COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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February 16, 2021

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: **Karen Kimsey**
Director, Virginia Department of Medical Assistance Services

SUBJECT: **Study of the current Personal Maintenance Allowance for waiver services and the impact of that amount on the ability of service recipients to engage in compensated employment.**

This report is submitted in compliance with the Virginia Acts of the Assembly – 2020 Session, Chapter 882 Enactment Clause 1, SB213, which states:

1. *§ 1. That the Department of Medical Assistance Services shall establish a work group to be composed of such stakeholders as the Department deems appropriate to evaluate the current Personal Maintenance Allowance amount established by the Commonwealth for individuals receiving Medicaid-funded waiver services and the impact of the current Personal Maintenance Allowance amount and other income limits on the ability of Medicaid waiver service recipients to engage in meaningful work and establish and maintain independence. The work group shall (i) evaluate the impact of the Commonwealth's current Personal Maintenance Allowance amount on eligibility for Medicaid-funded waiver services among individuals who otherwise meet eligibility criteria; (ii) compare the Commonwealth's current Personal Maintenance Allowance to actual expenses faced by individuals enrolled in the Commonwealth's Medicaid waiver programs; (iii) determine the impact of the Commonwealth's current Personal Maintenance Allowance amount on the ability of individuals receiving Medicaid-funded waiver services to engage in compensated employment; (iv) determine the impact on eligibility, enrollment, and cost to the Commonwealth of increasing the Commonwealth's current Personal Maintenance Allowance amount; (v) make recommendations related to increasing the Commonwealth's Personal Maintenance Allowance amount; and (vi) make recommendations for other changes to the Commonwealth's Medicaid-funded*

waiver programs to encourage and support engagement in compensated employment among Medicaid-funded waiver service recipients. The work group shall report its findings and conclusions to the Governor, the General Assembly, and the Chairman of the Joint Commission on Health Care by November 1, 2020.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK/sm

Enclosure
pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Recommendations for Changing Medicaid Programs to Remove Barriers to Independence

A Report to the Virginia General Assembly

February 1, 2021

Report Mandate:

Acts of the Assembly – 2020 Session, Chapter 882, SB213, states:

1. § 1. That the Department of Medical Assistance Services (DMAS) shall establish a work group to be composed of such stakeholders as the Department deems appropriate to evaluate the current Personal Maintenance Allowance amount established by the Commonwealth for individuals receiving Medicaid-funded waiver services and the impact of the current Personal Maintenance Allowance amount and other income limits on the ability of Medicaid waiver service recipients to engage in meaningful work and establish and maintain independence. The work group shall (i) evaluate the impact of the Commonwealth's current Personal Maintenance Allowance amount on eligibility for Medicaid-funded waiver services among individuals who otherwise meet eligibility criteria; (ii) compare the Commonwealth's current Personal Maintenance Allowance to actual expenses faced by individuals enrolled in the Commonwealth's Medicaid waiver programs; (iii) determine the impact of the Commonwealth's current Personal Maintenance Allowance amount on the ability of individuals receiving Medicaid-funded waiver services to engage in compensated employment; (iv) determine the impact on eligibility, enrollment, and cost to the Commonwealth of increasing the Commonwealth's current Personal Maintenance Allowance amount; (v) make recommendations related to increasing the Commonwealth's Personal Maintenance Allowance amount; and (vi) make recommendations for other changes to the Commonwealth's Medicaid-funded waiver programs to encourage and support engagement in compensated employment among Medicaid-funded waiver service recipients. The work group shall report its findings and conclusions to the Governor, the General Assembly, and the Chairman of the Joint Commission on Health Care by November 1, 2020.

Background

Medicaid covers Long-term Services and Supports (LTSS) provided to eligible Medicaid members in their homes and other community settings through the home-and-community-based waiver programs. The overarching purpose of the waivers is to allow the member to live as safely and independently as possible outside of an institutional setting. A wide variety of services are covered under the waivers, depending on the member's specific needs and criteria of the waiver. Virginia currently offers the following waiver Programs:

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.6 million Virginians. Members have access to primary and specialty health services, inpatient care, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

- The Commonwealth Coordinated Care (CCC Plus) Waiver, for members who are age 65 years and older or who are blind or disabled, including those who need a medical device to compensate for loss of a vital bodily function

- The Developmental Disabilities (DD) Waivers, which are offered to members with varying levels of intellectual and/or developmental disabilities
  - Building Independence (BI) Waiver
  - Community Living (CL) Waiver, targeted to the needs of individuals with intellectual disabilities
  - Family and Individual Supports (FIS) Waiver.

Statutory Context

Federal regulations in 42 CFR 435.1005 set the maximum income eligibility threshold for individuals needing LTSS to 300 % (percent) of the Supplemental Security Income (SSI) monthly payment for an individual. For calendar year 2020, the income eligibility threshold is $2,349 per month. Both gross unearned income, such as Social Security benefits, and any gross earnings from employment that the member may have are counted. Federal regulations in 42 CFR 435.733 require states to reduce the monthly Medicaid payment for LTSS by an amount equal to the member's total income minus all allowable deductions as permitted under federal and state regulations. This cost sharing requirement is referred to as a post-eligibility requirement. The amount of the member's income that must be contributed each month toward the cost of the member's LTSS is known as the Patient Pay.

Federal regulations in 42 CFR 435.735 set forth the allowable Patient Pay deductions for individuals receiving waiver services, as well as the state's flexibility in setting allowed deductions. Virginia Medicaid policy provides for all deductions from the Patient Pay as specified in federal regulations. Specified deductions include non-covered medical expenses, guardianship fees, a deduction of a limited amount of earnings (from the Patient Pay only; earnings are counted toward Medicaid eligibility), and a basic maintenance allowance for covering all of the member's expenses of living in the community, known as the Personal Maintenance Allowance (PMA).

42 CFR 435.735 allows states the option to set the amount for the monthly PMA at any amount provided that the amount is based on a "reasonable assessment of need" and the state establishes a maximum deduction amount that will not be exceeded for any individual under the waiver. In 2006, Virginia's PMA was set at 165% of the SSI payment for one person (12VAC30-120-920).

Impact of the Patient Pay on Individuals in Medicaid Waivers

In 2006, the PMA was $995. For calendar year 2020, that amount is $1,292. While the monthly PMA amount is raised by approximately $20 per year through a cost-of-living adjustment, the PMA meant to cover housing, food, and other expenses has increased by less than $300 in 14 years. By contrast, the median gross monthly **rent** (rent and utilities) **alone** in Virginia has risen from $1,008 in 2006 to $1,179 in 2017[1].

To be eligible for waiver services, a member's income must be no more than $2,349 per month; many members have income that is far lower. The Patient Pay for an individual whose income is $2,349 is calculated as follows:

$2,349	**gross monthly income**
-1,292	**PMA**
$1,057	**monthly Patient Pay**
$1,292	**income remaining for meeting living expenses**

After making the monthly Patient Pay, a member with income at the **top** of the eligibility cap is left with just $1,292 to cover any living expenses the member has. Given that the median cost of rent and utilities in Virginia is $1,037, many members face the inability to afford groceries, non-medical transportation, clothing, and other expenses necessary for independent living. Other types of expenses that are associated with a healthy quality of life, such as occasional social and recreational activities and pet care, are prohibitive for members living within these constraints.

Members receiving waiver services have provided DMAS and the SB 213 Workgroup with compelling

[1] The Department of Numbers (https://www.deptofnumbers.com/rent/virginia/) based on the American Community Survey of the United States Census.

stories of the difficulties with living on a restricted income.

Ms. S

Ms. S reported that due to the side-effects of a major stroke, including partial paralysis of her arms and legs. She is unable to bathe, cook, or shop for herself without physical assistance and was on the verge of needing nursing home placement. Ms. S was very happy to learn that she could receive services at home. After starting personal care services with an agency, Ms. S learned that her Patient Pay amount owed to the agency was $628.00. She receives $1900.00 monthly and her rent on her Northern Virginia apartment is $900.00. Her additional $628.00 in monthly expenses would make it impossible for her to pay for her food, rent, utilities and the copays for her many medications. Ms. S' nearest relative, a daughter, lives two hours away, and so is unable to help her on a daily basis. Ms. S stated that she would attempt to juggle this unaffordable combination of expenses on her own for as long as possible, but anticipated that she would soon have to have choose between giving up her housing or foregoing critical medical services.

Mr. J

Mr. J was very proud of the fact that, more than a year after a car accident had left him quadriplegic, he had continued to live independently with the assistance of the CCC Plus Waiver that provided personal care attendants. Mr. J had a friend who also was a live-in overnight attendant to make sure that someone would be available if needed. Mr. J's apartment was wheel chair accessible making life easier for him to adapt to in his new situation. During his first year of living in his apartment, he found himself struggling to afford to pay both his rent and his sizable Patient Pay contribution for Medicaid services. Mr. J made the difficult decision to move back in with his parents. Mr. J. stated that even though the rent for his apartment was quite affordable, the cost of utilities and medical expenses not paid by Medicaid were more than he could afford on top of his Patient Pay responsibility.

Mr. C

Mr. C is 70 years old and is unable to bathe, cook or food shop for himself. Although he was approved for CCC Plus Waiver services, Mr. C, stated that he did not feel that he could maintain his home and pay for necessary utilities and declined the much-needed services to remain safe in his home. Adult Protective Services called in to assess Mr. C's safety concluded that without appropriate supports inside of Mr. C's home, he was not safe and recommended nursing facility placement. Mr. C stated that his worst fear was placement into a nursing facility and did not want to lose his independence. Mr. C states that he would try to borrow money from family to pay his Patient Pay amount as long as he could so he could stay in his home.

Ms. B

Although Ms. B had suffered from Parkinson's disease for over two decades, she continued to live independently in her own apartment with the support CCC Plus Waiver services. When Ms. B broke her hip, and required a temporary stay in a rehabilitation facility, her Patient Pay obligation was significantly higher than it was in the community due to the loss of her PMA deduction expense. She was unable to afford the cost of maintaining her apartment while she was recovering from her broken hip. She lost her apartment, and now resides in a nursing facility.

Barriers to Independence and Employment

The Department of Behavioral Health and Developmental Disabilities (DBHDS) has indicated: "In an effort to better support people with disabilities through community-based integrated employment, Virginia's Employment First Initiative requires that employment be offered to the person first before offering other services. Virginia has long led the way by engaging individuals with disabilities in employment-related activities and providing effective, person-centered services. Employment First is the next and very essential step in our history of helping people with disabilities reach their fullest potential through improved employment opportunities."[2]

Organizations that partner with individuals with disabilities who wish to achieve a higher level of self-sufficiency routinely encounter Medicaid members who decline the opportunity to work out of fear of losing their DD Waiver services. Some programs that offer employment opportunities to individuals with disabilities actually require a minimum number of work hours for participation in the program. Individuals with higher Social Security Disability Insurance (SSDI) benefits, for example, may not be able to participate in such

[2] Virginia Department of Behavioral Health and Disability Services (http://www.dbhds.virginia.gov/developmental-services/employment).

programs because their earnings would jeopardize their waiver eligibility. Still other members find employment but must limit the number of hours or pass up advancement opportunities so that their income remains under the income limit for waiver Services.

Mr. F

Mr. F is a young adult enrolled in the CL Waiver. His mother is deceased, and his income from SSDI benefits as a surviving adult disabled child is just below the threshold for waiver eligibility. His monthly living expenses of over $600 for his residential program's room and board fees exceed his remaining income after his Patient Pay. Mr. F would like to find meaningful work to feel as independent as possible. Because his income is at the eligibility threshold, any employment that he could find would put him at eminent risk losing his waiver services.

Virginia's waiver programs are currently not set up to fully address the Virginia Employment First initiative. There are several barriers that cannot be addressed at the state level. Federal regulations cap the eligibility for waiver services at 300% of the SSI payment. Additionally, federal regulations require that a member's gross unearned and earned income be counted toward **eligibility**. For members in the waivers who work at least eight hours per month, Virginia does give a special earnings allowance from the post-eligibility Patient Pay. This allows members to retain more of their income from the Patient Pay. However, because earnings are countable toward the member's waiver eligibility; the member still is in the position of curtailing their work hours to avoid losing waiver eligibility.

While states are constrained from raising the income limit or disregarding income for waiver eligibility, states are permitted some options that offer a way to maintain Medicaid eligibility and waiver service for more members who wish to seek employment.

Barriers Within Existing Programs

Meeting a Spenddown

The Medically Needy (MN) Spenddown is an option for individuals age 65 and over and individuals with a disability to qualify for Medicaid even though their income is over the limit, by offsetting their excess income with medical expenses. The individual must have resources within the Medicaid limit and meet all non-financial eligibility criteria. The individual's spenddown liability is equal to the difference between the individual's income and the MN income limit. MN income limits vary by locality from $332.18 to $498.28 per month. If the individual's medical expenses meet or exceed the spenddown liability, the member is eligible for Medicaid. Individuals receiving LTSS must meet the spenddown each month, and their excess income is factored into their monthly Patient Pay.

Example – Waiver Member on a Spenddown

Mr. M receives monthly SSDI benefits of $2,300. With personal assistance services, he is able to engage in some work. His total income exceeds the 300% SSI income limit for waiver services, but he meets all other eligibility requirements. He is evaluated for a MN spenddown:

$2,800.00	**Total countable monthly income**
- 498.28	**MN income limit for Mr. M's locality**
$2,301.72	**spenddown liability**

The cost of Mr. M's monthly personal assistance services is $4,000 per month. Because he incurs medical expenses that exceed his MN spenddown liability of $2,301.72, he is eligible for Medicaid to cover the cost of his personal assistance services beyond his Patient Pay responsibility.

A barrier to spenddown eligibility currently exists in that the CCC Plus Waiver is the only waiver that allows members the option of meeting a spenddown. The DD Waivers **do not** have the spenddown option; the income cap is currently absolute for those needing services only covered under the DD Waivers.

Medicaid Works, Virginia's Medicaid Buy-in Program

Medicaid Works is Virginia's **non-waiver** program that allows members age 16 through 64 years with a disability or blindness to work and earn higher income while retaining Medicaid coverage. There are two key components to Medicaid Works that remain as barriers to many members who would like to work or increase their work hours.

The income limit for entry into Medicaid Works is currently 80% of the Federal Poverty Level (FPL). For calendar year 2020, that amount is $851 per month. The 2020 Virginia Budget Bill included an increase in the Medicaid Works income limit to 138% FPL ($1,469 in 2020). Due to the adverse impact of the COVID-19 pandemic on state revenue, Virginia has not yet been able to implement the change in the income limit. Once it can be implemented, the change should allow much greater opportunity for members with a disability to work and achieve greater independence.

The Medicaid Works income limit for entry into the program aside, another significant barrier to eligibility remains. Medicaid Works is not a waiver and does not currently cover the array of services covered in the waivers. Personal assistance services (PAS) are covered for members who require PAS to work. Members in the DD Waiver, in particular, typically qualify

for and receive specialized services that are currently not covered outside the waiver programs. These services include environmental modifications, assistive technology, and supportive residential services. Members who need these services and are capable of working face the dilemma of giving up needed services to work or choosing to remain in the waiver without a path to greater independence.

Recommendations to Increase Opportunities for Achieving Greater Independence

I. *Changes to the Personal Maintenance Allowance*

A. Raise the PMA to:

1) 200% of the SSI amount (currently $1,566)

2) 250% of the SSI amount (currently $1,958)

There are approximately 4,000 members with the personal care benefit under the CCC Plus Waiver and 650 members in the DD waivers who have a Patient Pay. Together they pay nearly $1.3 million in payments towards their Patient Pay each month or $15.5 million yearly. Each dollar of increase of the PMA reduces the Patient Pay of each individual until they are no longer obligated to make Patient Payments. If the PMA is raised to $1,566, then DMAS estimates the yearly cost to be $9.5 million ($4.8 million General Fund [GF]). Alternatively, if the PMA is raised to $1,958 or 250% of poverty, then DMAS estimates the cost to be $14.0 million ($7.0 million GF).

	Average Monthly	Yearly (FY20)
Current number of members with Patient Pay in CCC Plus Waiver	3,954	
Current total Patient Pay payments in CCC Plus Waiver	$1,152,943	$13,835,321
Current number of members with Patient Pay in DD Waivers	650	
Current total Patient Pay payments in DD Waivers	$140,983	$1,691,793

B. In addition to raising the PMA (1.A above), implement an "excess housing expenses" allowance for members in areas of the state with a higher housing costs.

Of the $15.5 million in Patient Pay paid by those with the personal care benefit or on one of the DD waivers, 21.3% were paid by those who live in the high cost Northern managed care region. Another 24.6% of the Patient Pay total was paid by those in the Central region. If the excess housing expenses were allowed in the Northern region, DMAS estimates the cost of raising that PMA to $1,566 would be $2.0 million ($1.0 million GF) and the cost of raising it to $1,958 to be $3.0 million ($1.5 million GF).

C. In conjunction with recommendation 1.A and 1.b **or** as a separate action, allow the PMA to continue as needed, for members in waivers who are temporarily in institutional settings

Each month, a small number of members leave the personal care benefit or the DD waiver benefit to enter a facility and then return to the community within two months. Consequently, their Patient Pay is temporarily increased during their facility stay. With a change in policy, DMAS estimates 10 members a month would no longer be required to contribute temporarily increased Patient Pay amounts. On average DMAS estimates these reduced payments to be $2,120 per member, and these amounts would instead fall to the Medicaid program, costing $254,450 ($127,225 GF) each year.

II. *Changes to the DD Waiver Eligibility Policy*

Implement the MN Spenddown for the DD Waivers

The DD Waivers have capped enrollment. Members do not receive DD Waiver benefits beyond the slots that have been allowed by the General Assembly; **therefore, this policy change would have no effect on Medicaid expenditures.** Individuals who enter the DD Waivers are generally receiving only SSI or SSDI income at the time of admission. By implementing a Medically Needy spenddown for the DD Waivers, there would not be any new enrollment in Medicaid or in the waivers. Rather, the members would be able to engage in employment without their earnings jeopardizing their DD Waiver enrollment.

III. *Changes to the Medicaid Works Program*

A. Extend financial eligibility for Medicaid Works to members who want to transition from a waiver to Medicaid Works.

Individuals in the CCC Plus Waiver and those in the Medicaid Works program are eligible to receive PAS; however, Medicaid Works does not have a Patient Pay requirement, as it is not a waivered service. The impact of the transition from the CCC Plus Waiver to Medicaid Works would be the loss of the individual's Patient Pay contribution for those members who opted to make the transition.

Allowing members to move out of the DD Waivers into Medicaid Works would allow additional members access to waiver slots and their benefits. In fiscal year 2020, there were 11,639 recipients in the CL Waiver, 2,734 in the FIS Waiver and 272 recipients in the BI Waiver. Surrendering a waiver slot in order to move into the Medicaid Works program with the same waiver services benefit but contingent on working is expected to be rare. If 1% of CL Waiver members were to transfer (116), we expect them to be replaced in the CL Waiver by 116 members with new waiver expenditures of $79,893 per year per person or $9.3 million ($4.6 million GF) per year. Likewise if 2% of the FIS Waiver (55 people) and 2% of the BI Waiver (5 people) transferred those new expenditures are expected to be $1.9 million (0.9 million GF) per year for a total of $11.1 million ($5.6 million GF).

B. In addition to PAS, cover additional services that are currently provided under the DD Waiver should a member leave the DD Waiver to participate in Medicaid Works, as long as the services are determined to be necessary in order for the member to work. Services might include assistive technology, environmental modifications, and selected supportive services. The cost of the services could be capped at an amount that ensures they do not exceed the cost of services were the person enrolled in a waiver.

While the population of those in Medicaid Works is small, as of 9/30/20, there were 39,071 with the personal assistance benefit through CCC Plus or through fee for services. If we assume 2% of this population would move to Medicaid works to use services at a utilization rate equal to those currently in the CL Waiver, then we would expect to incur costs of $13.6 million ($6.8 million GF).

Assumed Utilization Percentage	Service	Yearly cost per user	Yearly Cost per Service
2%	Assistive Technology	$1,500	$1,172,431
2%	Environmental Modifications Only	$4,226	$3,302,265
2%	Supported Employment Individual	$11,634	$9,090,943
	Total Cost		$13,565,639
39,071	Members with Personal Care Benefit as of 9/30/20		

Recommendations Summary

	Recommendations to Increase Opportunities for Achieving Greater Independence	Total	GF
IA 1)	Raise PMA to $1,566 (200% of the SSI amount)	$9.5 million	$4.8 million
IA 2)	Raise PMA to $1,958 (2050% of the SSI amount)	$14.0 million	$7.0 million
IB 1)	Allow excess housing expenses in Northern region and raise PMA to $1,566 (200% of the SSI amount)	$2.0 million	$1.0 million
IB 2)	Allow excess housing expenses in Northern region and raise PMA to $1,958 (250% of the SSI amount)	$3.0 million	$1.5 million
IC	Allow the PMA to continue as needed, for members in waivers who are temporarily in institutional settings	$254 thousand	$127 thousand
II	Implement the MN Spenddown for the DD Waivers	0	0
IIIA	Extend financial eligibility for Medicaid Works to members who want to transition from a waiver to Medicaid Works, assume 1% of CL Waiver members transfer and 2% of FIS and BI Waivers transfer	$15.7 million	$10.2 million
IIIB	Cover additional services that are currently provided under the DD Waiver should a member leave the DD Waiver to participate in Medicaid Works, as long	$13.6 million	$6.8 million

	as the services are determined to be necessary in order for the member to work.		

B 213 Workgroup

DMAS would like to acknowledge the members of the SB 213 Workgroup. We thank you for contributing your time and expertise to this project.

Lucy Beadnell, The ARC of Northern Virginia
Dennis Findley, Parent of an adult child enrolled in the DD Waiver
Maureen Hollowell, Virginia Association of Centers for Independent Living
Milton Johnson, The Choice Group
Beth Martin, The Choice Group

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