individual is obligated to notify the Respite provider if s/he applies for other covered services. Providers of the other service(s) must notify the Respite provider if an individual applies for a covered service. Both providers must issue a liability notice to the individual:

- The Respite provider must notify the individual that s/he will no longer be eligible for the limited exception by issuing liability notice, OPWDD LIAB 08.
- Providers of the other service(s) must notify the individual that s/he will no longer be eligible for the limited exception by issuing liability notice, OPWDD LIAB 09.

Limited Exception for Supported Employment

As of July 1, 2015, anyone enrolling in SEMP services, whether or not they are receiving any other services, must pay for them or have the type of Medicaid that pays for them. Individuals already enrolled in SEMP, who qualified for the limited exception on June 30, 2015, may remain eligible if certain criteria are met. Information can be found in notice OPWDD LIAB 15.

Funding for Pre-existing Services

For individuals receiving pre-existing services, the service provider may continue to receive state funding for the pre-existing services if the service provider has complied with the provisions specified in the regulations. The provisions include but are not limited to, providing the individual and/or liable party with a liability notice, and billing and pursuing collection of the full cost of services if the individual does not have “Full Medicaid Coverage”.

OPWDD *may* provide funding when all the following conditions have been met:

1) The individual is not paying for the preexisting services and no one else is paying for the services for the individual; and
2) The individual does not have full Medicaid coverage; and
3) The provider is meeting its obligations; and
4) OPWDD was paying the provider for the preexisting services immediately prior to the preexisting compliance date, or the individual had full Medicaid coverage immediately prior to the preexisting compliance date.

Appendix 1
Rules for Determining Waived or Reduced Fees for OPWDD Preexisting Services

Appendix 2
Billing and Collection for OPWDD Services

Additional References:
Benefit Development Resource Guide
Billing Account Notice OPWDD LIAB 03 (fillable form)
Fee Reduction/Waiver for Preexisting Services Request for Approval (fillable form)
Liability for Services Overview and Resources
Quick Reference Guide Appendix 1
Quick Reference Guide Appendix 2
Statewide Learning Management System (SLMS) Training