

Long-Term Services and Supports (LTSS) Medicaid Renewals for Aged, Blind, or Disabled (ABD) Members - Fact Sheet

The Renewal Process

Virginia Medicaid did not require its members to renew their eligibility during the COVID-19 pandemic. Normally, Medicaid reviews members' eligibility annually, unless a change in circumstances (*e.g., increase in income or resources*) requires Medicaid to complete a partial review throughout the year.

Renewals will resume beginning in March 2023. When a member's renewal is due, the member will receive a prepopulated paper renewal form, and information on how to submit the renewal:

- **Using the prepopulated paper form**, or
- **Online** at commonhelp.virginia.gov, or
- **Telephonically** by calling Cover Virginia at **855-242-8282 (TDD: 1-888-221-1590)**.

After the member submits the renewal form, Virginia Medicaid may need additional information to successfully process the renewal (*such as paystubs or bank statements*) and may send a checklist indicating what information is still needed. If the member does not return the renewal form within 30 days or the additional information within 10 days, **coverage will be cancelled**. When the member receives a cancellation notice, the notice will include the reason for cancellation and the member's right to appeal the decision and process for keeping their benefits during the appeal process if applicable, however a member has 3 months to return the renewal form and/or additional information to receive a full evaluation.

What if a member's countable resources exceed the limit for Medicaid upon renewal?

Members who are Aged, Blind, or Disabled (*ABD*) for whom Medicaid pays for Long-Term Services and Supports (*LTSS*), are required to maintain countable resources below Medicaid's limit (\$2,000 to \$3,000 depending on category of coverage and household composition) to stay enrolled. It is possible that a member may have gained excess countable resources during the pandemic. These members have options to reduce their countable resources. **But, if a member needs his/her Medicaid to pay for LTSS, the member should pay special attention to the manner they reduce resources. Giving money or other resources away without receiving value worth the same amount is considered an uncompensated transfer of assets, which may result in a disqualification period during which Medicaid will not cover an individual's LTSS. At renewal, resources will be evaluated for the 12 months prior to the renewal for any potential transfers.**

Some transfers of assets do not affect Medicaid payment for LTSS, including if:

- The member received value for the transfer worth the same amount,
- The transfer(s) was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTSS services (*proof will be required that the individual could not reasonably expect he would need LTSS within 5 years of the transfer*) and is only applied upon application for LTSS, not renewal, or
- The member's home property was transferred to:
 - The member's spouse, child under age 21, or a blind or disabled child of any age, OR
 - The member's sibling who has an equity interest in the home and resided in the home for at least one year immediately prior to the date the member became institutionalized, OR
 - The member's adult child who resided in the home for at least two years prior to the date of the member's institutionalization, so long as that adult child meets certain conditions.

Members may use accumulated 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 in which they live
- Burial items or pre-need burial contracts, including premiums on life insurance or burial policies on the recipient and from which the recipient's expenses (e.g., for burial) can be expected to be paid
- Vehicle for personal use
- Personal comfort items, including smoking materials, snacks, games, and candy
- Cosmetic and grooming items and services
- Personal clothing, personal reading matter, flowers and plants
- Social events and entertainment
- Non-covered special care services such as privately hired nurses or aides
- Specially prepared or alternative food requested instead of the food generally prepared by the facility (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

If a member's Medicaid is terminated due to excess resources, they should use their excess resources in an allowable manner, such as for their own use or to privately pay for care, until they are under the countable resource limit, and then reapply for Medicaid.

IMPORTANT! Exclusion for LTSS Members with Excess Resources

Due to federal requirements, Virginia Medicaid did not reduce or terminate most members' coverage during the COVID-19 pandemic (*unless the member died, requested termination of their coverage, or moved permanently out of Virginia*). Virginia also did not increase **patient pay** for members who receive Medicaid-covered LTSS. (*Patient pay is the amount a member pays to his/her LTSS provider for care, as explained on the member's Notice of Patient Pay Responsibility.*)

Since March of 2020, Virginia has not increased patient pay for individuals receiving LTSS, even if a member's medical expenses decreased, or his/her income increased (*such as due to a cost of living adjustment in Social Security income*), or the individual moved from Community Based care to care provided in a nursing facility. This money **was not** owed to the nursing facility or service provider, the way it normally would have been. As a result, some members who receive Medicaid-covered LTSS may have built up resources that are above Medicaid's usual limit.

When the state resumes Medicaid renewals (*beginning in March 2023*), each member's Medicaid eligibility will be reviewed. If a member who receives LTSS is found to have excess resources at his/her renewal, the state will review his/her patient pay history. **If that history indicates that the member's excess resources are solely due to the state having been unable to increase his/her patient pay during the pandemic, the amount of the would-be increase will be deducted from the member's excess resources.** If the member is under the resource limit after this deduction, and is otherwise still eligible, coverage will continue.

The member will then have 12 months from his/her renewal to reduce the excess resources (*as explained in the "What if a member's countable resources exceed the limit for Medicaid?" section*). At the member's next renewal, they will need to be under the countable resource limit for coverage to continue. Note: impact payments/stimulus money and other disaster assistance related to the COVID pandemic were excluded as income, but are countable as resource and not allowable under this exclusion.

Virginia Medicaid will also resume increasing members' patient pay, if applicable, upon renewal.

- If the case is current (renewal is not overdue) changes can also trigger a patient pay increase.
- Virginia Medicaid will not
 - cancel a member's coverage,
 - increase patient pay,
 - impose a penalty,
 - or change a member's category of coverage**without written notice.**

Members have the right to appeal

- a cancellation or reduction of Medicaid coverage,
- a change in patient pay,
- and penalties.

Eligibility workers at a member's local Department of Social Services (DSS) can answer questions about resources, and how they affect eligibility or Medicaid coverage. Members can look up contact information for their local DSS by going online to [commonhelp.virginia.gov](https://www.commonhelp.virginia.gov), and selecting "Find local office."