Medicaid Eligibility for the Aged, Blind and Disabled Residing in a Nursing Facility or Participating in a Home & Community Based Services (HCBS) Waiver Program

MISSISSIPPI DIVISION OF MEDICAID

What is Medicaid? Medicaid is a national health care program. It pays for medical expenses for individuals who qualify. Medicaid pays providers of health care services, such as doctors, hospitals, pharmacies and nursing facilities that accept Medicaid. Be sure the provider you see accepts Medicaid before you receive a service.

Who is eligible? You may qualify for Medicaid in a nursing home (or hospital) if you are a long-term care patient in a medical facility that accepts Medicaid. Individuals with income above 135% of the federal poverty level require a stay of 31 consecutive days or longer. HCBS waiver programs are for individuals who are in need of long term care services but are able to be cared for in a home setting.

Eligibility: To be eligible for Medicaid in a medical facility or HCBS waiver, you must be:

- A citizen of the U.S. or a qualified immigrant,
- A resident of Mississippi,
- Age 65 or over or blind or disabled and the placement in a nursing facility or HCBS waiver must be certified as medically necessary.
- Willing to apply and accept all benefits that you may be entitled to receive, such as VA benefits, retirement or disability benefits, etc.
- Eligible based on income. The monthly income limit for 2018 is $2,250 (before deductions). If your income is above this limit and you reside in a nursing facility (not in acute care in a hospital), you may be able to qualify under an Income Trust. If monthly income exceeds the private pay rate for the facility where you reside (or will reside), it is not possible to qualify for Medicaid under an Income Trust. For HCBS waiver participants, income over the Medicaid limit is payable to the Division of Medicaid under the terms of an Income Trust.
- Eligible based on resources. The resource limit is $4,000 for an individual. Resources are assets that you own individually and/or jointly and include real and personal property. Certain types of resources are not counted toward the $4,000 limit. These include:
    - ✓ Home property – one home may be excluded unless the equity value exceeds $572,000.
    - ✓ Income-Producing property – property may be excluded if it produces a net annual return of at least 6% of the equity value. You must receive the income in order for the property to be excluded. Annuities and promissory notes must also be actuarially sound, i.e., the return must be equal to your life expectancy.
    - ✓ Automobiles – up to two (2) vehicles may be excluded.
    - ✓ Household goods – these items are excluded.
    - ✓ Personal property – there is a $5,000 exclusion limit for personal property.
    - ✓ Life insurance – the cash value of whole life insurance policies may be excluded if the face values of all policies on an insured are $10,000 or less. Term life insurance is not counted.
    - ✓ Burial funds & plots – burial spaces for family members are not counted. Money set aside for burial up to $6,000 is not counted.
    - ✓ Transfers of assets – there is a 5-year look back period to determine if assets have been transferred with the intent to qualify for Medicaid. If assets have been transferred, a transfer penalty may apply whereby Medicaid will not pay the nursing facility for your care or for HCBS waiver participants, you will not be eligible for Medicaid.

ESTATE RECOVERY: Medicaid will seek recovery from the estate of deceased Medicaid recipients who are age 55 or older and in a nursing facility or enrolled in a HCBS waiver program at the time of death. Recovery will be made from any real or personal property in the estate of the recipient up to the value of payments made by Medicaid for nursing facility, hospital and drug services. Estate recovery will not apply to recipients who have a surviving spouse or dependent or disabled child.

INCOME & RESOURCE RULES FOR SPOUSES: Special rules apply to applicants for long term care who have a spouse living in the community. For HCBS participants, spouses must live together for these rules to apply:

- Effective January 1, 2018, the spouse who is living in the community or the HCBS participant's spouse is entitled to keep up to $123,600 in combined, countable resources (these are in addition to those resources that are excluded).
- At application, combined countable resources will be used to determine the spousal share of up to $123,600. The applicant's share is up to $4,000.
- If resources need to be transferred into the community or HCBS spouse's name, the time allowed is 90 days from the date the applicant or spouse or representative is informed of the need to transfer resources. Resources over the combined allowed limits count toward the HCBS or Long Term Care spouse applying.
- A couple may request an assessment of resources without applying for Medicaid. An assessment is a snap-shot of total verified resources and how Medicaid would treat the resources and income of both spouses if an application were filed. One spouse must be in long term care in order to request an assessment.

RETROACTIVE BENEFITS: An applicant for Medicaid may be eligible to receive Medicaid benefits for up to 3 months prior to the month of application. All eligibility factors must be met for each month requested.

MEDICAID INCOME: After an applicant has been determined eligible for Medicaid in a nursing facility, the individual is required to pay toward the cost of their care if income allows. This is referred to as Medicaid Income. It is total income less the following allowable deductions:

- A personal needs allowance (PNA) of $44 per month. Veterans and surviving spouses who receive a $90 VA pension get a $90 PNA. If active in a work therapy program with earnings, the PNA may be higher.
- A monthly allowance for the community spouse, less the spouse's own income. The maximum monthly allowance for 2018 is $3,090. The allowance is based on the nursing home spouse's actual income and he/she must make the allowance available to the community spouse.
- A monthly allowance for other dependent family members, based on the dependent's own income.
- A deduction for 1 health insurance premium that is paid by the individual in the nursing facility.
- Certain medical expenses that would ordinarily be paid by Medicaid, but due to service limits placed on these services, the individual is charged for the expense.
- Medicaid Income is not paid by a HCBS participant.

NOTE: If an applicant has Medicare, his/her pharmacy benefit is through Medicare, Part D. In order to have $0 premium, $0 deductible, $0 co-insurance and $0 co-pays, the individual must enroll in a $0 premium plan, referred to as a "benchmark" plan. If enrolled in any other plan, a premium may be charged by Medicare that is not allowed as a Medicaid deduction.

If you have questions about Medicaid eligibility or want to apply, call (toll free) 1-800-421-2408 or contact your nearest Medicaid Regional Office in:

Brandon RO	601-825-0477
Brookhaven RO	601-835-2020
Canton RO	601-978-2399
Clarksdale RO	662-627-1493
Cleveland RO	662-843-7753
Columbia RO	601-731-2271
Columbus RO	662-329-2190
Corinth RO	662-286-8091
Greenville RO	662-332-9370
Greenwood RO	662-455-1053
Grenada RO	662-226-4406
Gulfport RO	228-863-3328
Hattiesburg RO	601-264-5386
Holly Springs RO	662-252-3439
Jackson RO	601-978-2399
Kosciusko RO	662-289-4477
Laurel RO	601-425-3175
McComb RO	601-249-2071
Meridian RO	601-483-9944
Natchez RO	601-445-4971
New Albany RO	662-534-0441
Newton RO	601-635-5205
Pascagoula RO	228-762-9591
Philadelphia RO	601-656-3131
Picayune RO	601-798-0831
Senatobia RO	662-562-0147
Starkville RO	662-323-3688
Tupelo RO	662-844-5304
Vicksburg RO	601-638-6137
Yazoo City RO	662-746-2309

The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability as defined through the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964.