



# STATE OF NEW YORK DEPARTMENT OF HEALTH

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<b>LOCAL COMMISSIONERS MEMORANDUM</b>
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**DSS-4037EL (Rev. 9/89)**

**Transmittal No:** 98 OMM LCM-010

**Date:** October 15, 1998

**Division:** Office of Medicaid  
Management

**TO:** Local District Commissioners

**SUBJECT:** Evans v. Wing et al. Court Order

**ATTACHMENTS:** Evans Notice (Department mailing) (not available on-line)

Evans Notice (District mailing) (not available on-line)

District-specific report of potential Evans class members for the period January 1, 1995 through August 31, 1996 (not available on-line)

This Local Commissioners Memorandum (LCM) provides information concerning the Order issued in the Evans v. Wing et al. class action lawsuit. As advised in GIS message 98 MA026, dated August 12, 1998, this case concerns an action brought in Erie County Supreme Court on behalf of a class of institutionalized spouses who received home and community-based waived services (waiver recipient) and whose personal needs allowance (PNA) was reduced to \$50. Under the terms of the Order in Evans, waiver recipients who received a \$50 PNA during the period from January 1, 1995 to August 21, 1996, must be rebudgeted with a PNA equal to the Medicaid income level for a one person household (\$550 for 1995 and \$559 for 1996) and may be entitled to Medicaid reimbursement as a result of this budget change.

The following is a brief summary of the Department's policy concerning the PNA amount provided to waiver recipients and the actions that will be required as a result of this litigation.

### **Background**

Prior to January 1, 1995, it was the Department's policy to budget waiver recipients who have community spouses with a PNA equal to the Medicaid

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income level for a one person household rather than the usual \$50 PNA provided to institutionalized spouses who reside in medical facilities. However, in 1994, the Department issued GIS message 94 MA026, instructing social services districts to budget all institutionalized spouses with a \$50 PNA effective January 1, 1995. This policy change was based on the Department's understanding that the Health Care Financing Administration (HCFA) mandated the PNA be the same for all institutionalized spouses. The Department's interpretation of Federal statutes also supported this policy change.

In a decision dated June 30, 1997, the court found that the Department's justification for reducing the PNA of waiver recipients to \$50, namely that HCFA had not required the Department to change its policy, could not be upheld. As a result, the Department must provide retroactive relief to waiver recipients who received a \$50 PNA during the period from January 1, 1995 to August 21, 1996. (On August 21, 1996, the Department issued a GIS message clarifying that the basis for the policy change was the Department's interpretation of Federal law, and not a mandate from HCFA.)

While the Department is required to provide relief to a retroactive group of waiver recipients as a result of the decision already made in Evans, a second issue in this case, prospective relief (the statutory authority for the \$50 PNA after August 21, 1996) has yet to be addressed by the Court.

#### **Identifying Individuals Who Are Entitled To Relief**

An individual is entitled to Medicaid reimbursement under the Evans Court Order if he/she (1) had a spouse in the community; (2) received home and community-based waived services through the Long Term Home Health Care program at any time during the period from January 1, 1995 through August 31, 1996; (3) was budgeted with a \$50 PNA in determining Medicaid eligibility; and (4) had a contribution towards the cost of care during the above time period.

If a waiver recipient meets the above criteria, Medicaid eligibility must be re-calculated as follows:

From	Through	Personal Needs Allowance		Difference Each Month
		Old Amount	New Amount	
January 1, 1995	December 31, 1995	\$50	\$550	\$500.00
January 1, 1996	August 31, 1996	\$50	\$559	\$509.00

The "difference" **each month** is the maximum amount of reimbursement the waiver recipient may be entitled to. Since individuals may only receive reimbursement for money they have actually paid towards their medical bills,

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reimbursement is limited to the amount of income the individual actually contributed toward the cost of care. For example:

A monthly contribution of \$200 for January 1, 1995 through April 30, 1995 would mean that the individual would be entitled to reimbursement of \$800.00 (\$200 x 4 months).

If an individual had a monthly income contribution in excess of the capped difference between the applicable Medicaid level and the \$50 PNA (e.g., \$600), reimbursement would be capped at the amount of the difference (\$500 for 1995 or \$509 for 1996).

Generally, the use of the Medicaid income level for one instead of the \$50 PNA will result in a decrease in the amount of income that is considered to be available to the community spouse as part of the community spouse monthly income allowance. In cases where the community spouse was at the maximum community spouse monthly income allowance amount, and the waiver recipient had income remaining that was applied toward the cost of care, the waiver recipient will be entitled to reimbursement.

It should be noted that in re-determining an individual's Medicaid eligibility for purposes of providing retroactive reimbursement, it is not necessary to do a new budget on MBL. A comparison of the individual's previous contribution amount(s) (as found in the individual's case record) to \$500 and/or \$509, as applicable, will determine the amount of reimbursement the waiver recipient may be entitled to.

#### **Notification to Potential Class Members**

To assist in identifying individuals who may be entitled to reimbursement, the Department has identified all waiver recipients who received services during the period from January 1, 1995 to August 31, 1996. Enclosed is a copy of this district specific report. It should be noted that the report could not be tailored to specifically identify only those waiver recipients who have community spouses.

Based on the report, the Department will send a notice to potential class members advising them of the Department's obligation to provide reimbursement in accordance with the Order in Evans. The notice will instruct affected individuals to obtain documentation from their provider(s) to verify that the provider(s) has received payment of the individual's contribution amount for the specified period. The individual is instructed to provide this documentation to his/her social services district for reimbursement.

Individuals who still owe money to their Long Term Home Health Care provider or other medical provider, are instructed to submit a copy of the outstanding bill(s) to their local social services district for possible payment or adjustment to the amount owed. The Department will be mailing the notice to potential class members within two weeks of the release of this LCM. Enclosed for your reference is a copy of the notice (Attachment A).

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It is important to note that out of the 22,712 waiver recipients identified statewide, 2,448 were found not to have an address match on the EMEVS file. If a district's report includes an individual for whom no address was found, the district must check the individual's case record for a mailing address and send a copy of the enclosed notice to the individual.

As offered in GIS message 98 MA/026, some districts have elected to send the notices directly rather than have the Department do the mailing. If your district has chosen to be responsible for the mailing, enclosed as Attachment B is a copy of the notice that must be sent. This notice is to be reproduced on agency letterhead and should not be modified except to include information concerning a contact person and/or telephone number. The notices should be sent within 30 days of the receipt of this LCM. This time period should allow districts to accurately identify waiver recipients who have community spouses. If a district wishes to further tailor their mailing, they may review past MBL budgets or notices and only notify those cases where the waiver recipient had a contribution towards the cost of care.

#### **Medicaid Payments or Reimbursement as a Result of the Order in Evans**

Individuals who request Medicaid reimbursement of paid bills must provide proof of payment from their Long Term Home Health Care provider or other medical provider. Requests for reimbursement shall be handled in accordance with the procedures set forth in the New York State Fiscal Reference Manual for Local Departments of Social Services (Volume I, Chapter 7, pages 29-33). Social services districts are reminded that if they elect to reimburse class members directly, each class member requesting reimbursement must be sent the DSS-3869, "Notice of Reimbursement by the Medical Assistance Program". In addition, individuals must be sent the DSS-3868, "Notice of Medical Assistance Review", indicating that Medicaid eligibility has been reevaluated as a result of the Evans v. Wing court case. The Medicaid notice of decision to be used with the DSS-3868 is the DSS-4021, "Notice of Intent to Change the Contribution Toward Chronic Care Costs". A copy of this notice is not required to be sent to the individual's Long Term Home Health Care provider or other medical provider.

Reimbursement to an individual is to be considered exempt as income in the month received and exempt as a resource in the following month. Thereafter, any funds remaining are counted as a resource.

Individuals who still owe money to their Long Term Home Health Care provider, or other medical provider, for any time during the period of January 1, 1995 to August 31, 1996, must submit a copy of the unpaid bill(s) for possible payment. If the recomputation of the individual's eligibility results in a reduced contribution amount required to be applied towards the bill(s), both the individual and provider must be notified of the change in liability (DSS-3868 and DSS-4021). Although medical bills are generally processed by MMIS, the bills relating to this court case are more than two years old and, therefore, cannot be processed by MMIS. Similar to the handling of Medicaid reimbursements to individuals, social services districts have the option of either processing the claims and issuing payments to providers directly, or

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having the New York State Department of Health process the claims and issue the required payments. If a district decides to provide payments to providers directly, the DSS-3869 must be used to inform the provider of decision to make payment.

Questions regarding the Evans litigation or the actions that are required as a result of this court case should be directed to Wendy Butz, of my staff, at (518) 473-5500. Questions in New York City may be directed to (212) 417-4853.

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Ann Clemency Kohler  
Deputy Commissioner  
Office of Medicaid Management

Enclosures