Medicaid Renewals for Aged, Blind & Disabled Members Receiving Long-Term Services & Supports

The Renewal Process

Most Medicaid members have their eligibility evaluated every 12 months through the renewal process. An eligibility review may occur earlier if the member experiences a change in circumstances (*e.g., increase in income or resources*).

At each renewal, the state attempts to verify eligibility without contacting the member by using electronic data sources. A notice that the coverage has been renewed is mailed to members whose eligibility is confirmed this way. If eligibility cannot be verified electronically, a renewal form with a return deadline is mailed to the member.

The renewal form can be submitted:

- **Online** at commonhelp.virginia.gov
- **Telephonically** by calling CoverVA at 855-242-8282 (TDD: 888-221-1590)
- **By mail or in-person** to your local Department of Social Services (LDSS)

If additional information is needed after the renewal form is submitted, the member will be mailed a verification request. This letter will say what information is needed and the deadline for submitting it. The member's coverage will be canceled if the renewal or additional information is not received by the deadline. A notice with the reason for the cancelation, coverage end date, and appeal rights will be sent. Members who are canceled for not returning the renewal form or responding to a verification request are granted a 3-month period during which they can complete renewal steps and receive a full evaluation. After that period, a new application must be submitted.

Resource Evaluations

Members enrolled in Aged, Blind and Disabled (ABD) categories of Medicaid must maintain countable resources below the Medicaid limit ($2,000 for an individual and $3,000 for a couple). Resources are checked at application and each renewal. If applicant or members is requesting Medicaid coverage for Long-Term Services and Supports (LTSS, sometimes also called Long-Term Care), the state conducts an additional check for uncompensated transfers of assets.

Uncompensated Transfers of Assets

An uncompensated transfer of assets is when money or another resource is given away without the owner receiving something of equal value in return. The state reviews the prior five years for uncompensated transfers when a new request for LTSS coverage is made and the prior one year at each renewal if the member is receiving LTSS. If an uncompensated transfer is identified, a disqualification period during which Medicaid will not cover the individual's LTSS may be imposed.

Allowable Transfers

Certain transfers do not trigger a disqualification period:

- The individual received something of equal value to the asset that was transferred.
- The transfer was made for reasons other than becoming eligible for Medicaid payment of LTSS services. *This applies only at application for LTSS and proof is required that the individual could not have reasonably expected that they would need LTSS within 5 years of the transfer.*
- The individual transferred their home or property to:
    - Their spouse, child under age 21, or a blind or disabled child of any age.
    - Their sibling who has an equity interest in the home and resided in the home for at least one year immediately before the date that the individual began receiving LTSS.
    - Their adult child who resided in the home for at least two years before the date that the individual began receiving LTSS, so long as that adult child meets certain conditions.

Allowable Uses of Resources

Members may use resources to purchase **any items for their own use** not limited to:

- Telephone, television, computer, or radio for personal use
- Repairs or renovations to the home they own and live in
- Burial items or pre-need burial contracts, including premiums for life insurance or burial policies from which the recipient's expenses (e.g., for burial) will be paid
- Vehicle for personal use
- Personal clothing and goods and services
- Social events and entertainment
- Non-covered special care services such as privately hired nurses or aides
- Specially prepared or alternative food, instead of facility prepared food (if in nursing facility)
- Travel funds for the recipient to visit home or family
- Outstanding medical bills that Medicaid, Medicare, or other insurance didn't cover
- Any other bills incurred by the Medicaid member for items or services for their own use

Undue Hardship Claims

Members who are subject to a disqualification period have the right to claim an undue hardship and request that the disqualification period be waived. For an undue hardship to be granted, documentation must be submitted to verify that:

- the member is unable to recover the transferred assets, and
- the imposition of the disqualification period would result in the member becoming unable to receive life-sustaining medical care, food, clothing, shelter, or other necessities of life.

Your local Department of Social Services (LDSS) can answer questions about resources, and how they affect Medicaid eligibility. LDSS contact information is available at www.dss.virginia.gov/localagency.