NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

ADMINISTRATIVE DIRECTIVE

Transmittal:	23-ADM-06
To:	Developmental Disabilities State Operations Office (DDSOO) Directors Developmental Disability Regional Office (DDRFO) Directors Care Coordination Organization (CCO) CEOs Voluntary Provider Executive Directors
Issuing OPWDD Office:	Division of Service Access, Program Implementation and Stakeholder Support – Regional Field Offices
Date:	7.17.23
Subject:	Individual Eligibility and Enrollment for the Office for People with Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) 1915(c) Waiver and Requests for Service Authorization
Suggested Distribution:	Enrollment Specialist Care Managers Care Manager Supervisors Clinical Staff
Contact:	peoplefirstwaiver@opwdd.ny.gov
Attachments:	

Related ADMs/INFs	Releases Cancelled	Regulatory Authority	MHL & Other Statutory Authority	Records Retention
		14 NYCRR §§ 629, 630.5, 635-10.3; 42 CFR Part 435	NY MHL § 1.03(22); NY SSL §366(7-a)(b); SSA §§ 1634, 1902; OPWDD's Comprehensive HCBS Waiver under §1915(c) of the Social Security Act	18 NYCRR 504.3(a) New York False Claims Act (State Finance Law §192)

Purpose:

New York State's Office for People With Developmental Disabilities (OPWDD) maintains a statewide Medicaid waiver approved by the federal Centers for Medicare and Medicaid Services (CMS). This waiver is formally known as the OPWDD Comprehensive Home and Community-Based Services (HCBS) 1915(c) Waiver (HCBS Waiver) and authorizes an array of community-based habilitation services to eligible individuals with developmental disabilities. The available services are Day Habilitation, Prevocational Services, Residential Habilitation, Community Habilitation, Respite, Supported Employment, Pathway to Employment, Live-In Caregiver, Community Transition Services, Fiscal Intermediary, Individual Directed Goods and Services, Support Brokerage, Family Education and Training, Intensive Behavioral Services, Assistive Technology – Adaptive Devices, Environmental Modifications, and Vehicle Modifications.

The terms of the HCBS Waiver agreement with CMS, which is part of the U.S. Department of Health and Human Services, require OPWDD to oversee providers of HCBS and to enforce the HCBS Waiver rules. A key component of OPWDD's role is to ensure that HCBS are only delivered to eligible individuals under the HCBS Waiver's rules. This ADM describes how OPWDD establishes HCBS Waiver eligibility including level of care, appropriate residential settings, and New York State residency status. The Guidance further describes how OPWDD evaluates the requirement that a person's need for HCBS Waiver services is demonstrated through a "Reasonable Indication of Need" evaluation.

Background:

Individuals seeking supports and services offered through OPWDD's HCBS Waiver must enroll in the HCBS Waiver program through their appropriate OPWDD Service Access, Program Implementation, Stakeholder Supports, Developmental Disabilities Regional Field Offices (DDRFOs). DDRFOs help individuals who indicate a need for services by using OPWDD's tools for assessing individual needs and service planning. This process includes the determination of a developmental disability, a level of care and an evaluation of need. Once an individual's eligibility for OPWDD services is established, they are provided with opportunities for supports and services, which may include HCBS waiver services, that meet their needs.

Discussion:

The rules required for HCBS Waiver eligibility and enrollment are described below.

In addition to these rules, individuals must be enrolled in a Care Management service (OPWDD Care Management) to coordinate HCBS Waiver services. OPWDD Health Home Care Management services or OPWDD Basic Home and Community-Based Services Plan Support services are provided by Care Coordination Organizations (CCOs) to assist people with developmental disabilities and their families to gain access to services and supports appropriate to their needs. These services are provided by qualified Care Managers (also known as Care Coordinators). The Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plan is available for adults with long-term care needs who are eligible for Medicare and Medicaid (i.e., dual-eligible) and reside in one of the five New York City boroughs or Nassau, Suffolk, Rockland or Westchester Counties. Individuals enrolled in the FIDA-IDD receive both Medicare and Medicaid benefits from one managed care plan. These benefits are coordinated through the FIDA-IDD Care Management service which is also provided by qualified Care Managers/Care Coordinators. Additional information about OPWDD Care Management services can be found at: https://opwdd.ny.gov/care-management.

A. HCBS WAIVER ELIGIBILITY AND ENROLLMENT

OPWDD must ensure that every applicant meets the HCBS Waiver's eligibility rules before permitting the individual to enroll. Under those rules, the individual must:

1. Have a developmental disability as defined by New York Mental Hygiene Law Section 1.03(22) that: originated before the age of 22; has continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such person's ability to function normally in society;
2. Need a Level of Care that would be provided in an Intermediate Care Facility for Individuals with Intellectual and/or Developmental Disabilities (ICF/IID);
3. Be a Resident of New York State and live in an appropriate living arrangement, as defined in 14 NYCRR 635-10.3(b)(5);
4. Be in a Medicaid eligibility group that is eligible to enroll in Medicaid as described in the HCBS Waiver and defined in SSA §§ 1634(c) and 1902(a)(10)(A)(i) and (ii) and 42 CFR Part 435;
5. Not be enrolled in another HCBS Waiver or a managed long-term care plan, as described in 42 CFR §433 Subpart D; and
6. Meet the requirement of a Reasonable Indication of Need for Services as defined in 42 CFR §441.302(c) and described in the HCBS Waiver.

See below for additional information for each requirement.

1. **The person must have a developmental disability as defined by New York Mental Hygiene Law Section 1.03(22) that: originated before the age of 22; has continued or can be expected to continue indefinitely; and constitutes**

a substantial handicap to such person's ability to function normally in society.

To have eligibility established with OPWDD, the person must begin the process of applying for eligibility. This process includes:

i. Person contacts the Front Door at the DDRFO to show their interest in getting OPWDD services.

ii. Front Door connects the person with a Care Coordination Organization (CCO) or service access agency.

iii. The CCO works with the person to gather all documents for an eligibility determination. This includes:
   - Required documents *(also see OPWDD Eligibility Guidelines ADM #2023-02*:
     - Cognitive testing;
     - Adaptive assessments;
     - Medical documentation;
     - OPWDD Transmittal Form;
     - Physical or Medical summary (i.e., general medical report completed in the last 12 months);
     - Social/developmental history, psychosocial report or other report that shows that the person became disabled before age 22 (unless contained in other reports);
     - Social evaluation (completed in the last 12 months); and
   - Other helpful documents, as applicable:
     - Individualized Education Plan (IEP), 504 Plan, and other educational documents; and
     - Mental health evaluations and records.

iv. Once all documents have been gathered, the CCO uploads the documents and a Transmittal Form to CHOICES. Note, an application must have a Transmittal Form and include all required documents to be considered complete.

v. After uploading the information to CHOICES, the CCO must send an e-mail to the CCO Mailbox informing OPWDD that the information is ready for OPWDD review.

OPWDD will only review formally submitted applications for eligibility determination. An application for eligibility is considered formally submitted when:

- all required documents (outlined on page 4) and the transmittal form is uploaded to CHOICES; and
- an e-mail is sent to the CCO Mailbox informing OPWDD of the CHOICES upload.

Once the application is formally submitted, OPWDD reviews and determines whether the person is eligible for OPWDD services based on the criteria outlined in MHL § 1.03(22) and 14 NYCRR § 629.

2. **The individual must need a Level of Care that would be provided in an Intermediate Care Facility for Individuals with Intellectual and/or Developmental Disabilities (ICF/IID).**

   All individuals with an Intellectual and/or Developmental Disability (I/DD) who are seeking to access or maintain eligibility for the HCBS Waiver, FIDA-IDD plan, OPWDD Care Management services, and other OPWDD Medicaid State Plan Services must demonstrate the need for the level of care that would be provided by an Intermediate Care Facility for Individuals with Intellectual and/or Developmental Disabilities (ICF/IID). Individuals must have an initial **determination** and annual **redeterminations** to determine level of care when there is a reasonable indication of need for services as defined in federal regulations 42 CFR §§ 441.302 and 441.303 and described in the HCBS Waiver.

   The service documentation requirements, instructions, and ICF/IID level of care eligibility determination (LCED) form are found in OPWDD Administrative Directive 20-ADM-02 https://opwdd.ny.gov/adm-2020-02-revised-intermediate-care-facilities-individuals-intellectual-disabilities-icfidd-level

3. **The individual must be a Resident of New York State and live in an appropriate living arrangement, as defined in 14 NYCRR 635-10.3(b)(5).**

   An individual who chooses to apply for HCBS Waiver services must be a resident of New York State and reside in an appropriate living arrangement at the time of enrollment in the HCBS Waiver. An appropriate living arrangement is limited to an individual's own home or that of a relative, an OPWDD certified community residence, an OPWDD-certified Individualized Residential Alternative (IRA), or an OPWDD-certified family care home (FCH).

Ineligible residential settings for waiver enrollment include, but are not limited to, institutional settings (e.g., ICFs/IID, Developmental Center (DCs), Skilled Nursing Facility (SNFs), hospitals). If an individual lives in an ineligible setting, they must be fully discharged from that setting before receiving most HCBS waiver services. In limited circumstances, the individual may receive some HCBS waiver services as part of their transition to an eligible service setting (e.g., Community Transition Services).

4. The individual must be in a Medicaid eligibility group that is eligible to enroll in Medicaid as described in the HCBS Waiver and defined in SSA §§ 1634(c) and 1902(a)(10)(A)(i) and (ii) and 42 CFR Part 435.

i. Medicaid Eligibility

To participate in the HCBS Waiver, an individual must be enrolled in Medicaid. The Care Manager assists the individual and/or family with accessing supports and services for the individual. Care Managers must help individuals apply for the appropriate type of Medicaid to ensure coverage for the HCBS waiver services that are needed.

ii. Compatible Medicaid Waiver of Deeming of Parental Income and Resources for Medicaid Eligibility

Children seeking OPWDD services may require Medicaid eligibility. In some cases, a child under the age of 18 may not qualify for Medicaid based on their family's income and resources. In these cases, the child can ask for parental income and resources to not be counted (i.e., a waiver of parental deeming) toward their financial resources so they may meet Medicaid financial eligibility criteria in order to access OPWDD's HCBS waiver services. A complete HCBS Waiver application must be submitted prior to requesting a waiver of parental deeming. This process is described fully in Memorandum, *HCBS Waiver Application Process for Children Who Require Waiver of Parental Deeming*, 8/24/2021 https://opwdd.ny.gov/system/files/documents/2021/09/hcbs-waiver-application-requirements-for-parental-deeming.pdf.

iii. Maintaining Medicaid Eligibility

a. Recertification/Renewal

Medicaid coverage for an individual not eligible as a Supplemental Security Income (SSI) recipient must be recertified at least annually. The individual or their representative must complete a recertification form and provide all

required documentation. Care Managers are expected to monitor or assist individuals with maintaining benefits such as Social Security, SSI, Medicaid and Medicare coverage and/or the Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps. When an individual lives in a certified residential setting, the provider is responsible for maintaining the person's benefits if the provider is the Representative Payee and Authorized Representative. This includes the completing applications, recertifications and reporting requirements. If an individual does not have a Representative Payee or the individual lives in the community, the care manager will assist as needed.

b. Reporting Changes to the Medicaid District

The individual or their representative must notify the Medicaid district promptly of changes in address, living arrangement, the source or amount of income (including windfalls and lump sums), amount or location of assets, change in disabling condition, or any other factors that might affect Medicaid eligibility or coverage.

c. County-to-County Moves

When an individual moves from one county to another, the sending county (i.e., county **from** which the individual is moving) continues Medicaid coverage for a full month following the month it is notified by the Medicaid recipient of the move. The receiving county (i.e., county **to** which the individual is moving) opens Medicaid coverage based on the original county's existing authorization period (usually 12 months). The receiving county keeps Medicaid coverage open until the individual's next scheduled Medicaid recertification or for a minimum of four (4) months. Medicaid recipients must notify their sending county of their move and their new address for this policy to apply. The policy does not apply to:

- Supplemental Security Income recipients (there is an existing automated process to move coverage to the receiving county);
- Individuals moving from a chronic care setting (e.g., ICF/IID, hospital, psychiatric center, or skilled nursing facility (SNF)); or
- Individuals being placed into a residence where OPWDD (Medicaid District 98) or New York State's Office of Mental Health (Medicaid District 97) is the Medicaid district.

d. Region to Region Moves

When a HCBS Waiver enrolled individual moves from one OPWDD Region to another OPWDD region, the OPWDD Inter-Region Transfer (IRT) Process is followed to ensure continuity of care.

5. **Not be enrolled in another HCBS Waiver or a managed long-term care plan, as described in 42 CFR §433 Subpart D.**

   Individuals must not be enrolled in or receive services from more than one Medicaid waiver or managed long-term care plan at a time.

6. **Meet the requirement of a Reasonable Indication of Need for Services as defined in 42 CFR §441.302(c) and described in the HCBS Waiver.**

   Under CMS rules, enrollment in the HCBS Waiver is contingent on an individual requiring one or more HCBS waiver services to avoid institutionalization. If the individual's need for services can be met through other sources of funding, then those options must be explored first. An individual can only access HCBS waiver services when the individual has a reasonable need for a type of waiver service that is not available from other sources. Other sources may include natural or community supports, early intervention, school supports, or Family Support Services (FSS).

   To show a Reasonable Indication of Need for HCBS Waiver services, the individual must:

   - Require at least one (1) HCBS Waiver service as documented in their Life Plan; and
   - Require the HCBS Waiver service(s) at least monthly; or
   - Require regular monthly monitoring if their need for service(s) is less than monthly, as documented in their service plan/Life Plan.

   A Request for Service Authorization is not enough to satisfy this requirement. Service Authorization and enrollment in the HCBS Waiver must be based on a plan for services. This is described in the following memorandum: life-plans-and-service-authorization-memo-3.15.22.pdf (ny.gov)

   The need for Respite Services alone is not sufficient to demonstrate the person's reasonable indication of need for a monthly HCBS waiver service, where such respite services are sufficiently available through a non-Medicaid funding source.

   i. Reasonable Indication of Need for HCBS Waiver Services by Age

The following outlines criteria that are used to assess an individual's need for waiver services and enrollment:

a. Birth to Age 3

Families seeking supports for children ages birth to 3 years old must first use services through the Early Intervention (EI) program, if available, before accessing HCBS waiver services. To be eligible for enrollment in the HCBS Waiver, a child who is receiving services from an EI program must demonstrate a reasonable indication of need for monthly waiver services that cannot be met through the EI program or other funding options. The requirement of monthly monitoring for children who receive EI services is met by the service coordination provided through the EI program. Therefore, the need for monthly monitoring does not substantiate a reasonable indication of need for HCBS Waiver enrollment for children enrolled in an EI program.

HCBS Waiver services cannot be duplicative of the services provided through the EI program. Therefore, individuals who are enrolled in EI and also deemed eligible for HCBS waiver services must be enrolled in non-Medicaid Care Management through a CCO to prevent duplication of the provision of service coordination. Children participating in the EI Program receive an Individual Family Service Plan (IFSP) for their EI services, but they must also have a Life Plan if they are receiving an HCBS waiver Service at the same time. The individual receiving EI services is not eligible for OPWDD Health Home Care Management or OPWDD Basic HCBS Plan Support services**.**

b. Preschool (Ages 3 to 5)

Children ages 3 to 5 who qualify for special education services receive educational and related support services via the State Education Department Committee on Preschool Special Education (CPSE) through the development of an Individualized Educational Plan (IEP). Monthly OPWDD Care Management is not a part of the continuum of IEP services. To be eligible for HCBS waiver services, individuals in this age group must demonstrate a reasonable indication of need to receive HCBS Waiver services and they must receive Care Management services through either OPWDD Health Home Care Management or OPWDD Basic HCBS Plan Support.

c. School-Age (Ages 5 to 18)

Individuals of school age receive services primarily through the State Education Department. Individuals in this age group requesting HCBS Waiver

enrollment must be evaluated and must demonstrate a reasonable indication of need. If the individual is eligible for and receiving HCBS waiver services, they must receive Care Management services through either OPWDD Health Home Care Management or OPWDD Basic HCBS Plan Support.

d. Adults Receiving School Services (Ages 18 – 21)

Individuals of school age receive services primarily through the State Education Department. Individuals in this age group requesting HCBS Waiver enrollment must be evaluated and must demonstrate a reasonable indication of need. If the individual is eligible for and receiving HCBS waiver services, they must receive Care Management services through either OPWDD Health Home Care Management or OPWDD Basic HCBS Plan Support.

e. Adults No Longer Receiving School Services (Ages 18+)

If the individual needs monthly monitoring only and does not need HCBS waiver services, they can receive OPWDD Health Home Care Management (a state plan service) without enrollment in the waiver. Individuals in this age group who choose to enroll in the HCBS Waiver must receive Care Management services through either the FIDA-IDD (if eligible), OPWDD Health Home Care Management, or OPWDD Basic HCBS Plan Support.

ii. Reasonable Indication of Need for HCBS Waiver Services and Self-Direction

Individuals needing a Fiscal Intermediary (FI) and/or Support Brokerage services require the receipt of at least one (1) additional HCBS waiver service in order to meet the reasonable indication of need requirement for HCBS waiver enrollment as defined in 42 CFR §441.302(c) and described in the HCBS Waiver. In addition to the services identified above, HCBS under Self-Direction also includes Individual Directed Goods and Services (IDGS). FI, Support Brokerage**, and Individual Directed Goods and Services (IDGS)** are not stand-alone services but are rather support services under the Self-Direction model. FI, Support Brokerage**, and/or IDGS** services alone are not enough to meet the requirement for the receipt of a monthly HCBS waiver service.

B. DOCUMENTATION OF CHOICES

If an individual meets the eligibility requirements and wants to receive one or more HCBS waiver services, they must choose community-based services over institutional care as defined in 42 CFR §441.302(d) and described in the HCBS Waiver. Individuals

must document that choice on OPWDD's "Documentation of Choices" form, available at:
https://opwdd.ny.gov/system/files/documents/2022/02/final-waiver-application-doc-form_final-11.19.20.pdf

The individual's Care Manager collects the documents needed to apply for the HCBS Waiver and Service Authorization. These documents include:

- OPWDD Eligibility;
- HCBS Waiver Application;
- Documentation of Choice;
- Medicaid;
- Current LCED signed by Physician/Nurse Practitioner;
- Current DDP2;
- Completed CAS/CANS, as applicable for age;
- In-Process Life Plan; and
- Request for Service Authorization form.

Once all of the documents have been gathered, the CCO must upload the documents to CHOICES using the Documentation of Submission form. After uploading the documents to CHOICES, the CCO must send an email to the CCO Mailbox informing OPWDD the information is ready for OPWD review.

An application for the HCBS waiver and service authorization is defined as submitting all documentation outlined above to CHOICES and e-mailing the CCO Mailbox that the information is ready for review.

C. HCBS WAIVER TERMINATION

Individuals must continuously meet the eligibility rules to maintain enrollment in the HCBS Waiver as specified in section A above. If an individual is deemed to no longer meet one or more of the above criteria, CMS requires OPWDD to disenroll the individual from the HCBS Waiver.

The individual may be terminated from the HCBS Waiver when they:

- Choose to no longer receive services;
- Are no longer eligible for HCBS waiver services because they are no longer eligible for Medicaid or do not meet the statutory and/or regulatory requirements for HCBS Waiver enrollment as described herein; or
- Are permanently admitted to an ICF/IID (including a Developmental Center), a community-based ICF, a Small Residential Unit (SRU), a specialty hospital, a

SNF, or a psychiatric center.

Individuals terminated from the HCBS Waiver will receive a notice, including information on how to request a fair hearing if they disagree with the termination.

Care Managers are responsible for notifying the OPWDD Regional Office when an individual's participation in OPWDD's HCBS waiver program should be reviewed for termination. Care Managers are encouraged to complete and submit the Waiver Termination Request Form at the following link: https://opwdd.ny.gov/system/files/documents/2022/09/hcbs_waiver_termination_request_form-10.1.2022.pdf

Records Retention:

New York State regulations require Medicaid providers to prepare records demonstrating its right to receive Medicaid payment for a service. All documentation specified above, including the Life Plan and service documentation, must be prepared contemporaneously with the corresponding service and retained for a period of at least ten (10) years from the date the service was delivered or when the service was billed, whichever is later.