



May 2011

**Q1. Where are the reference materials and forms related to the liability for services regulations located?**

A1. On the OPWDD website under News and Publications/Benefits Information at: <http://www.OPWDD.state.ny.us/wt/publications/msc/index.jsp>

**Q2. What ramifications does the provider agency face if information is not returned by the identified deadline from the liable party?**

A2. The service provider must comply with the requirements in the regulations to request information, but the provider is not responsible for compelling the person or liable party to provide information. If an individual or liable party does not provide the information requested, and Medicaid is not paying for the service, s/he must be billed the full fee for the service.

<b>Noticing:</b>
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**Q3. How do service providers determine who must receive a liability notice?**

A3. All individuals who are requesting or receiving the following services from a provider (except for state-operated services) regardless of the funding source are covered by the regulations and must receive a liability notice: day habilitation; residential habilitation provided in an Individualized Residential Alternative (IRA), family care, or community residence (CR); ICF/DD; Medicaid service coordination; day treatment; prevocational services; community habilitation (formerly named at home residential habilitation); supported employment; respite; blended services and comprehensive services.

See the instructions for the liability notice forms on the OPWDD website, referenced in A1 above, for guidance.

**Q4. The regulation requires us to notify all people and liable parties receiving preexisting services about their obligation to pay for services. Is that only for people who are currently state funded or for all people regardless of funding type? What about Family Support Services or county funded services?**

A4. You will have to notify all people receiving preexisting services that are covered by the regulations, regardless of funding type. The following services are



considered preexisting if they occurred before February 15, 2009: day habilitation; residential habilitation provided in an IRA, family care, or community residence; and ICF/DD services. The following services are considered preexisting if they occurred before March 15, 2010: Medicaid service coordination; day treatment; prevocational services; community habilitation (formerly named at home residential habilitation); supported employment; respite; blended services and comprehensive services. Notices do not have to be provided for any other types of services at this time.

**Q5. If someone is about to receive our services and already has Medicaid and is Waiver enrolled, do we still need to send them a Liability Notice?**

A5. All individuals must be provided notices in order to inform them about the requirements that exist under the regulations.

**Q6. Do we have to send out a notice of the new fee every time our fees/payment levels change?**

A6. No. New notices do not need to be reissued each time a rate changes. However, for individuals and/or liable parties who are being billed for the services they receive, an account notice should be issued to alert the payor to the change. The Fillable Account Notice (OPWDD LIAB 03), located on the OPWDD website, referenced in A1 above, should be used.

**Q7. For individuals receiving more than one covered service, can a single notice be sent including a list of the services being provided with appropriate fees?**

A7. Yes, this is recommended.

**Q8. How often should the liability notices be sent out?**

A8. The liability notices must only be sent out once to the individual and/or liable party. Additional notices should only be sent out when new information is learned or when new services are applied for.

**Q9. Can OPWDD provide any additional guidance on its expectations of providers concerning the discovery of “new information” which would generate new notices?**

A9. The provider gives an initial round of notices to all liable parties, before services begin or by March 15, 2009 or May 15, 2010 for preexisting services, depending on the service. Only if the provider later discovers information about additional liable parties, or if new services are applied for, does the provider have



to give additional notices. For example, if the provider later learns that there is a person holding the assets on behalf of the service recipient or if a guardian with authority over property is appointed.

**Q10. My biggest worry is that the new noticing rules may make it more difficult to accommodate some of the emergency cases we often get (such as a result of the loss of a family care provider).**

A10. A process exists to request interim state funding when services are necessary for a person's health or safety. Please refer to the Liability for OPWDD Medicaid and Home and Community Based Waiver Services Process Document, available on the OPWDD's website, referenced in A1 above.

**Q11. As an agency we are rep payee for about 85% of our residential individuals, do we have to send a notice to ourselves? Are we liable for each of these person's services?**

A11. An agency does not need to send a notice to itself. OPWDD recognizes that most benefits handled by a representative payee are utilized to pay residential charges (rent or room and board) and that these funds are not available to pay for covered services provided to the individual. However, if the individual's income exceeds the Medicaid eligibility level for a particular living arrangement, the individual's funds under the control of the representative payee would be used to pay the fee for residential habilitation. As is the case with other liable parties and entities holding funds for the individual in a fiduciary capacity, the liability extends only to the amount of the individual's resources held. The Liability Process Document referenced in the previous answer can help agencies determine how much of the resources are owed.

**Q12. We provide day habilitation and have individuals living in a residence certified or operated by OPWDD. Do we need to send a notice to the DDSO or the voluntary provider which operates the residence?**

A12. A notice should be sent to the DDSO if the DDSO is acting as the representative payee for the individual. Notices will generally be routed from the DDSO to the RSFO. If an individual receives residential services from another agency a notice should be sent to that agency.

**Q13. Regarding mailing/receipt of the liability notices: Will copies of the notice be required to be produced? Will we need any proof of mailing?**

A13. Service providers must be able to document that notices have been sent to all individuals receiving covered services. OPWDD is not mandating the particular format.



**Q14. Do new liability notices need to be issued as a result of the name change and increase in fees for At Home Residential Habilitation to Community Habilitation?**

A14. No, new liability notices do not have to be issued, however, because of the fee change, OPWDD LIAB 03, Billing Account Notice to inform the individual and/or liable parties of the change in rate.

**Fees:**

**Q15. If an individual is not Medicaid or Waiver eligible, how do we figure out the "Medicaid Amount" for the cost of services?**

A15. The "Medicaid Amount" is the provider's Medicaid reimbursement rate, price or OPWDD fee for the service.

**Q16. For Residential Habilitation Services provided in an IRA, the fee shall equal the Medicaid price OPWDD established for the IRA Residential Habilitation Services for the dates the Services were provided. Does this mean we should not include the Room & Board component of the price in our fee schedule?**

A16. You should not include room and board charges in your fee schedule. Room and board charges are not reimbursable under the Medicaid program and are therefore not covered by the regulations.

**Q17. If an Agency is the Representative Payee how does that factor into determining who is a liable party? Are provider agencies liable for individuals that they serve as representative payee?**

A17. An Agency which is a representative payee for an individual is a liable party for that individual. Representative payees are liable to the extent of the funds being managed. (see Q11)

**Q18. Are parents liable to pay for services for their son or daughter?**

A18. Section 43.03 of the New York State Mental Hygiene Law states that parents of individuals under the age of 21 are liable, unless they do "not share the common household even if the child returns to the common household for periodic visits." This means that parents of children under the age of 21 who live in a residence certified or operated by OPWDD are not liable for their child's services just because they are a parent.

In the case of individuals under the age of 21 living with their parents, both the individuals and their parents may be charged for the cost of services



received in accordance with the “Parental Fee Schedule OPWDD Medicaid Funded Services” on page 32 of the “Liability for OPWDD Medicaid and Home and Community Based Waiver Services (Process Document)” referenced in A10.

Parents of individuals over 21 years of age and parents of children under the age of 21 who do not live with them may also be liable if they hold the individual’s money or resources, up to the amount of the individual’s money or resources. For example, the parent may serve as representative payee or property guardian and be liable in that capacity.

**Q19. If a parent or sibling holds even nominal amounts of funds or may have possessions left at home for an individual's use when home visiting, does this now obligate us to list them and so declare?**

A19. Liability is determined by resources or income available to pay the cost of care, not nominal possessions.

**Q20. If the money management assessment for an individual without Medicaid identifies that (s)he is not capable of managing funds in the amount of the full fee, but the individual does not have a court appointed guardian or someone else to manage the funds, is (s)he only liable up to the amount (s)he can manage?**

A20. The fees for which an individual will be liable for are the Medicaid rates for the services being provided, unless OPWDD has approved a waiver or reduction of a fee. The individual’s money management assessment does not determine his or her liability for services. A waiver or reduction of fees can be requested based on an individual’s financial circumstances (income and/or available resources) if the individual has fully cooperated in the process to obtain Medicaid and/or HCBS Waiver enrollment.

<b>State funding:</b>
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**Q21. Is OPWDD going to stop paying for mirrored services?**

A21. OPWDD may continue to pay State funding (mirrored) to an agency for preexisting services, if the service provider complies with the requirements set forth in the regulations. OPWDD may approve a fee waiver or fee reduction based on available income and resources of the individual, and the individual’s living situation and ability to meet Medicaid and HCBS waiver requirements. If an individual loses Medicaid coverage, the agency can apply for state funding through the local DDSO.



For a new applicant (other than preexisting services) OPWDD may fund services if an individual needs services right away necessary to his or her health or safety, no one is private paying, the provider is complying with the regulations, and the individual either unsuccessfully applied for Medicaid or the HCBS waiver (unless asking to live in an ICF) or explains why he or she did not apply in the first place. State funding for other than preexisting services is at the discretion of the local DDSO.

**Q22. Who is eligible for up to three months of state funded service coordination for assistance with Medicaid and Waiver Enrollment?**

A22. Up to 90 days of state funded service coordination is available only for individuals who have not been in receipt of service coordination to facilitate the development of Medicaid and, if necessary, HCBS Waiver enrollment.

**Q23. In the event someone is approved for state funded services how often do we need to verify benefit(s) amounts or wages?**

A23. State funding is authorized for a time limited period which differs based on individual circumstances. The time period of state funding is identified on the approval.

<b>Fee Waivers and Fee Reductions:</b>
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**Q24. Under what conditions can fees be waived?**

A24. OPWDD may approve a reduction or waiver of fees based on the individual or liable parties' available income and resources, the individual's living situation and the individual's ability to meet Medicaid and HCBS waiver eligibility requirements. OPWDD approval for a reduction or waiver of fees is only available when the individual has fully cooperated in the Medicaid application and, if necessary, HCBS Waiver enrollment processes and has taken all necessary steps to obtain and maintain Full Medicaid Coverage and HCBS waiver enrollment or an explanation is provided for why the individual is unable to apply. Providers may also waive or reduce fees at their discretion without OPWDD's approval when they are *not* requesting state payments.

**Q25. What is the process to get OPWDD to waive or reduce a fee for someone?**

A25. The provider, not OPWDD, waives or reduces a fee. If OPWDD approves the waiver or reduction of a fee, OPWDD will pay the provider the full fee (in the case of a waiver) or the difference between the full fee and the reduced fee (in the case of a reduction). A provider will request approval of a waiver or reduction of charges from the local Revenue Support Field Office (RSFO) by completing



the “Fee Reduction / Waiver For Preexisting Services Request For Approval-Form OPWDD LIAB 04”, located on the OPWDD website referenced above in A1. The RSFO will only consider a request if the individual has recently applied for Medicaid and/or Waiver enrollment and been denied, or if the provider gives the RSFO a detailed explanation of why the individual did not apply for Medicaid or the Waiver and the service provider attaches all relevant supporting documentation (Medicaid denial notice, Waiver NOD) with the fee reduction or waiver.

**Q26. Can the Provider agency reduce or waive fees for individuals without OPWDD approval?**

A26. Providers can waive or reduce fees without OPWDD approval if they are *not* requesting State payments.

**Q27. Since there is currently severely limited access to MSC services in our local DDSO, and such access is required to acquire HCBS eligibility, will the affected individuals still be subject to the liability regulations since this situation is outside their control?**

Q27. The regulations require individuals to pursue Full Medicaid Coverage and HCBS Waiver enrollment. If there is an external impediment the service provider can request a fee waiver or reduction.

<b>Medicaid and HCBS Waiver:</b>
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**Q28. What constitutes evidence of Full Medicaid coverage?**

A28. Full Medicaid Coverage is defined in the liability for services regulations as the type of Medicaid that will pay for the services provided or requested. A notice from the responsible Medicaid district indicates the type of coverage provided. A Medicaid Coverage Chart is located on the OPWDD website as referenced in A1 above that can help you determine which type of Medicaid coverage will pay for the services received. Coverage type can also be verified by the local OPWDD Revenue Support Field Office.

**Q29. Please provide clarification for discharge for preexisting services vs. other than preexisting services. Can an agency stop services for an individual who refuses to apply for Medicaid?**

A29. If someone is refusing to apply for Medicaid and is not private paying, he or she is essentially refusing to pay. You cannot discontinue preexisting services for failure to pay. You may discontinue other than preexisting services for failure to pay (if provision of these services is not subject to a court order), but you must adhere to the process specified in 14 NYCRR Section 633.12.



**Q30. If individuals receiving preexisting services choose not to enroll in the HCBS waiver, how long will OPWDD provide state payments for these services?**

A30. Because the individuals are receiving preexisting services, OPWDD will continue to pay the provider as long as the provider complies with the requirements set forth in the regulations and as long as the Medicaid does not pay for and no one else pays for the services. The person and/or liable party must be billed for the full cost of services and collection must be pursued by the service provider. If payments are made by the individual, state payments must be refunded. If reasonable collection attempts are unsuccessful, the service provider may request that OPWDD accept assignment of the outstanding balance and pursue collection.

**Q31. What happens if an individual loses Medicaid?**

A31. The individual and/or liable parties must be billed for any period when Medicaid coverage is not available. The service provider can also request state funding based on specific circumstances through the local DDSO. The provider may seek to discontinue “other than preexisting” services if Medicaid does not pay for the services, however, “preexisting” services cannot be discontinued for nonpayment.

**Q32. If an individual is denied Medicaid or loses Medicaid and then obtains Medicaid retroactively back to the date of application (or other date), what happens if state payments were already made?**

A32. If the individual obtains Medicaid or Medicaid is reinstated, the provider must bill Medicaid retroactively back to the earliest date possible and OPWDD will recoup the state payments.

**Q33. Can the service provider forgo billing while a Medicaid application is pending?**

A33. No. In order to be in compliance with the regulations (and continue receiving state funds), the service provider must bill the individual and/or liable party. If the person subsequently qualifies for Medicaid funding of their services, Medicaid should be billed retroactive to the onset of eligibility. The individual and/or liable party must then be reimbursed. OPWDD will recoup any state payments.

**Q34. We have some individuals who are in the process of applying for the waiver. Some have taken steps to apply for Medicaid and/or eligibility and are still waiting to hear back before they can proceed and apply for the**



**Waiver. What happens to these individuals if they are still in the process but do not have a NOD?**

A34. Applications for enrollment in the HCBS should be made concurrently with the application for Medicaid. If the individual is not eligible for Medicaid funding of the service s/he must be billed for the cost of the covered services being received.

**Q35. We have individuals who have been living in Community Residences for many years and who have Medicaid but can not be enrolled in the waiver as they do not meet clinical eligibility requirements. How will they be handled?**

A35. If appropriate, you can ask that OPWDD reevaluate the person's clinical eligibility. If the person still doesn't qualify, the service provider can submit a fee waiver with supporting documentation to the local RSFO. OPWDD will determine if the individual is eligible for a fee waiver.

**Private Pay:**

**Q36. If the consumer pays us the fee for service, and OPWDD is no longer paying for services, is our provision of service and service documentation still subject to all OPWDD regulations?**

A36. Yes.

**Q37. What is the enrollment process for individuals who are private pay? Do people still need to be determined clinically eligible and complete a Developmental Disabilities Profile (DDP)?**

A37. Yes, people who are paying for their services still have to be determined eligible and a DDP form has to be completed if required for the service requested.

**Q38. Are we able to establish an escrow account for people who are private pay? Somewhat like a security deposit system; people front what it will cost for one month of their requested service(s) to protect us from people who will default.**

A38. The regulations do not specifically include this situation. However, providers are allowed to require that individuals or liable parties establish an escrow account. Providers are advised to keep these requirements reasonable, as OPWDD will be scrutinizing practices in the field and may establish additional protections for individuals and liable parties if necessary.



**Limited Exception for Supported Employment or Respite:**

**Q39. If a SEMP participant has Medicaid but it is not sufficient to support HCBS waiver enrollment should he/she pursue full Medicaid coverage to support the waiver enrollment or does this individual qualify for the exception?**

A39. If the individual only has Medicaid but has not been HCBS Waiver enrolled on or after March 15, 2010 s/he would qualify for the Limited Exception.

An individual who is eligible for Medicaid funding (Medicaid and HCBS Waiver enrolled) of SEMP or Respite at any time on or after March 15, 2010 cannot qualify for the Limited Exception.

**Q40. We serve an individual whose waiver eligibility ended because he came into money. Respite is now his ONLY service. Does he qualify for the limited exception?**

A40. If his Medicaid/HCBS Waiver eligibility terminated prior to March 15, 2010, he qualifies for the Limited Exception.

**Q41. We serve an individual whose waiver eligibility was terminated in 2008, for unknown reasons; respite is his ONLY service. Does he qualify for the limited exception?**

A41. Yes.

**Q42. When might an individual 'opt out' of other services in order to qualify for the limited exception for supported employment or respite?**

A42. An individual who is receiving *state-funded* supported employment or *state-funded* respite may opt out of receiving another covered service in order to qualify for the limited exception. An individual who is receiving *Medicaid-funded* supported employment or Medicaid-funded respite may *not* opt out of receiving another covered service in order to qualify for the limited exception.

**Q43. If an individual is receiving both state funded SEMP and another covered service such as hourly waiver respite (paying that provider out of pocket), my understanding is that there is no limited exception. Is that interpretation accurate?**

A43. Correct. The individual is not eligible for the Limited Exception if s/he receives another covered service which would include individuals receiving both SEMP and respite.



**Q44. If an individual receives state provided services and single service voluntary operated SEMP or Respite would that individual meet the limited exception for SEMP or Respite?**

A44. No. The Limited Exception is intended for individuals who only receive either Supported Employment or Respite services as their only service.

**Q45. As the supported employment provider, we are not always informed when an individual begins receiving an additional service from another agency. Will we be penalized for failing to provide notices to the other agency when the limited exception ends for an individual because of the receipt of another covered service?**

A45. It is an obligation of both the individual and the other service provider to notify you of the new service. It is possible neither will report this information to you. You should send the liability notice as soon as you find out.

<b>Billing:</b>
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**Q46. For individuals receiving pre-existing services, can we continue to bill the state while also billing the consumer and/or liable party? If not, at what point can we bill the state for uncollected costs?**

A46. Yes. A service provider will bill the individual or liable party and may continue to submit claims to OPWDD. OPWDD payments are contingent on the service provider's compliance with the regulations. The service provider must reimburse OPWDD for any payments that the individual or liable party subsequently makes.

**Q47. At training, it was stated that billing should occur no more than 30 days after the service delivery date. We have situations where an individual's Medicaid lapsed and we are not aware of this until we receive a denial for our billing. This does not occur within 30 days of service delivery date and would cause us to be out of compliance. How do we handle those situations?**

A47. You may bill the individual or liable party effective with the lapse in eligibility for Medicaid billing. Be sure to document that you issued the bill as soon as you became aware of the lapse in Medicaid eligibility.

**Q48. Can the service provider forgo billing while a Medicaid application is pending?**

A48. No. In order to be in compliance with the regulations (and continue receiving state funds), the service provider must bill the individual and/or liable



party. If the person subsequently qualifies for Medicaid funding of their services, Medicaid should be billed retroactive to the onset of eligibility. The individual and/or liable party must then be reimbursed. OPWDD will recoup the state payments.

**Q49. If an agency with MSC offers to assist an agency without MSC will they be paid for three months?**

A49. The request for state funded service coordination should be made through the local DDSO. OPWDD will fund up to three months to help with the Medicaid and HCBS waiver enrollment processes. If the individual becomes eligible for Medicaid the provider would be expected to bill retroactively, back to the earliest date and OPWDD will recoup the state payments.

<b>Collection:</b>
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**Q50. Beyond monthly billing of the consumer and liable party, what actions to “pursue collection” are expected by OPWDD of the provider?**

Q50. In addition to monthly billing, the service provider must attempt to collect unpaid charges. Collection attempts vary on an individual basis but may consist of written correspondences or copies of case notes of conversations with the individual or liable party. The content must refer to the specific debt, indicate that the service provider considers the debt a viable debt and expects payment. Collection efforts cannot interfere with ongoing services.

**Q51. How long does the agency need to show that they are doing everything they need to do on collecting from the person liable to pay for services before we can request that the OPWDD take over the assignment?**

Q51. There is no standard answer as actions may differ depending on the specific situation. It is important, however, to document all collection attempts with copies of correspondence and written case notes which must be submitted to the local Revenue Support Field Office with the request.