



# STUDY OF PERSONAL MAINTENANCE ALLOWANCE FOR WAIVER SERVICES & IMPACT ON RECIPIENTS' ABILITY TO WORK AND EARN

Virginia Acts of the Assembly –  
2020 Session, Chapter 882  
Enactment Clause 1, SB213

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DMAS  
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# SB213

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.

# What is Medically Needy 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.
- 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.

# HJ 85 Community Living, Family & Individual Support, and Building Independence waivers

Requests the Department of Medical Assistance Services (DMAS) to study the feasibility of implementing a spenddown provision for the Community Living, Family and Individual Support, and Building Independence waivers

- 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 (now designated Community Living, Family and Individual Support, and Building Independence waivers).
- SB213 study recommended implementing the MN spenddown for the DD Waivers

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- No fiscal impact
  - 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 not change 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 be **no new enrollment** in Medicaid or in the waivers.
- Individuals would be able to engage in employment without their earnings jeopardizing their DD Waiver enrollment.
- State option – Virginia can choose to provide the Medically Needy option to DD waiver recipients

# Federal Requirements

## Income Limit

- 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 2022, the income eligibility threshold is \$2,523 per month

## Patient Pay

- 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
- 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

## Patient Pay Deductions

- 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

## Patient Pay Deductions

- 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).

# Federal Option

- 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)
- There has been no increase to the Personal Maintenance Allowance since 2006. SB213 study recommended raising the PMA

# Recommendation 1

## Changes to the Personal Maintenance Allowance (PMA) set in 2006 – 2020 cost estimates

- Raise the PMA to:
  - 200% of the SSI amount (\$1,566 in 2020)
  - 250% of the SSI amount (\$1,958 in 2020)
- Cost:
  - 200% of the SSI amount, DMAS estimates the yearly cost to be \$9.5 million (\$4.8 million General Fund)
  - 250% of SSI amount, DMAS estimates the cost to be \$14.0 million (\$7.0 million GF).
- 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.

# Recommendation-2

## Changes to the Personal Maintenance Allowance (PMA) set in 2006 -2020 cost estimates

- Implement an “excess housing expense allowance for members in areas of the state with higher housing costs
- Cost:
  - If the excess housing expenses were allowed in the Northern region, DMAS estimates the additional cost (if PMA was \$1,566) would be \$2.0 million (\$1.0 million GF) and the cost if the PMA was \$1,958 would be \$3.0 million (\$1.5 million GF).
- 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

# Recommendation-3

## Changes to the Personal Maintenance Allowance (PMA) set in 2006 -2020 cost estimates

- Allow the PMA to continue as needed, for members in waivers who are temporarily (less than 6 months) in institutional settings
  - Total Cost: \$254,000 (GF \$127,000)
- 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. Patient Pay is temporarily increased during the facility stay.
- With this 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

# Thank you

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