Title 23: Medicaid

Part 103: Resources

Chapter 1: Introduction to Resources

Rule 1.10: Liberalized Resource Policy Overview

A. The following briefly describes the liberalized resource policies currently in effect. The liberalizations are described in greater detail in the discussion of each resource type:

1. Spend down of resources within a month to become eligible in that month, i.e., eligibility may be established effective the first day of the month if countable resources fall below the applicable limit within the month.

2. Excess resources earmarked for payment of private pay in a nursing facility in month(s) prior to Medicaid eligibility are not considered countable resources.

3. Income that accumulates pending Medicaid approval that results in excess resources can be excluded if this income is obligated for Medicaid income purposes.

4. Certain property and types of ownership are totally excluded, regardless of value:

    a) Home property located in Mississippi, life estate and remainder interests in any property, 16th Section land leaseholds, mineral rights or timber rights that are not under production and housing on government-owned land are excluded under liberalized policy,

    b) Income producing property is excluded if it produces at least six percent (6%) of the equity value of the property,

    c) Promissory notes, loans and property agreements are excluded if the note produces a net annual return of six percent (6%) of the principal balance,

    d) Up to two (2) automobiles may be excluded,

    e) Household goods are totally excluded and personal property up to five thousand dollars ($5,000.00) in equity value is excluded,

    f) The cash value of whole life insurance is excluded if the combined face value of all life insurance policies on any one individual is ten thousand dollars ($10,000.00) or less,

    g) Burial spaces for family members are excluded as resources, and

h) Burial funds set aside in a revocable arrangement are subject to a six thousand dollar ($6,000.00) limit effective April 1, 2001.

5. The current market value of real property is established using the county tax assessed true value as shown or calculated using the appropriate county property tax assessment notice.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.601.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017.

Part 103 Chapter 2: Ownership Interest

Rule 2.9: Verifying Current Market Value (CMV)

A. Once ownership or ownership interest in property has been verified, the current market value (CMV) of the client's ownership interest is determined based on the coverage group of the applicant or beneficiary and whether Supplemental Security Income (SSI) or liberalized resource policy is applicable.

B. Under liberalized resource policy, the CMV is established using the most recent county property tax assessment notice unless a tax assessment for a prior time period is needed, such as to establish CMV when a transfer of assets occurred.

1. The true value of the property as shown on the county property tax assessment notice is used to establish CMV. If the true value is not shown, the property tax assessed true value is calculated as follows:

a) A tax assessed value divided by the county tax assessment ratio is the CMV based on the assessment. Class 1 property is home property and Class 2 property is non-home property. Class 2 property may adjoin home property and therefore be included in the definition of home property.

b) Property in Mississippi is assessed at ten percent (10%) for Class 1 (home) property and fifteen percent (15%) for Class 2 (non-home) property.

c) The assessed value divided by the applicable assessment ratio is used to arrive at the true value of property. For example, Class 1 (home) property has an assessed value of five thousand dollars ($5,000.00). Divide five thousand dollars ($5,000.00) by ten percent (10%). The true value is fifty thousand dollars ($50,000.00) based on the county tax assessment.

2. If the individual disagrees with the true value as shown on the appropriate county property tax assessment notice or calculated using the county property tax assessed value, the individual must obtain a knowledgeable source estimate to establish CMV as required under SSI policy.

C. SSI Policy requires obtaining a knowledgeable source estimate to establish the CMV of real property. Knowledgeable sources include, but are not limited to:

1. Real estate brokers,

2. Local office of the Farmer's Home Administration (for rural land),

3. Local office of the Agricultural Stabilization and Conservation Service (for rural land),

4. Banks, savings and loan associations, mortgage companies and similar lending institutions, and

5. An official of the local property tax jurisdiction (must obtain an estimate rather than the office's assessment).

6. Licensed Mississippi real estate appraisers.

D. When CMV has an impact on eligibility and applicants or beneficiaries disagree with the CMV evidence submitted or obtained by the Medicaid specialist, a rebuttal determination must be made.

1. The rebuttal determination must take into account:

a) All the evidence previously in the file including, but not limited to, the individual's original allegation, any tax assessment notices and any estimates from knowledgeable sources,

b) Any additional evidence the individual wishes to submit including, but not limited to, evidence that the individual's ownership interest in the property is worth less than the CMV determined total value of the property divided by the number of owners, and

c) Any other facts about the property or about market conditions where it is located.

2. The rebuttal must be supported by a preponderance of the evidence which may require one (1) or more additional estimates from knowledgeable sources.

E. For both SSI and liberalized policy, the CMV less any legally binding debts against the property is the countable equity value for real property that cannot be excluded under any real property exclusion.

Source: Miss. Code Ann. § 43-13-121.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017.

Part 103 Chapter 5: Trust Provisions

Rule 5.17: Income Trusts

A. The purpose of an Income Trust is to allow an individual with excess income who has exhausted all available resources to become eligible for Medicaid. The trust may be used only for income belonging to the individual. No resources (assets) may be used to establish or augment the trust. Inclusion of resources voids the trust exception. It is intended to assist individuals with excess recurring monthly income who have income that exceeds the Medicaid institutional limit in effect at the time eligibility is requested but have insufficient income to pay the private cost of institutional care. Individuals with income above the private pay rate for the facility in which the individual resides will not be eligible for Medicaid under the Income Trust provision.

B. This type of trust established for the benefit of the individual is limited to institutionalized individuals, not those in an acute care hospital setting. Persons participating in the home and community-based services (HCBS) waiver may also utilize an Income Trust for eligibility purposes.

C. An Income Trust must meet all the following requirements:

1. The trust is composed only of the pension(s), Social Security, and other income due the individual from all sources, including accumulated interest in the trust. Total income does not include income that is not countable under Medicaid rules, such as payments from the Veterans' Administration for Aid and Attendance (A&A) and payments for unreimbursed medical expenses.

2. Income Trusts, once accepted by the Division of Medicaid, cannot be modified without the Division of Medicaid's approval. An Income Trust must specify that the trust will terminate at the individual's death, when Medicaid eligibility is terminated, when the trust is no longer necessary or in the event the trust is otherwise terminated. Trusts may need to be terminated prior to an individual's death due to changes in the individual's income or changes in Medicaid policy regarding how certain income must be counted or in the event the individual is discharged from the nursing facility.

3. A portion of the individual's income may be protected in the month of entry into a nursing facility. When income protection is applicable, there is no cost of care payable to the nursing facility for beneficiaries whose income is less than the institutional income limit. However, income above the amount that is one dollar ($1.00) less than the Medicaid institutional limit is payable to the Division of Medicaid for beneficiaries eligible under an Income Trust within thirty (30) days after receipt of the notice approving eligibility issued by the Division of Medicaid. The approval notice informs the Trustee of the amount payable for the month of entry.

4. For all subsequent month(s), if income of the individual is less than the individual's cost of care at the nursing facility, all income of the individual, less authorized deductions, must be paid directly to the nursing facility. In that case no funds will be retained in the

trust. If the income of the individual exceeds the cost of care at the nursing facility in any month the individual is eligible under an Income Trust, the trust must retain the income in excess of the cost of care until such time that payment of the accumulated Income Trust fund is requested by the Division of Medicaid.

5. Income Trusts for HCBS Waiver enrollees require that the trust must distribute to the individual, or for his/her benefit, an amount equal to not more than one dollar ($1.00) less than the then current Medicaid income limit as approved by the Division of Medicaid. The trust should not specify the amount of the individual's income as this amount may change each year and the amount to be released from the trust will change to an amount equal to one dollar ($1.00) less than the current Medicaid income limit.

6. At the dissolution or termination of an Income Trust, the death of the individual, loss of the individual's Medicaid eligibility or in the event that the individual's income no longer exceeds the current Medicaid income limits, the trust agreement must provide that all amounts remaining in the trust up to an amount equal to the total medical assistance paid by the Division of Medicaid on behalf of the individual that has not previously been repaid will be paid to the Division of Medicaid.

7. The trust agreement must provide that at the time of each review of the individual's Medicaid eligibility (at least annually) while this trust is in existence, when notified by the Division of Medicaid, the Trustee must pay to the Division of Medicaid the amount that should be accumulated in the trust up to the amount expended by the Division of Medicaid on behalf of the individual that has not previously been repaid. Failure to make the requested payments will result in the loss of Medicaid eligibility for the individual.

8. The trust agreement must provide for an accounting of all receipts and disbursements of the trust during the prior calendar year when requested by the Division of Medicaid.

9. No fees are allowed to be paid to the Trustee for their service. In the event funds are retained in the trust, administrative fees are limited to ten dollars ($10.00) per month and are intended to cover any bank charges required to maintain the trust account.

10. Any disbursements not approved by the Division of Medicaid or provided for by the trust agreement will result in a loss of the trust exemption.

11. The trust agreement must specify an effective date. Unless the applicant is requesting retroactive eligibility of up to ninety (90) days, which will require that the applicant have the funds necessary to fund the trust for that period, the effective date will be the date of execution. If a retroactive date is being sought, the effective date will be determined through consultation with the Division of Medicaid's Regional Office. In that case the Regional Office should be consulted to determine the effective date prior to execution of the agreement.

D. An Income Trust will not be allowed on a temporary or intermittent basis except in instances when monthly excess income will be reduced at a future date. In such a case, an Income

Trust will be allowed until such time as the excess monthly income no longer requires an Income Trust to allow eligibility. Income received less than monthly does not qualify as recurring excess monthly income that allows the use of an Income Trust. Income received irregularly or infrequently must be converted to monthly income before evaluating the need for an Income Trust.

E. The Division of Medicaid will provide model Income Trust agreements for individuals in need of an Income Trust. Model agreements are provided for individuals in institutional care and for individuals enrolled in an HCBS waiver that need an Income Trust in order to qualify for Medicaid based on income. The only changes to these legally binding documents that the Division of Medicaid will accept are to add language regarding a successor trustee or co-trustee. Changes must be approved by the Division of Medicaid prior to execution of the trust. In completing the Income Trust document, the individual cannot be the Trustee of the Income Trust.

F. It is possible to have an Income Trust during the time a transfer of assets penalty is in effect. Although the Division of Medicaid will not pay for an individual's room and board during a transfer penalty period, the Income Trust will allow an individual with excess income who otherwise requires an Income Trust in order to be eligible to qualify for all Medicaid covered services other than payment of room and board and will allow the penalty period to be implemented.

G. An applicant or beneficiary requiring an Income Trust who has a court appointed conservator must furnish a copy of the Chancery Court Order authorizing the conservator to establish the Income Trust. The court must be made aware of the Income Trust requirement to pay the Division of Medicaid any accumulated trust funds up to an amount expended by the Division of Medicaid under the terms of the trust.

Source: 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017; Revised eff. 11/01/2014.

Part 103 Chapter 6: Annuities

Rule 6.4: Treatment of Annuities Purchased on or after February 8, 2006

The Deficit Reduction Act of 2005 (DRA), P.L. 109-171 adds new requirements to the Medicaid statute with respect to the treatment of annuities purchased on or after the date of enactment, February 8, 2006, by or on behalf of an annuitant who has applied for Medicaid for nursing facility services or other long-term care services. The DRA requirements also apply to certain other transactions involving annuities that take place on or after the date of enactment that are described below.

A. Disclosure Requirement

1. At each application and annual review for Medicaid eligibility, all long-term care applicants or beneficiaries are required to disclose any interest the applicant/beneficiary or community spouse may have in an annuity or similar financial instrument. Parents of a minor child must report any annuities in which the child may have an interest.

2. This disclosure is a condition for Medicaid eligibility for long-term care services, including nursing facility services and home and community-based waiver services (HCBS) and applies regardless of whether or not an annuity is irrevocable or is treated as a resource.

3. Refusal to disclose sufficient information related to any annuity will result in denial or termination of Medicaid eligibility, based on the applicant or beneficiary's failure to cooperate in accordance with existing Medicaid policies.

4. When an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, appropriate steps to terminate payment for long-term care services will be taken, including allowing for rebuttal and advance notice.

B. Annuity-Related Transactions Other than Purchases Made on or after February 8, 2006.

1. In addition to purchases of annuities, certain related transactions which occur to annuities on or after February 8, 2006, make an annuity, including one purchased before that date, subject to all provisions of the DRA that went into effect on February 8, 2006.

2. Any action taken on or after February 8, 2006, by the individual that changes the course of payment to be made by the annuity or the treatment of the income or principal of the annuity result in the annuity being treated as if purchased on or after February 8, 2006. These actions include:

   a) Additions of principal,

   b) Elective withdrawals,

   c) Requests to change the distribution of the annuity, and

   d) Elections to annuitize the contract and similar actions.

3. For annuities purchased prior to February 8, 2006, routine changes and automatic events that do not require any action or decision after the effective date are not considered transactions that would subject the annuity to treatment under the DRA provisions. Routine changes could be notification of an address change or death or divorce of a remainder beneficiary and similar circumstances.

4. Changes which occur based on the terms of the annuity which existed prior to February 8, 2006, and which do not require a decision, election or action to take effect are also not subject to the DRA.

C. Requirement to Name the Division of Medicaid as Remainder Beneficiary on Annuities

1. The purchase of an annuity within the five (5) year look back-period and in all subsequent months will be treated as a transfer of assets unless the Division of Medicaid is named as a remainder beneficiary in the correct position as described herein.

   a) This requirement applies to annuities purchased by the applicant or spouse and to certain annuity-related transactions other than purchases made by the applicant or spouse.

   b) An annuity must name the Division of Medicaid as the remainder beneficiary in the first position for the total amount of Medicaid assistance paid on behalf of the institutionalized beneficiary who is the annuitant unless there is a community spouse and/or a minor or disabled child.

   c) If there is a community spouse and/or minor or disabled child, the Division of Medicaid may be named in the next position after those individuals.

   d) If the Division of Medicaid is named beneficiary after a community spouse and/or minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the Division of Medicaid must then be named in the first position.

   e) If verification is not provided which reflects the Division of Medicaid as remainder beneficiary in the correct position on annuities purchased by the institutionalized spouse or community spouse, the purchase of the annuity will be considered a transfer for less than fair market value. The full purchase value of the annuity will be considered the amount transferred.

2. An annuity purchased prior to the five (5) year look-back period is treated as a resource and/or income source, depending on the terms of the annuity as outlined in Miss. Admin Part 103, Rule 6.1.

D. Information Provided by the Division of Medicaid to Issuer

1. For any annuity disclosed for the applicant or community spouse, the Division of Medicaid must inform the issuer of the annuity of the Division of Medicaid's right to be named as a preferred remainder beneficiary and may require the issuer to notify the Division of Medicaid regarding any changes in amount of income or principal being withdrawn from the annuity.

2. The issuer of the annuity may disclose information about the Division of Medicaid's position as remainder beneficiary to others who have a remainder interest in the annuity.

E. Treatment of Annuities in Determining Eligibility for Long-Term Care

1. In addition to the requirement for the Division of Medicaid to be named as a remainder beneficiary for an annuity purchased by the institutionalized spouse or community spouse within the five (5) year look-back period and in all subsequent months, an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility or other long-term care services will not be treated as a transfer of assets if purchased within the five (5) year look-back period or any subsequent month if certain conditions are met which are described below.

2. The annuity meets one of the following conditions for employment-related annuities that are treated as retirement funds:

   a) It is an individual retirement annuity according to (b) or (q) of section 408 of the Internal Revenue Code (IRC) of 1986, or,

   b) The annuity is purchased with proceeds from an account or trust described in subsection (a), (c) or (p) of section 408 of the IRC, or,

   c) The annuity is purchased with proceeds from a simplified employee pension within the meaning of section 408 of the IRC, or,

   d) The annuity is purchased with the proceeds from a Roth Individual Retirement Account (IRA) described in section 408A of the IRC.

3. The purchase of an annuity not described in Miss. Admin. Code Part 103, Rule 6.4.E.2. above will be considered a transfer of assets unless it meets all of the following requirements for every month in which eligibility is being considered:

   a) The annuity is irrevocable and non-assignable, and,

   b) The annuity is actuarially sound as outlined in Miss. Admin. Code Part 103, Rule 6.5., and

   c) The annuity is providing payments in equal amounts during the term of the annuity with no deferred or balloon payments, and

   d) The annuity is issued by a business licensed and approved to issue commercial annuities in the state in which the annuity was purchased; and

   e) The Division of Medicaid has been named as beneficiary of the annuity in the correct position as outlined in Miss. Admin. Code Part 103, Rule 6.4.C. above.

4. The purchase of a single-premium life insurance policy, endowment policy or similar instrument which has no cash value, and for which the individual receives no valuable consideration will be considered a transfer of assets if purchased within the five (5) year look-back period or any subsequent month.

5. To determine that an annuity is established under any of the various provisions of the IRC referenced above and/or meets all of the conditions required to be excluded from a transfer of assets penalty or counted as a resource, rely on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the individual or representative to produce needed documentation. The individual or representative must produce the annuity contract in order to evaluate the annuity. Without documentation, the purchase of an annuity will be considered a transfer of assets subject to a transfer penalty in the amount of the full purchase value of the annuity.

6. An annuity that does not meet the conditions cited above, or an annuity that is not changed to meet the necessary requirements and/or documentation that is not provided relating to an annuity will result in the annuity being treated as a transfer of assets if purchased within the five (5) year look-back period or any subsequent month using the full purchase value as the amount transferred.

7. Even if an annuity is determined to meet the requirements above and the purchase is not treated as a transfer, if the annuity or income stream from the annuity is transferred, that transfer may be subject to a penalty with the exception of transfers to a spouse or to another individual for the sole benefit of the spouse, to a minor or disabled child or to a Special Needs Trust.

F. Consideration of Income from an Annuity

1. An annuity that does not comply with the requirements described in this chapter will be treated as a transfer of assets. During the penalty period, the income produced by the annuity counts as income to the individual or spouse, as appropriate, in determining eligibility and post-eligibility cost of care and spousal allocation, as applicable.

2. The income produced by an annuity that complies with the requirements in this chapter counts as income to the individual or spouse, as appropriate, in determining eligibility and post-eligibility cost of care and spousal allocation, as applicable.

G. Requirements for the Community Spouse

1. Annuities purchased by the community spouse on or after February 8, 2006, must name the Division of Medicaid as the preferred remainder beneficiary.

2. The institutionalized spouse may not be named as a beneficiary ahead of the Division of Medicaid.

3. However, if there is a minor or disabled child, the child may be named as first beneficiary and the Division of Medicaid must be named in the next position after those individuals.

4. It does not matter if the community spouse's annuity is actuarially sound or provides payments in approximately equal amounts with no deferred or balloon payments. These provisions apply only to annuities purchased by or on behalf of the individual who has applied for medical assistance, not a community spouse.

H. Estate Recovery

1. Annuities purchased on or after February 8, 2006, will be subject to estate recovery.

2. The rules for the institutional spouse and the community spouse are the same for annuities purchased prior to February 8, 2006.

Source: 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017; Revised eff. 11/01/2014.