

Liability for OPWDD Medicaid and Home and Community Based Waiver Services (Process Document)

Introduction

The Office For People With Developmental Disabilities (OPWDD) has promulgated regulations concerning the liability for services for specified OPWDD Medicaid and Home and Community Based Services (HCBS) Waiver funded services.

The processes described in this document are based on the provisions contained in 14 NYCRR Subpart §635-12*. This regulation requires individuals with developmental disabilities who wish to receive a specified OPWDD Medicaid funded service to file and be approved for “Full Medicaid Coverage”. “Full Medicaid Coverage” is defined as the minimum level of coverage necessary under the Medicaid program 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†.

The regulations impose different requirements depending on whether a service is ‘preexisting’ or ‘other than preexisting’. Refer to the attached flowcharts that illustrate the different paths taken for these distinct services. Preexisting services are those that an individual has been receiving on a regular basis at the time the regulations are implemented for the specific services. Other than preexisting services are those that commence on or after the date the regulations go into effect for the specific service. The implementation dates were:

February 15, 2009 for ICF/DD facilities; residential habilitation delivered in IRAs, CRs, and family care; and day habilitation

March 15, 2010 for Medicaid Service Coordination‡, Day Treatment Services, At Home Residential Habilitation (now named Community Habilitation), Prevocational Services, Supported Employment Services (SEMP), Respite Services and Blended and Comprehensive Services.

* Can be found on OPWDD’s Web Site at:
http://www.opwdd.state.ny.us/regs/hp_regs_liability_index.jsp

† 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).

‡ This includes “Other Service Coordination” also referred to as mirrored MSC or state paid/funded MSC.

In the future, as new services are implemented within the OPWDD delivery system, these services may also be subject to the liability for services regulations.

Interim Funding

For individuals receiving preexisting services, the service provider will continue to receive state funding while an individual is waiting to be approved for Medicaid and/or the HCBS Waiver provided 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 “Full Medicaid Coverage” is not in place.

OPWDD has clarified that service providers will not receive “interim funding” for other than preexisting services while an individual is waiting to be approved for Medicaid and/or the HCBS Waiver except under extenuating circumstances. OPWDD may provide interim funding when all of the following conditions have been met:

- 1) The individual is not now paying and has not paid in the past, the full fee for the services, and no one else is now paying or has paid in the past the full fee for services for the individual; and
- 2) The individual took all necessary steps to obtain and maintain full Medicaid coverage and was denied full Medicaid coverage; and
- 3) The provider is meeting its obligations; and
- 4) The individual has an immediate need for services and delaying the start of services would endanger the individual’s health and safety

Service providers who elect to provide services in anticipation of an individual’s eligibility for Medicaid and/or the HCBS Waiver will not be reimbursed by OPWDD should the individual’s application for Medicaid and/or the HCBS Waiver be denied. Rather, the service provider must bill the individual and/or liable party for the cost of services while the applications are pending.

Limited Exception for Supported Employment or Respite Services

Effective March 15, 2010, if an individual is applying for or receiving either Supported Employment Services or 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 SEMP or Respite is not subject to the provisions listed under 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. Individuals who are receiving state-funded SEMP or respite services may discontinue other covered services received in order to qualify for the Limited Exception.

Although pursuit of Medicaid and Waiver is not required of individuals receiving only SEMP or only Respite services, these individuals must be provided with specific liability notices by the service provider*. Agencies providing SEMP and 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” or by May 15, 2010 for individuals receiving “preexisting services”. The notices include information about the limited exception and the obligation of the individual to notify the provider if s/he applies for other services.

If an individual begins to receive additional services covered under the liability for services regulations, the limited exception for SEMP or Respite is no longer applicable and the individual is subject to all provisions of the regulations, including pursuit of Medicaid and Waiver enrollment. The individual is obligated to notify the SEMP or Respite provider if s/he applies for other covered services. In addition, there are service provider noticing obligations when an individual applies for new covered services regulations as follows:

- The SEMP or 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
- Providers of the other service(s) must notify the SEMP or Respite provider if an individual applies for a covered service

The Enrollment Processes

The enrollment processes involve an interaction between the individual, the individual’s representatives, the service provider, the service coordinator, the local Social Services district office and various OPWDD entities. OPWDD expects full cooperation from all parties as they work together to enroll the individual in Medicaid and/or the HCBS Waiver.

This document details the role played by each of the following parties:

- The Service Provider
- The Service Coordinator

* Can be found on OPWDD’s Web Site at <http://www.opwdd.ny.gov/wt/publications/msc/index.jsp>

- The Developmental Disabilities Services Office (DDSO) and Region 2 Service Delivery and Integrated Solutions (SDIS) (formerly known as NYCRO)
- The Revenue Support Field Office (RSFO)
- DDSO Director or Authorized Designee
- Revenue Support Central Operations (Central Operations)

A. The Service Provider's Role in the Enrollment Processes

The enrollment processes are often initiated by a service provider in response to a request for services from an individual. The request may come 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's role in the enrollment process for an individual requesting other than preexisting services consists of the following steps:

Step 1: Service Provider Verifies the Individual's MR/DD Status

In order for an individual to qualify for enrollment in any OPWDD-sponsored program, the individual must be documented as having a developmental disability. The first step the service provider must take is to contact the local DDSO/Region 2 SDIS office to verify that the DDSO/Region 2 SDIS has determined that the person has a developmental disability or to utilize the eligibility determination process established by OPWDD to determine whether the person has a developmental disability.*

Step 2: Service Provider Conducts a Pre-Admission Review

The service provider meets with the individual, the individual's representatives (family members and/or advocates) and the individual's service coordinator, and determines what services the individual is requesting and what services the provider can provide for the individual.

Note: If, at the time of the pre-admission review, the individual has neither Medicaid coverage nor a service coordinator, state-funded service coordination is available for up to three months and must be requested from the responsible DDSO/Region 2 SDIS at this time. First, the service provider should obtain authorization for state funding from the DDSO. Then, the DDSO can provide service coordination or the service provider can contact another agency that provides service coordination.

* 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 DDSO/Region 2 SDIS office to verify the applicant's eligibility for OPWDD services.

Individuals with Medicaid coverage who are seeking HCBS Waiver services must apply for Medicaid Service Coordination. For more details about the role of the service coordinator, refer to page 15.

The service provider presents the individual and/or liable party with:

- The appropriate liability notice together with the fee schedule for services requested

The service provider then determines the applicant's Medicaid and HCBS Waiver enrollment status.

Note: The service provider can opt to provide services to an individual while Medicaid is pending. However, if the individual does not have Medicaid (and HCBS waiver enrollment, if seeking waiver services) upon the receipt of services, the individual and/or liable party must be billed for the full cost of services. The service provider can opt to 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. If OPWDD payments are being requested, the service provider can waive or reduce fees owed by the individual or liable party only with OPWDD approval after the individual's income, resources, living situation and Medicaid eligibility have been analyzed by the provider and reviewed and approved by the local RSFO.

Step 3: Requesting Confirmation of the Individual's Medicaid and HCBS Waiver Status

The service provider contacts the local DDSO/Region 2 SDIS to confirm the individual's HCBS Waiver status and contacts the local RSFO to confirm the individual's Medicaid status.

Step 4: Acting on the Response Received From the RSFO and DDSO/Region 2 SDIS

The individual's Medicaid and HCBS Waiver enrollment status are verified by the local RSFO or DDSO/Region 2 SDIS respectively. They may determine that:

- 1) The individual is already enrolled in Medicaid and the HCBS Waiver
- 2) The individual is enrolled in neither Medicaid nor the HCBS Waiver
- 3) The individual is enrolled in Medicaid but not the HCBS Waiver
- 4) The individual's Medicaid and/or HCBS Waiver enrollment application is being processed
- 5) The individual appears to be ineligible for enrollment in Medicaid or the HCBS Waiver

Note: If an individual or representative receives a notice from the Medicaid district that the individual is losing Full Medicaid Coverage, s/he must notify the service provider within 5 days of receipt of notice.

We will examine the action required of the service provider in each of these five cases below when the individual is receiving *other than preexisting* services:

Case 1: The Individual is Already Enrolled in Medicaid and the HCBS Waiver

Action: Upon approval of service delivery by the DDSO/Region 2 SDIS the service provider:

- a) Submits the Developmental Disabilities Profile 1 (DDP1) form to the DDSO/Region 2 SDIS to add the individual to the appropriate program(s) in OPWDD's Tracking and Billing (TABS) system.
- b) Provides the individual and/or liable party with the appropriate liability notice together with the fee schedule for services requested.
- c) Begins appropriate services for the individual once DDSO/Region 2 SDIS approval is received.

Note: If, at any subsequent time, Medicaid coverage is lost or HCBS Waiver is suspended for individuals receiving other than preexisting services, the service provider can decide whether to continue providing services. If the service provider opts to continue services, private payment arrangements can be made or the service provider can submit a request for state funding to the local DDSO/Region II SDIS. State funding is initially approved for up to 90 days. When 90 days has expired, OPWDD will determine if state payments will continue. Services cannot be discontinued to individuals where receipt is mandated by court order.

Case 2: The Individual is Enrolled in Neither Medicaid Nor the HCBS Waiver

Action: The individual, representative or service provider initiates *simultaneous* Medicaid and HCBS Waiver enrollment processes as follows:

- a) The service provider presents the individual or the individual's representative with an Eligibility Investigation Form and corresponding instructions.

Note: The service provider informs the individual or the individual's representative that the Eligibility Investigation Form must be fully completed in order to evaluate if he or she is eligible for benefits. The individual and/or liable party must also be informed that they will have to pay for services and will be billed by the service provider while the applications Medicaid and/or HCBS Waiver are pending and thereafter if the applications are not successful.

- b) The service provider informs the individual's service coordinator of the steps that must be taken to qualify the individual for Medicaid and the HCBS Waiver.

Note: As indicated earlier, if the individual does not have a service coordinator, state-funded service coordination may be requested from the responsible DDSO/Region 2 SDIS to coordinate Medicaid and HCBS Waiver enrollment processes.

- c) The service provider can opt to provide services to an individual while Medicaid is pending. While Medicaid is pending, the individual and/or liable party must be billed if state payments are being provided. However, 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.
- d) The service provider notifies the responsible DDSO/Region II SDIS and the individual or the individual's representative of its decision.
- e) Unless the individual or representative does so, the service provider, in conjunction with the service coordinator, initiates the Medicaid/HCBS Waiver enrollment process by submitting the Medicaid application to the appropriate local Social Services district office and contacting the HCBS Waiver coordinator at the responsible DDSO.
- f) The service provider issues the individual and/or liable party with the appropriate liability notice together with the fee schedule for services requested.

Note: If extenuating circumstances exist which necessitate immediate delivery of services (as distinct from service coordination), the provider may prepare and submit to the DDSO/Region 2 SDIS a request for temporary state funding authorization for up to 90 days. Before making this request, the service provider must consult with the local DDSO/Region 2 SDIS regarding the need for services. The service provider will not receive temporary funding unless the DDSO Director or Authorized Designee approves the request. Refer to page 19.

Case 3: The Individual is Enrolled in Medicaid But Not the HCBS Waiver

A pre-requisite to HCBS Waiver enrollment is that the individual must be enrolled in Medicaid.

Action: The service provider:

- a) If requested by the individual or representative, initiates the enrollment process by collecting required documentation to submit an HCBS Waiver application.
- b) Issues the individual and/or liable party with the appropriate liability notice together with the fee schedule for services requested.
- c) Decides whether to provide services prior to the individual's successful enrollment with the understanding that if the individual does not become enrolled in the HCBS waiver, the individual and/or liable party are liable for full cost of services. The service provider can request state funding from the local DDSO/Region 2 SDIS or 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. If OPWDD payments are being requested, the service provider can waive or reduce fees owed by the individual or liable party only with OPWDD approval after the individual's income, resources, living situation and Medicaid eligibility have been analyzed by the provider and reviewed and approved by the local RSFO.
- d) Notifies the responsible DDSO or Region 2 SDIS and the individual or the individual's representative of its decision, regarding providing services.

Case 4: The Individual's Enrollment Application is Being Processed

It is possible that an application for Medicaid or the HCBS Waiver has already been submitted by, or on behalf of, the individual and is currently being processed.

Action: The service provider:

- a) Issues the appropriate liability notice to the individual and/or liable party with the fee schedule for services requested.
- b) Decides whether to provide services prior to the individual's successful enrollment with the understanding that if the individual does not become enrolled in Medicaid and the HCBS waiver (if necessary), the individual and/or liable party are liable for full cost of services. The service provider can request state funding authorization from the local DDSO/Region 2 SDIS or 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. Lastly, the service provider can waive or reduce fees owed by the individual or liable party with OPWDD approval after the individual's income, resources, living situation and

Medicaid eligibility have been analyzed by the provider and reviewed and approved by the local RSFO.

- c) The service provider notifies the responsible DDSO/Region 2 SDIS and the individual or the individual's representative of its decision.

Case 5: The Individual Appears to Be Ineligible for Enrollment in the HCBS Waiver

The actions required of the service provider in the case of an individual who is, or appears to be, ineligible for enrollment vary as follows:

- 1) If the DDSO/Region 2 SDIS determines that the individual has previously been denied or terminated from enrollment in the HCBS Waiver, an eligibility reassessment should be discussed with the responsible DDSO/Region 2 SDIS. The reassessment could lead to the individual reapplying for Waiver enrollment and subsequently being found eligible for funding.
- 2) 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 it 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.

Note: OPWDD will not reimburse services provided when the individual does not take all necessary steps to enroll. If the service provider requires reimbursement for services, it must advise the individual or liable party that s/he will be charged at full cost for the services and provide the individual or liable party with a fee schedule listing the cost of services provided.

- 3) If an application for Medicaid or the HCBS Waiver has been filed but the application process is taking longer than expected, the service provider must decide if it will provide services prior to the individual's successful enrollment in Medicaid or the HCBS Waiver. If the individual does not become enrolled, the individual and/or liable party are liable for full cost of services. In the interim, 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. Lastly, the service provider can waive or reduce fees owed by the individual or liable party with OPWDD approval after the individual's income, resources, living situation and Medicaid eligibility have been analyzed by the provider and reviewed and approved by the local RSFO.

Note: If extenuating circumstances exist, related to the health and safety of the individual, which necessitate immediate delivery of services (as

distinct from service coordination) the provider may prepare and submit to the DDSO/Region 2 SDIS a request for temporary state funding of up to 90 days for the services to be provided. Before making this request the service provider must consult with the local DDSO/Region 2 SDIS regarding the need for services. The service provider will not receive temporary funding unless the DDSO/ Region 2 SDIS approves the request. Refer to page 15.

- 4) If there is a final determination that the individual does not qualify for Medicaid or meet the OPWDD eligibility criteria for the service being requested*, the service provider must decide if it will provide services to the individual without receiving either Medicaid or OPWDD reimbursement. If the service provider requires reimbursement for services, it must advise the individual or liable party that s/he will be charged at full cost for the services and provide the individual or liable party with a fee schedule listing the cost of services provided.
- 5) Individuals who have not been approved for Medicaid funding will be charged at the full cost of services unless s/he is eligible for a reduction or waiver of fees based on the "Rules for Determining Waived or Reduced Fees for OPWDD Services" outlined in Addendum 1. The service provider will be required to bill and collect the appropriate fee listed. The provider will also show a reduced fee as an offset to any approved monthly claim submitted for state funding.

Note: The service provider must assess the individual's, and in certain cases, the individual's parent or parents' financial responsibility based on the "Rules for Determining Waived or Reduced Fees for OPWDD Services" outlined in Addendum 1 and submit a request to the responsible DDSO/Region 2 SDIS for extended state funding of services. Before making this request, the service provider must consult with the local DDSO/Region 2 SDIS regarding the need for services. The service provider will not receive state funding unless OPWDD approves the request. Waivers and/or reductions of fees owed by the individual or liable party must be approved by OPWDD after the individual's income, resources, living situation and Medicaid eligibility have been analyzed by the provider and reviewed and approved by the local RSFO.

* There is a final determination that a person is not eligible for Medicaid when the local Social Services district denies the application and the person does not request a fair hearing or, if a fair hearing is requested, the denial is affirmed at the fair hearing or at any subsequent judicial appeal. There is a final determination that a person does not meet the eligibility criteria for the service being requested when OPWDD has made a determination that the person does not meet the eligibility requirements and the person does not request a fair hearing or, if a fair hearing is requested, the denial is affirmed at the fair hearing or at any subsequent judicial appeal.

The Service Provider's role in the enrollment processes for an individual receiving preexisting services consists of the following steps:

Step 1: Service Provider Presents the Individual with relevant documents

The service provider presents the individual or the individual's representative with:

- The appropriate liability notice together with the fee schedule for the services being received.

The service provider then reviews the individual's Medicaid and HCBS Waiver enrollment status.

Step 2: Requesting Confirmation of the Individual's Medicaid and HCBS Waiver Status

The service provider contacts the local DDSO/Region 2 SDIS to confirm the individual's HCBS Waiver status and contacts the local RSFO to confirm the individual's Medicaid status.

Step 3: Acting on the Response Received From the RSFO and DDSO/Region 2 SDIS

The individual's Medicaid and HCBS Waiver enrollment status are verified by the local RSFO or DDSO/Region 2 SDIS respectively. They may determine that:

- 1) The individual is already enrolled in Medicaid and the HCBS Waiver
- 2) The individual is enrolled in neither Medicaid nor the HCBS Waiver
- 3) The individual is enrolled in Medicaid but not the HCBS Waiver
- 4) The individual's Medicaid and/or HCBS Waiver enrollment application is being processed
- 5) The individual appears to be ineligible for enrollment in Medicaid or the HCBS Waiver

We will examine the action required of the service provider in each of these five cases below when the individual is receiving *preexisting services*:

Case 1: The Individual is Already Enrolled in Medicaid and the HCBS Waiver

Action:

Provides the individual with the appropriate liability notice together with the fee schedule for services. All individuals in receipt of preexisting services

must receive a liability notice which notifies the individual and/or liable party that if an individual becomes ineligible for Medicaid funding of their services, or if Medicaid or Waiver enrollment is terminated, s/he will be responsible for the full cost of services provided.

Case 2: The Individual is Enrolled in Neither Medicaid Nor the HCBS Waiver

Action: The individual, representative or service provider initiates *simultaneous* Medicaid and HCBS Waiver enrollment processes as follows:

- c) The service provider presents the individual or the individual's representative with an Eligibility Investigation Form and corresponding instructions.

Note: The service provider informs the individual or the individual's representative that the Eligibility Investigation Form must be fully completed in order to evaluate if he or she is eligible for benefits. The individual and/or liable party must also be informed that they will have to pay for services if the application for Medicaid and/or HCBS Waiver is not successful.

- d) The service provider informs the individual's service coordinator of the steps that must be taken to qualify the individual for Medicaid and the HCBS Waiver.
- g) Unless the individual or representative does so, the service provider, in conjunction with the service coordinator, initiates the Medicaid/HCBS Waiver enrollment process by submitting the Medicaid application to the appropriate local Social Services district office and contacting the HCBS Waiver coordinator at the responsible DDSO.
- h) The service provider issues the individual and/or liable party with the appropriate liability notice, together with the fee schedule for services. This notice notifies the individual and/or liable party that if Medicaid funding is not secured, s/he is responsible for the full cost of services provided, unless s/he meets the limited exception for supported employment or respite services.
- i) The service provider establishes billing and pursues collection as identified in Addendum II, Billing and Collection for OPWDD Services

Case 3: The Individual is Enrolled in Medicaid But Not the HCBS Waiver

A pre-requisite to HCBS Waiver enrollment is that the individual must be enrolled in Medicaid.

Action: The service provider:

- a) If requested by the individual or representative, initiates the enrollment process by collecting required documents to submit an HCBS Waiver application.
- b) Issues the individual and/or liable party with the Liability Notice for Preexisting Services, together with the fee schedule for services.
- c) Continues to provide services to the individual and understands that since the individual is not enrolled in the HCBS waiver, the individual and/or liable party is liable for full cost of services. The service provider will continue to receive state funding, only if it fulfills all requirements outlined in the liability for services regulations regarding issuance of notices, establishment of charges and pursuit of collection have been followed. Refer to the Addendum 2, Billing and Collection Billing and Collection for OPWDD Services for more details. If receiving OPWDD payments, the service provider can waive or reduce fees owed by the individual or liable party only with OPWDD approval, based on individual circumstances.
- d) Individuals receiving preexisting services for which a service provider is receiving state funding of their services are liable for the full cost of these services. For individuals for whom a service provider would like to approve a waiver or reduction of fees based on the individual's financial circumstances, a "Fee Reduction/Waiver for Preexisting Services Request For Approval" form must be submitted to the local RSFO for review and approval. The form can be accessed on the OPWDD website at:
http://www.opwdd.ny.gov/wt/publications/msc/images/wt_msc_feereductionwaiver.pdf

Case 4: The Individual's Enrollment Application is Being Processed

It is possible that an application for Medicaid or the HCBS Waiver has already been submitted by, or on behalf of, the individual and is currently being processed.

Action: The service provider:

- a) Issues the appropriate liability notice to the individual and/or liable party together with the fee schedule for services.
- b) Follows the rules set forth in the liability for services regulations regarding billing and collecting from the individual and/or liable party for the full cost of services beginning April 15th, 2009 for ICF residential, CR/IRA/FC residential habilitation, and day habilitation services and June 15th for

MSC, day treatment, prevocational, at-home residential habilitation, supported employment, respite, and blended and comprehensive services. The service provider may opt to submit a fee waiver or reduction to the local RSFO, depending on the individual's financial circumstances. For further details, refer to Addendum 1, Rules for Determining Waived or Reduced Fees for OPWDD Services.

Case 5: The Individual Appears to Be Ineligible for Enrollment in the HCBS Waiver

The actions required of the service provider in the case of an individual who is, or appears to be, ineligible for enrollment vary as follows:

- 1) If the DDSO/Region 2 SDIS determines that the individual has previously been denied or terminated from enrollment in the HCBS Waiver, an eligibility reassessment should be discussed with the responsible DDSO/Region 2 SDIS. The reassessment could lead to the individual reapplying for Waiver enrollment and subsequently being found eligible for funding.
- 2) If an individual wishes to receive services but does not wish to comply with the requirements necessary to obtain funding for the services, by enrolling in Medicaid and/or the HCBS Waiver, the service provider must pursue billing and collection processes. These processes must not interfere with the individual's receipt of services and service providers are obligated to continue services to individuals while pursuing billing and collection.

Note: OPWDD will not approve requests for reductions or waivers of fees for individuals when the individual does not take all necessary steps to qualify for Medicaid funding of their services. If the service provider receives OPWDD payments for services, it must advise the individual or liable party that s/he will be charged at full cost for the services and provide the individual and/or liable party with a fee schedule listing the cost of services provided.

- 3) If an application for Medicaid or the HCBS Waiver has been filed but the application process is taking longer than expected, the service provider must bill the individual and/or liable party for the full cost of services and pursue collection. Fee waivers and reductions generally are not approved while applications are pending.
- 4) If there is a final determination that the individual does not qualify for Medicaid funding of the service being requested*, the service provider

* There is a final determination that a person is not eligible for Medicaid when the local Social Services district denies the application and the person does not request a fair hearing or, if a fair hearing is requested, the denial is affirmed at the fair hearing or at any subsequent judicial

must bill the individual and/or liable party for the full cost of services received, beginning April 15th, 2009 for ICF residential, CR/IRA/FC residential habilitation, and day habilitation services or June 15th for MSC, day treatment, prevocational, at-home residential habilitation, supported employment, respite, and blended and comprehensive services, and actively pursue collection. The service provider will then decide if it is appropriate to request a fee waiver or reduction from the local RSFO. The provider will show any OPWDD approved reduced fee as an offset to the monthly claim submitted for state funding. These processes must not interfere with the individual's receipt of services and the service provider is obligated to continue services to the individual while pursuing billing and collection.

Note: One exception to this rule is when an individual meets the criteria of the limited exception for supported employment or respite. Medicaid and waiver do not have to be applied for when an individual meets the limited exception.

- 5) Individuals receiving preexisting services for which a service provider is receiving state funding of their services are liable for the full cost of these services. For individuals for whom a service provider has approved a waiver or reduction of fees based on the individual's financial circumstances, a "Fee Reduction/Waiver for Preexisting Services Request For Approval" form must be submitted to the local RSFO to be reviewed and approved. The form can be accessed on the OPWDD website at: http://www.opwdd.ny.gov/wt/publications/msc/images/wt_msc_feereductionwaiver.pdf

B. The Service Coordinator's Role in the Enrollment Process

The service coordinator helps connect individuals with developmental disabilities to the resources and services they need to maintain and improve their lives.

With regard to Medicaid/HCBS Waiver enrollment, the service coordinator's role is to work with the individual, the individual's representative(s), and the service provider to coordinate the filing of a Medicaid application with the responsible local Social Services agency. This role includes:

- Ensuring that all necessary documentation is secured, including financial information and citizenship or legal resident status
- Ensuring compliance with requests for additional information by the local Social Services agency

appeal. There is a final determination that a person does not meet the eligibility criteria for the service being requested when OPWDD has made a determination that the person does not meet the eligibility requirements and the person does not request a fair hearing or, if a fair hearing is requested, the denial is affirmed at the fair hearing or at any subsequent judicial appeal.

- Monitoring the outcome of the Medicaid and/or HCBS Waiver application processes
- Keeping the individual, the individual's representative(s), and the service provider informed on the progress of the Medicaid and/or HCBS Waiver application
- Consulting with the local RSFO if the individual's eligibility for Medicaid appears questionable
- Immediately providing the local RSFO with a copy of a Medicaid denial notice if one is received
- Helping the individual and the individual's representative(s) request a fair hearing if the RSFO recommends requesting a fair hearing
- Monitoring the Medicaid appeal until a fair hearing decision is received
- Notifying the RSFO and the service provider of the fair hearing decision

C. The DDSO/Region 2 SDIS's Role in the Enrollment Process

The DDSO/Region 2 SDIS (Region 2 SDIS represents the five boroughs of New York City) plays a key role in the process of enrolling individuals in OPWDD services. The DDSO/Region 2 SDIS is responsible for authorizing the delivery of OPWDD services.

Responsibilities of the DDSO/Region 2 SDIS include:

Developmental Disability Determination

- Determining if an individual is eligible for OPWDD services

Developmental Disability Profile (DDP1)

- Processing the DDP1 to add an individual to an appropriate program (adding an individual to a program is not a guarantee of funding by OPWDD to the provider).

HCBS Waiver Enrollment

- Processing the HCBS Waiver application from the individual seeking HCBS Waiver services
- Issuing a Notice of Decision (NOD) reflecting the determination made concerning the HCBS Waiver enrollment application or request for determination of developmental disability

- Enrolling the individual in the HCBS Waiver in TABS if the individual meets all the HCBS Waiver eligibility requirements
- Notifying the service provider(s) if the individual has been determined eligible for HCBS Waiver enrollment
- Evaluating whether a request for extended state funding of the services should be submitted to the DDSO Director or Authorized Designee if the individual does not qualify for HCBS Waiver enrollment
- Approving or denying State Funding Authorization Requests and advising the service provider of the decision

Responsibilities of the DDSO/Region 2 SDIS regarding State Funding include:

State-Funded Service Coordination

- Reviewing requests from service providers for state-funded service coordination for up to three months to assist individuals and their representative(s) in filing for Medicaid and HCBS Waiver enrollment
- Advising the service provider if it has been approved for up to 3 months of state-funded service coordination
- Completing and forwarding authorization requests for state-funded service coordination in excess of three months to the DDSO Director or Authorized Designee

Funding Requests for Services other than Service Coordination

- Responding to a service provider's request for temporary or extended funding for an individual (e.g., deciding if the individual is a member of a special targeted population or qualifies due to other extenuating circumstances)
- If the funding request is supported by the DDSO/Region 2 SDIS, completing a State Funding Authorization Request form and submitting it with supporting documentation to the local RSFO for a review of Medicaid eligibility and the fee to be charged to the individual
- Upon return of the form from the RSFO, forwarding the request to the DDSO Director or Authorized Designee for final approval
- Notifying the service provider of the decision regarding the funding request

Requests for Extensions

- Reviewing requests from service providers for funding extensions for individuals approved for temporary or extended state funding
- Completing a State Funding Authorization Request and submitting it to the local RSFO for a review of current Medicaid eligibility and fees to be charged to the individual based on the individual's financial circumstances
- Upon return of the form from the RSFO, forwarding the request to the DDSO Director or Authorized Designee for final approval
- Notifying the service provider of the decision regarding the funding request

State Funding Authorizations

- Advising the service provider of the determination made by the DDSO Director or Authorized Designee

D. The Revenue Support Field Office's Role in the Enrollment Process

During the Medicaid enrollment process the RSFO provides support and coordination to individuals and their representatives, service providers and the DDSO/Region 2 SDIS. Specific responsibilities of the RSFO are listed below:

The RSFO Responds to Requests from a Service Provider Regarding an Individual's Medicaid Status by:

- Verifying the individual's Medicaid enrollment
- Verifying the individual's type of Medicaid coverage and determining if it is sufficient to support billing for the type of service(s) being requested
- Verifying if a Medicaid application for an individual is already filed and pending in the New York State Medicaid system

The RSFO Provides Technical Assistance to an Individual, an Individual's Representative(s), and Service Coordinators by:

- Providing technical assistance in the preparation of Medicaid applications
- Notifying interested parties if it is of the opinion that the social services district will find the individual ineligible for Medicaid
- Reviewing Medicaid denial notices
- Evaluating the potential for an appeal of negative determinations

- If appropriate, advising an individual, an individual's representative(s), and the service coordinator to file a request for an appeal
- Assisting with the wording of the appeal

The RSFO Reviews Requests for State Funding:

- Reviews requests for state funding for services
- Verifies the accuracy of the fee determined by service provider. Evaluates the amount 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, based on a review of residential status, income and OPWDD's liability policy as outlined in Addendum 1: Rules for Determining Waived or Reduced Fees for OPWDD Services
- The RSFO's determination, listing the monthly individual liability (if any), is then entered on the State Funding Authorization Request form which is signed and returned to the DDSO/Region 2 SDIS for submission to the DDSO Director or Authorized Designee
- Reviews requests for extensions of state funding for individuals when requested to do so by the responsible DDSO/Region 2 SDIS by evaluating both Medicaid eligibility and financial liability
- The RSFO's determination, listing the monthly individual liability (if any), is then entered on the State Funding Authorization Request form, which is signed and returned to the DDSO/Region 2 SDIS for submission to the DDSO Director or Authorized Designee for final approval

Note: If an individual's circumstances have changed and s/he now appears to be eligible for Medicaid, the RSFO advises the individual or the individual's representative, the provider and the service coordinator to file a new Medicaid application. The RSFO also notifies the responsible DDSO/Region 2 SDIS.

The RSFO Reviews Requests for Fee Reduction or Waiver Requests for Individuals Receiving Preexisting Services

Upon receipt of a "Fee Reduction/Waiver for Preexisting Services Request For Approval" form the RSFO

- Verifies the accuracy of the fee determined by service provider. Evaluates the amount 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, based on a review of residential status, income and OPWDD's liability policy as outlined in the Addendum 1: Rules for Determining Waived or Reduced Fees for OPWDD Services

- Approves or denies the request. If the request has been denied provides the service provider with the reason(s)
- Provides technical assistance to service providers regarding fee reduction or waiver requests
- Assigns an authorization period for the fee waiver or reduction
- Reviews requests for extensions when service providers submit new fee reduction or waiver requests

E. The DDSO Director or Authorized Designee's Role in the Enrollment Process

The DDSO Director or Authorized Designee responds to requests for temporary and extended state funding as indicated below.

Temporary Funding

The DDSO Director or Authorized Designee:

- Reviews requests for up to 90 days of temporary state funding of services and requests for subsequent extensions
- Reviews requests for state paid service coordination extensions after the three month time period has lapsed
- Authorizes or denies funding requests as appropriate
- Provides a copy of the State Funding Authorization Request form to Central Operations Payment Processing Unit

Extended Funding

The DDSO Director or Authorized Designee:

- Reviews requests for extended state funding for individuals who do not qualify for either Medicaid or HCBS Waiver enrollment
- Authorizes or denies funding requests as appropriate
- Provides a copy of the State Funding Authorization Request Form to Central Operations Payment Processing Unit

Note: For Medicaid eligible individuals who do not qualify for Medicaid or HCBS Waiver enrollment, a detailed explanation of why the individual does not qualify must be provided when considering extended funding requests.

F. Revenue Support Central Operation's (Central Operations) Role in the Enrollment Process

Central Operations plays an oversight role in the Medicaid/HCBS Waiver Enrollment Process.

Central Operations screens claims submitted by service providers in order to determine if state funding has been authorized for an individual by evaluating the individual's:

- Date of enrollment
- Eligibility for services
- Authorization for state funding for the period approved by the DDSO Director or Authorized Designee

In addition, Central Operations:

- Monitors services recorded by providers on web-based applications
- Determines if services are being recorded for ineligible individuals
- Maintains a database of individuals authorized for state funding and of the period for which they are authorized
- Processes service provider claims for state funding
- Issues payments for delivered services (for the duration of the authorization period)
- Notifies service providers in writing if their claim for services rendered has been rejected or adjusted in the event that a service provider submits a claim for an individual who has not been authorized for state funding

Addendum 1

Rules for Determining Waived or Reduced Fees for OPWDD Services

1. Overview

This addendum seeks to specify the process for establishing charges for individuals receiving OPWDD authorized services and determining when fees should be waived or reduced with OPWDD approval. All individuals are fully liable for the full cost of services rendered unless Medicaid is paying for their services. This means that for individuals receiving HCBS Waiver services, the individual must also be enrolled in the HCBS Waiver. An individual's liability is the Medicaid rate or OPWDD fee assigned for the service.

Under clearly defined circumstances, OPWDD may approve a waiver or reduction or a waiver of fees for services*. This concession will be based on the availability of state funds, who paid for services in the past (if the service(s) is preexisting), the individual's or the liable parties' available income and resources, the individual's living situation and the individual's ability to meet Medicaid eligibility requirements.

There are two categories of services that one must take into account when liability is established—Preexisting and Other than Preexisting. Effective February 15, 2009 liability was established for the following residential and day services:

1) Preexisting Services- ICF, Family Care Residential Habilitation, CR, IRA and Day Habilitation services which commenced *prior to* February 15, 2009 as well as Medicaid Service Coordination, Day Treatment Services, At Home Residential Habilitation (now named Community Habilitation), Prevocational Services, Supported Employment Services (SEMP), Respite Services and Blended and Comprehensive Services which commenced *prior to* March 15, 2010.

2) Other than Preexisting Services- ICF, Family Care Residential Habilitation, CR, IRA and Day Habilitation services which commenced *on or after* February 15, 2009 as well as Medicaid Service Coordination, Day Treatment Services, At Home Residential Habilitation (now named Community Habilitation), Prevocational Services, Supported Employment Services (SEMP), Respite Services and Blended and Comprehensive Services which commenced on or after March 15, 2010.

In the future, as new services are implemented within the OPWDD delivery system, these services may also be subject to the liability for services regulations.

* An OPWDD approved reduction or waiver of a fee does not release an individual and/or liable party from liability for payment of the full fee.

The following chart depicts a graphical version of the date requirements for liability for services:

Service	Preexisting	Other than Preexisting	Service providers provide individuals/liable parties with a liability notice and fees for the service	Individuals/liable parties are liable for payment of the full cost of services	Bills must be issued to the individual and/or liable parties
ICF, CR, IRA, FC Residential Habilitation, and Day Habilitation Services		X	Prior to service delivery	When services start (No earlier than 2/15/2009)	3/30/09* and after
ICF, CR, IRA, FC Residential Habilitation, and Day Habilitation Services	X		3/15/2009	4/15/2009 and after	5/30/2009* and after
MSC, SEMP, Respite, Prevocational, Community Habilitation, Day Treatment, Blended and Comprehensive Services		X	Prior to service delivery	When services start (No earlier than 3/15/10)	4/30/2010* and after
MSC, SEMP, Respite, Prevocational, At-Home Residential Habilitation (now Community Habilitation), Day Treatment, Blended and Comprehensive Services	X		5/15/2010	6/15/2010 and after	7/30/2010* and after

*Going forward, the provider must present the bill no later than 30 days after the month in which the provider rendered the services.

Individuals who are receiving *Other than Preexisting* services must present evidence of and maintain Full Medicaid coverage or pay for the services in accordance with the applicable fee schedule as of the date that the services commence. Prior to receipt of those services, the provider will give the individual or the individual's representative a liability notice together with a fee schedule for the services requested. In certain circumstances, the service provider can waive

or reduce the fee with OPWDD approval. A fee waiver or reduction will be considered, based on income, resources, living situation and ability to meet Medicaid requirements, and if the individual has taken all necessary steps to obtain and maintain Full Medicaid Coverage* .

By April 15, 2009 individuals who had been receiving *Preexisting* ICF, Family Care Residential Habilitation, CR, IRA, or Day Habilitation Services must have presented evidence of and maintained “Full Medicaid Coverage” or started paying for services in accordance with the applicable fee schedule, which accompanied Liability Notice, OPWDD LIAB 02 that was issued no later than March 15, 2009.

By June 15, 2010 individuals who had been receiving *Preexisting* MSC, SEMP, Respite, Prevocational, At-Home Residential Habilitation, Day Treatment, or Blended and Comprehensive Services must have presented evidence of and maintained “Full Medicaid Coverage” or started paying for services in accordance with the applicable fee schedule, which accompanied either Liability Notice, OPWDD LIAB 06 that was issued no later than May 15, 2010.

For preexisting services, the service provider can waive or reduce the fee, with OPWDD approval, when OPWDD is paying the full or partial fee for preexisting services. A waiver or reduction is based on the individual’s income, resources, living situation and ability to meet Medicaid requirements, and is contingent on the individual having taken all necessary steps to obtain and maintain Full Medicaid Coverage* and, if necessary, enrollment in the HCBS Waiver.

2. Applying for a Fee Waiver or Fee Reduction for Preexisting Services

After referring to the criteria listed above and the “Guidelines for Determining Fees” that follow this page, the service provider must determine if a fee waiver or reduction is appropriate. If appropriate, the service provider must submit Form OPWDD LIAB 04, “Fee Reduction/ Waiver For Preexisting Services Request For Approval” to the local Revenue Support Field Office (RSFO). The RSFO will only consider requests that provide detailed explanations of the reason why the individual is not eligible for Medicaid funding of their service(s), actions taken to secure Medicaid funding or a detailed explanation as to why the individual did not apply for Medicaid or the HCBS Waiver. It is required that all relevant accompanying documentation, such as a Medicaid denial notice or a Waiver Notice of Decision, and financial information be enclosed with the request form.

Approval: If the RSFO approves a waiver of the fees, OPWDD will pay the service provider the full fee. If the RSFO approves a reduction in the fee,

* Full Medicaid Coverage is defined as the minimum level of coverage necessary under the Medicaid program to pay for the services being requested or received.

OPWDD will pay the difference between the full fee for the service and the reduced fee being billed to the individual.

As it is recognized that an individual's potential eligibility for Medicaid funding is subject to change, approvals are time limited. The authorization date will be noted on the form. One month prior to the expiration date of the fee reduction or waiver authorization, the service provider must submit a request for an extension and provide updated information in support of the request or else commence billing the individual or liable party for the full cost of the services being provided.

Denial: If a Fee Reduction/Waiver request is denied, the reason will be indicated in the response to the service provider. Some *reasons for the denial* may include:

- The service provider has submitted an incomplete form
- The service provider did not provide sufficient documentation to justify the request
- The individual, family and/or liable parties have not fully cooperated in the Medicaid and/or HCBS Waiver enrollment processes

In cases where a fee reduction is granted, bills must be issued to all individual and/or liable parties no later than 30 days after the month in which services were provided. Refer to Addendum 2 Billing and Collection of OPWDD Services on page 33 for more details.

Note: The provider may waive or reduce the fee without OPWDD approval if state funding is *not* being requested.

3. Guidelines for Determining Fees

This addendum also clarifies the financial liability of individuals with developmental disabilities who do not qualify for Medicaid funding for OPWDD services but who are requesting State funding.* These individuals are fully liable for the full cost of services. If it is determined the individual is eligible for a waiver or reduction of the fee, this waiver or reduction does not legally release the individual from liability for the full cost of services. Fees charged to the individual will offset State funding to the individual's certified residential service provider or other service provider.†

* Individuals who choose not to cooperate in the benefit development process are liable for the full cost of services they receive.

† The offset is applied first to the residential provider (IRA, Family Care, ICF or CR). If the individual does not reside in a certified residence, the offset will be applied to the non-residential services providers. The provider responsible for collecting the liability amount shall be the provider with the highest Medicaid fee for the services the person is receiving followed by other providers in descending order if the individual's liability exceeds the Medicaid fee of an individual provider.

This document is particularly relevant to service providers as the service provider is required to calculate the financial responsibility for the cost of services of individuals under their care. Refer to pages 27 through 31 for calculation examples.

This addendum clarifies the process for calculating the financial responsibility for the cost of services for individuals in the following situations:

- Living in certified residential programs
- Living alone, or age 21 or older and living with their parent(s) or someone else or
- Living with their parent(s) and under the age of 21

This addendum also clarifies the policy regarding the financial responsibility for the cost of services of parents of individuals who are under the age of 21 and living at home with a parent or parents.

The personal financial responsibility for the cost of services an individual receives is based on the same principles of equity used to determine an individual's eligibility for Medicaid as illustrated by the following guidelines for determining fees:

For individuals who have fully cooperated in the Medicaid and, if necessary, HCBS Waiver enrollment processes but have failed to qualify for both, charges will be determined by the same monthly budgeting methodology used to establish an individual's eligibility for Medicaid, namely:

If an individual's income and resources are at or below the Medicaid eligibility level, the individual will not be required to pay for services received.

If an individual's income or resources exceed the eligibility level for Medicaid, the individual will be required to pay for all or part of the cost of services received.

Guideline for limiting charges:

An individual will be charged at the service provider's full Medicaid reimbursement rate for services received or the amount of the individual's financial responsibility, whichever is less.

4. General Factors Determining an Individual's Financial Responsibility

As previously mentioned, individuals who do not qualify for Medicaid funding of the OPWDD services being provided to them are financially responsible for the cost of these services. In certain situations, an individual's parents may also have to pay for the cost of services received.

The amount the individual will be required to pay from his or her personal funds for services received is assessed through an ongoing evaluation of the following factors:

- The individual's living situation
- The individual's countable monthly income
- The individual's countable resources

If an assessment of these factors concludes that the individual is in possession of funds in excess of the allowable amount for a given living situation, the excess funds will be applied toward payment of the services the individual received if no additional payers exist.

Note: The individual will only be charged up to the service provider's Medicaid reimbursement rate for the services being provided.

An account of how these factors are applied for different living situations follows:

5. Determining Fees by Living Situation

A. Individuals Living In Certified Residential Programs

For individuals residing in an OPWDD certified congregate care facility*, the concepts of countable income, personal allowance, charges for residential care, and excess resources are defined in 14NYCRR section §633.15, §686.13 and §635-9.1. These regulations are the basis for determining financial liability for residential services.

These regulations determine the monthly personal allowance amount and charges for residential care based on the Supplemental Security Income (SSI) payment level of the residential program. An individual's excess funds must be applied to pay for the cost of services if no additional payers exist (e.g., Medicare, Third Party Health Insurance).

To ensure equity of treatment, OPWDD will apply the following rules in determining an individual's financial liability for services:

Income

Excess income is the amount of monthly income remaining after earned and unearned income disregards are applied and the personal needs allowance and residential charges are calculated and subtracted from the individual's total monthly income. This amount must be used to pay for the cost of non-residential services and is equivalent to a Medicaid eligible individual's monthly "spenddown" amount.

Note: For individuals with developmental disabilities residing in an Intermediate Care Facility (ICF), income in excess of a \$35 monthly

* Family Care (FC), Community Residence (CR), Individualized Residential Alternative (IRA)

personal needs allowance is determined to be Net Available Monthly Income (NAMI) and must be used to pay for the cost of their residential services.

Resources

Resources greater than the SSI eligibility level for an individual (currently \$2,000) must be used to pay for residential services in a congregate care residential program (FC, CR, IRA).

Note: Resources in excess of the Medicaid eligibility level for an individual (currently \$13,800) must be used to pay for ICF residential services and all non-residential services. OPWDD will allow the same resource exclusions as the Medicaid Program (i.e., up to \$1,500 for a burial fund or any amount placed into an irrevocable burial agreement).

In situations where an individual will not meet Medicaid eligibility for non-financial reasons (i.e., an undocumented immigrant), financial responsibility for the cost of services must still be determined based on income, resources, and living situation.

B. Individuals Who Live on their Own or Who Live With Their Parents or Someone Else and are Age 21 or Older

For individuals who live on their own in the community, or are age 21 or older and live in the household of a parent or someone else, fees for services will be determined based on the individual's income and resources as follows:

Income

Monthly income in an amount which exceeds the Medicaid eligibility level (currently \$767) for an individual after earned and unearned income disregards are applied, must be used to pay for the cost of services and is equivalent to a Medicaid eligible individual's monthly "spenddown" amount.

Resources

Resources in excess of the Medicaid eligibility level for an individual (currently \$13,800) must be used to pay for the cost of services. OPWDD will allow the same resource exclusions as the Medicaid Program (e.g., up to \$1,500 for a burial fund or any amount placed into an irrevocable burial agreement).

C. Individuals Living with their Parents Who Are Under 21 Years Old

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.

Individuals with developmental disabilities who are not eligible for Medicaid, who are under 21 years old, and who reside in the household of their parents will be charged for the cost of services provided to them as follows:

Individual:

Income

Monthly income which exceeds the Medicaid eligibility level (currently \$767) for an individual after earned and unearned income disregards are applied must be used to pay for the cost of services and is equivalent to a Medicaid eligible individual's monthly "spenddown" amount.

Resources

Resources in excess of the Medicaid eligibility level for an individual (currently \$13,800) must be used to pay for the cost of services. OPWDD will allow the same resource exclusions as the Medicaid Program (i.e., up to \$1,500 in a burial fund or any amount placed into an irrevocable burial agreement).

Parental Fees

In addition to the individual's fees, the parent(s) of individuals* with developmental disabilities who are not eligible for Medicaid, who are under 21 years old, and who reside in their parent's household will be charged for the cost of services provided to the individual based on the federal taxable income of the parent(s) in accordance with the "Parental Fee Schedule OPWDD Medicaid Funded Services" on page 32.

6. Calculation Examples of Available Monthly Income and Resources

A. Congregate Care Level II Residential Program (IRA & CR Downstate)

Example 1: Unearned Income Only:

VA \$1,280 & Pension \$1,400

Total Unearned Income:	\$2,680
Less \$20 Unearned Income Disregard:	- 20
Less Personal Needs Allowance	- 150
Less Room & Care payment (Rent)	- 959
Available Income	\$1,551

Fee:

If the value of services provided during the month equals or exceeds \$1,551, the individual's fee will be \$1,551.

If the value of services provided during the month is less than \$1,551, the individual's fee will be limited to the value of the services provided.

* A liable parent is the natural or adoptive parent of the individual with developmental disabilities. It does not include brothers, sisters, grandparents or other relatives if the individual does not live with a parent.

Example 2: Unearned Plus Earned Income:

Wages \$1,800 & Pension \$1,000

Earned Income:	\$1,800.00
Less \$65 Earned Income Disregard:	- 65.00
Less ½ Remaining	<u>- 867.50</u>
Available Earned Income	\$ 867.50
Unearned Income	\$1,000.00
Less \$20.00 Unearned Income Disregard	<u>- 20.00</u>
Available Unearned Income	\$ 980.00
Total Available Income	\$1,847.50
Less Personal Needs Allowance	- 150.00
Less Room & Care Payment (Rent)	<u>- 959.00</u>
Available Income	\$ 738.50

Fee:

If the value of services provided during the month equals or exceeds \$738.50, the individual's fee will be \$738.50.

If the value of services provided during the month is less than \$738.50, the individual's fee will be limited to the value of the services provided.

Example 3: Unearned Income and Resources

Pension \$600 & Bank Account: \$15,000

Resource amount greater than \$2,000 is available for residential services

Resource amount greater than \$13,800 is available for non-residential services

Total Unearned Income:	\$ 600
Less \$20 Unearned Income Disregard:	- 20
Less Personal Needs Allowance	- 150
Room & Care payment (Rent) from Income	- 438
Room & Care payment (Rent) from Resources	- 492
Available Resources	\$15,000
Amount applied to Room & Care	- 492
Medicaid Resource Level	<u>- 13,800</u>
Excess Resources	\$ 708

Fee:

If the value of services provided during the month equals or exceeds \$708, the individual's fee will be \$708

If the value of services provided during the month is less than \$708, the individual's fee will be limited to the value of the services provided.

B. Individuals with Developmental Disabilities Living on their Own or Living With Their Parents or Someone Else (not in an OPWDD certified residence)

Example 1: Earned & Unearned Income:

Wages \$1,200 & Pension \$1,400

Earned Income:	\$1,200.00
Less \$65 Earned Income Disregard:	- 65.00
Less ½ Remaining	<u>- 567.50</u>
Available Earnings:	\$ 567.50
Total Unearned Income:	\$1,400
Less \$20 Unearned Income Disregard:	- 20
Available Unearned Income	<u>\$1,380</u>
Total Available Income	\$1,947.50
Medicaid Income Level	<u>- 767.00</u>
Available Income	\$1,180.50

Fee:

If the value of services provided during the month equals or exceeds \$1,180.50, the individual's fee will be \$1,180.50.

If the value of services provided during the month is less than \$1,180.50, the individual's fee will be limited to the value of the services provided.

Example 2: Unearned Income and Resources

Annuity \$500 & Bank Account \$24,000

Total Unearned Income:	\$ 500
Less \$20 Unearned Income Disregard:	- 20
Available Unearned Income	\$ 480
Medicaid Eligibility Level	<u>- 767</u>
Available Income	\$ 0
Available Resources	\$ 24,000
Medicaid Resource Level	<u>- 13,800</u>
Excess Resources	\$ 10,200

Fee:

If the value of services provided during the month equals or exceeds \$10,200, the individual's fee will be \$10,200.

If the value of services provided during the month is less than \$10,200, the individual's fee will be limited to the value of the services provided.

7. Parental Fee Schedule

This fee schedule is only applicable when an individual is under 21 years of age, and lives with his or her natural or adoptive parents and the individual has

applied for but does not qualify for Medicaid. The parent(s) will not be charged if the individual is in receipt of Medicaid.

While parental resources are not a factor in determining financial responsibility for the cost of services, parental income is considered. The parent(s) may attest to the amount of their federal taxable income.

Annual Taxable Family Income	Fee Per Service	Monthly Family Maximum*
\$1 - \$100,000	\$ 0	\$ 0
\$100,001 - \$125,000	\$ 9	\$ 27
\$125,001 - \$150,000	\$ 15	\$ 45
\$150,001 - \$175,000	\$ 20	\$ 60
\$175,001 - \$200,000	\$ 30	\$ 90
\$200,001 - \$225,000	\$ 40	\$ 120
\$225,001 - \$250,000	\$ 50	\$ 150
\$250,001 and above	\$ 100	\$ 300

* The monthly maximum is for all OPWDD services, not per individual provider.

If the parent notifies the provider of a change in income which impacts the parent's financial responsibility, the provider will adjust the fee to match the new income threshold, and notify the DDSO/Region 2 SDIS of this change so that the offset to state funding can be adjusted accordingly.

The parental fee schedule is only applicable to individuals who have fully cooperated in the Medicaid and HCBS Waiver application processes. This refers to individuals who attempt to obtain Medicaid coverage and/or HCBS Waiver enrollment, have taken all measures necessary to qualify (including placing available assets into Supplemental Needs Trusts, yet are denied. Conversely, if the individual or family is not willing to apply for Medicaid, they will be responsible for the full cost of services and the parental fee schedule will not be applicable to their situation.

Addendum 2

Billing and Collection for OPWDD Services

1. Overview

This addendum identifies the responsibilities and processes used by the service provider, the individual and/or liable parties and OPWDD related to the billing and collection of fees for OPWDD services.

The following rules apply to both Preexisting and Other than Preexisting Services:

- The service provider must issue bills to all individuals and/or liable parties no later than 30 days after the month in which services were provided (unless a fee(s) have been waived)
- 30 days written notice must be given for any changes in the reduction or waiver of fees granted with prior OPWDD approval
- The provider must make reasonable attempts to collect unpaid bills
- After making reasonable collection efforts and upon consent of OPWDD, a provider will assign OPWDD its claim for payment for any unpaid amount

2. Billing Account Notice

Individuals and/or liable parties who are billed either for the full cost of services or an OPWDD approved reduced rate should be provided with the Billing Account Notice, Form OPWDD LIAB 03.

The fee charged may change in the future if OPWDD changes the Medicaid rate, fee or price for the service, or if the provider-specific rate, fee or price changes (e.g., due to a rate appeal). Further, an individual may be charged by a service provider in order to recover a Medicaid rate, fee or price increase. Conversely, the form should also be used to notify individuals when refunds are being issued due to a rate decrease. For further information please refer to “Billing Requirements in Liability for Services Regulations” at:

<http://www.opwdd.ny.gov/wt/publications/msc/index.jsp>

3. Billing and Collection Scenarios

There are several billing and collection scenarios that may arise given the diversity of each individual’s unique situation as follows:

1) The individual has been approved for state funding

The service provider must submit claims to OPWDD to receive state funding for the service. State funding is initially approved for a time limited period, dependent upon the specific circumstances. When the authorization has expired, a new request must be submitted to OPWDD.

2) The individual has been approved for a fee reduction

OPWDD will pay the service provider the difference between the full fee and the reduced fee. The service provider will bill the individual and/or liable party for the amount of the reduced fee, utilizing the billing and collection procedures that have been detailed throughout this document.

3) An individual who was state funded is now enrolled in Medicaid and HCBS

When a service provider has received state funding for an individual's service(s) and the individual has since been 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.

4) The individual and/or liable party is paying privately

If the service provider is beginning to receive payments, it must reimburse OPWDD for all state funds that were received for this individual. The service provider should submit a Standard Voucher with Billing Form (applicable to the service for which they received state payment). The voucher and billing form should be completed similarly to when sending in the voucher and billing form for payment EXCEPT, the service provider will identify minus units (e.g., -19 units) on the billing form (so a negative amount totaled on the billing form) and a negative amount on the voucher.

Upon receipt of the form, OPWDD will enter the minus units into Voucher Processing and will offset the negative amount against a future positive voucher for the provider.

In the rare instance where a service provider is no longer billing OPWDD any state payments to offset the negative amount against, OPWDD Central Operations will contact the service provider for a check. Providers should NOT send OPWDD a check as settlement unless specifically instructed to do so.

- Charges to private pay individuals must be at the Medicaid rate, fee or price for the service, excluding room and board charges which are not reimbursable under the Medicaid program and therefore not covered under the liability for services regulations.
- Charges to a private pay individual cannot differ from charges for identical services delivered to a Medicaid funded individual.

5) The individual and/or liable party agrees to pay privately and later decides not to pay the bills

The service provider must continue to issue bills on a regular basis, no later than 30 days after the month in which the services were provided. The service provider is also required to make reasonable efforts to collect unpaid bills. These

collection efforts should be documented (e.g., written correspondence). If the collections efforts are unsuccessful, the provider should contact the Revenue Support Field Office for the next steps. With OPWDD consent, the service provider may assign its claim for payment to OPWDD.

For individuals receiving preexisting services, the provider cannot discontinue services to the individual on the basis of nonpayment but will continue to receive OPWDD payments, as outlined in the Liability for Services regulations, as long as the service provider complies with the requirements set forth in the regulations.

OPWDD funding will be discontinued to service providers who do not comply with the regulatory requirements.

For individuals receiving “other than preexisting services,” the provider can discontinue services unless receipt of services is subject to a court order, utilizing the procedures specified in OPWDD regulations, Section §633.12. Otherwise, the service provider can continue to provide services with waived or reduced fees at their discretion, with the understanding that OPWDD payments are not available when such concessions are granted.

4. Assignment of Collection Activities to OPWDD

Per the Liability for Services Regulations Section 635-12.5, service providers are required to provide viable monthly bills and pursue collection of unpaid balances owed by individuals and/or liable parties for individuals who do not qualify for Medicaid funding of covered services when a waiver of fees has not been approved by OPWDD.

In situations where a service provider has taken the necessary actions to secure payment for services provided but has not been successful, the service provider may request that OPWDD agree to accept assignment of the claim and the pursuit of collection actions. Requests must be made to the manager of the local Revenue Support Field Office by completing the “Request To Assign Unpaid Amounts To The New York State Office Of Mental Retardation And Developmental Disabilities” Form. This form, including instructions, as well as the process and a list of Revenue Support Field Offices can be located on the OPWDD web site at: <http://www.opwdd.ny.gov/wt/publications/msc/index.jsp>

Note: OPWDD will not consent to accept claims when a service provider has not documented its efforts to collect outstanding balances. Also, OPWDD will not accept claims when a referral is received from a service provider that does not contain sufficient details and documentation in order to proceed.

All documents referenced in this document can be located at:
<http://www.opwdd.ny.gov/wt/publications/msc/index.jsp>