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560 Wheeler Road, Hauppauge, NY 11788
(631) 234-5588

ZOOM PROGRAM

SUMMER TRUSTS & ESTATES SERIES #4
Medicaid Update

FACULTY

Richard A. Weinblatt, Esq.

Program Coordinator: Ashley M. Valla, Esq. & Marianne S. Rantala, Esq.

June 24, 2020
Suffolk County Bar Association, New York

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Richard A Weinblatt
Attorney at Law

Richard A. Weinblatt is a partner in the law firm of Haley Weinblatt & Calcagni, LLP located in Islandia, New York. He practices primarily in the areas of Elder Law and Trusts and Estates. Richard graduated *magna cum laude* from St. John's University School of Law in 1988. He is a member of the New York State Bar Association, National Academy of Elder Law Attorneys and a former Director of the Suffolk County Bar Association. He is a Past Chair of the New York State Bar Association's Elder Law and Special Needs Section. Richard is a past Associate Dean of the Suffolk County Bar Association's Academy of Law, past President of the Estate Planning Council of Long Island, Suffolk Chapter and is a former Co-Chair of the Suffolk County Bar Association's Elder Law Committee, Surrogate's Court Committee and Tax Committee. Richard is also an adjunct professor at Touro College Jacob D. Fuchsberg Law Center.

Richard A. Weinblatt, Esq.
Haley Weinblatt & Calcagni, LLP
1601 Veterans Memorial Highway, Suite 425
Islandia, New York 11749
(631) 582-5151; raw@hwclaw.com

MEDICAID

I. Overview

A. Medicaid was created by Congress in 1965. It is a joint federal and state funded program that is administered by the states.

B. The federal Department of Health and Human Services (HHS) has the authority to approve state plans for medical assistance. The immediate responsibility for administering Medicaid is delegated to the Centers for Medicare and Medicaid Services (CMS), which in turn passes the legal administration of the program to each states department of health or the equivalent.

1. In New York, the program is administered by the New York State Department of Health with local administration by the counties. In Nassau and Suffolk Counties it is the Department of Social Services that administers the program. In New York City, the program is administered by the Human Resources Administration (HRA).

C. The Medicaid program is subject to both federal and state law.

1. The federal regulations are found at Title 42 of the Code of Federal Regulations (CFR), parts 430 through 456.

2. New York State regulations are found at 18 NYCRR § 360.

3. With limited exceptions, state Medicaid regulations cannot be more restrictive than the Supplemental Security Income (SSI) regulations.

D. Medicaid is a means tested program. It is designed to limit participation to the poor.

1. Because of the high cost of nursing home care, Medicaid is now being utilized by the middle-class to avoid becoming impoverished should nursing home care be required.

II. Types of Medicaid

A. Standard Medicaid (SSL § 366 2)

1. Standard Medicaid has two different programs.

a. Community Medicaid. This program covers services rendered in the community. It includes personal-care aides providing services in the home. It also includes Medicaid's managed long-term care program.

b. Chronic care program. This program covers care in a nursing home.

B. MAGI Medicaid (SSL § 366 1)

1. This program was added by the Affordable Care Act.

a. Expands coverage of Medicaid benefits to individuals between the ages of 19 and 64 who are otherwise not eligible for standard coverage

b. It covers what is known as Benchmark Medicaid which is basically standard Medicaid coverage without coverage for long-term institutional care.

c. Eligibility is based upon household MAGI that does not exceed 133% of the federal poverty level.

d. MAGI is defined by reference to Internal Revenue Code Section 36B(d)(2)(B).

(1) IRC Section 36B(d)(2)(B) defines modified adjusted gross income as adjusted gross income plus:

(a) foreign earned income

(b) tax-exempt interest

(c) portion of Social Security excluded from taxable income

III. Non Financial Eligibility Requirements

A. Citizenship

1. Medicaid is available to citizens of the United States and certain qualified aliens.

2. In New York State, Medicaid is available to aliens lawfully residing in the state. See Aliessa v. Novello, 96 NY 2d. 418. See also 18 NYCRR § 360-3.2(j).

3. Aliens who are not residing lawfully in the state are still eligible for Medicaid emergency medical services.

B. Residence

1. To be eligible for Medicaid in New York State, an individual must be a resident of the state. (18 NYCRR § 360-3.2 (k))

2. There is no durational residency requirement. (18 NYCRR § 360-3.2 (k)(7))

a. Thus, an individual can enter New York State, go immediately to a nursing home, and be a resident of New York State.

b. However, if an individual is placed in a New York State nursing home by another state, that person will not be a resident of New York State.

C. The County with Fiscal Responsibility for Payment

1. New York State gives the counties the responsibility of administering the Medicaid program.

2. If an individual receives Medicaid while residing in a nursing home or an assisted living facility, it is the county in which such individual resided prior to entering the nursing home or assisted living facility which bears the financial responsibility.

a. Thus, if an individual was residing in Nassau County and enters a nursing home in Suffolk County, the responsibility for Medicaid falls on Nassau County.

3. If an individual enters a New York State nursing home or assisted living facility directly from another state, it is the county in which the nursing home or assisted living facility is located that bears the fiscal responsibility for Medicaid.

D. Individuals eligible for standard Medicaid (18 NYCRR § 360-3.3)

1. Individuals under the age of 21 or 65 years of age or older .

2. Individuals between the ages of 21 and 65 are eligible if they are either:

a. Disabled;

b. Blind;

c. Eligible for public assistance; or

d. Recipients of Supplemental Security Income (SSI).

E. Individuals eligible for MAGI Medicaid

1. Individuals between the ages of 19 and 64 whose modified adjusted gross income is below 133% of the federal poverty level.

F. Medically Needy Category (SSI Related)

1. In New York, the aged (65 and older), disabled, blind and SSI recipients are classified as SSI Related and medically needy. This means that if their income and/or resources exceed the allowable amounts, such excess income and/or resources may be spent down on the medical needs after which they will be eligible for Medicaid.

IV. Financial Eligibility for Standard Medicaid

A. To be eligible for standard Medicaid, an individual may not have resources or income that exceed the allowable amounts. Each year, Medicaid publishes the resource and income allowances. (See GIS 19MA/12 for 2020 allowances)

B. Resources General Rules

1. Limited to $15,750 for one person and $23,100 for family of two. Applicant is also permitted $1,500 in a *separate* burial account or an Irrevocable Pre-Needs Funeral Trust of any amount.

a. Includes resources of legally responsible relative unless the legally responsible relative refuses to make such resources available. (SSL § 366 3).

b. Federal law authorizes spousal refusal for nursing home care only. See 42 USC § 1396r-5(c)(3). There is no federal law provision for spousal refusal for home care other than in the Managed Long-Term Home Health Care Program (MLTC).

2. Exempt resources (not counted in limit above) (see 18 NYCRR § 360-4.7) (See also 42 USC § 1382b):

a. Homestead (for applications on or after January 1, 2020, the equity value is limited to $893,000 unless the home is occupied by a spouse, or by a child under age 21, blind or disabled).

(1) the Homestead loses its exemption if the owner is in a medical facility in permanent absent status with no intent to return home. (18 NYCRR § 360-4.7) The intent to return home, however, is a subjective intent. (See Anna W. v. Bane 863 F. Supp 125)

b. One car if in use

c. Certain prepaid burial and funeral expenses

d. Personal and household property

C. Resources of Community Spouse

1. The community spouse is permitted to retain one-half (½) of the couple's resources with a minimum of $74,820 and a maximum of $128,640. Since January 2006, the community spouse resource allowance includes retirement plans.

D. Income General Rules

1. Includes gross earned income and gross unearned income.

2. Exempt income (See 18 NYCRR § 360-4.6)

a. German reparations

b. The first $20 per month of unearned income

c. The first $65 a month of earned income

d. Veterans aid and attendance benefits

E. Income for Community Medicaid

1. Monthly income of applicant. (18 NYCRR § 360-4.3)

a. Limited to $875 for one person and $1,284 family of two. Income in excess of these amounts will be required to be spent down.

b. Includes income deemed available from legally responsible relatives.

(1) Does not include income of legally responsible relative if the legally responsible relative refuses to make such income available. (SSL § 366 3)

(2) Federal law authorizes spousal refusal for nursing home care only. See 42 USC § 1396r-5(c)(3). There is no federal law

provision for spousal refusal for home care other than in the Managed Long-Term Home Health Care Program (MLTC).

F. Income for Nursing Home Care

1. All monthly income of a nursing home resident in excess of $50 (the personal needs allowance) plus allowance for health insurance premium and the community spouse Minimum Monthly Maintenance Needs Allowance ("MMMNA") must be paid to the nursing home.

   a. The personal needs allowance for a participant of a waiver program is $409 if spousal impoverishment budgeting is elected and $875 if it is not elected.

   b. The MMMNA for 2020 is $3,216.

2. The monthly income of a non-applicant spouse is not considered as available to the applicant spouse.

MEDICAID CHRONIC CARE TRANSFER OF ASSETS

I. **Transfer of Assets.**

A. Overview

1. Although federal law permits a state to impose a penalty period on transfers of assets for community Medicaid (42 USC § 1396p (c) (1) (B) (II)), until recently New York State only imposed a transfer penalty on the application for nursing home benefits.

2. New York State regulations covering the transfer of assets can be found at 18 NYCRR § 360-4.4.

B. Rules for transfers made prior to February 8, 2006 (SSL § 366 5 (d)).

1. Look-back period was 3 years for outright transfers and 5 years for trust related transfers.

2. 96 ADM -8 was issued by the Department of Social Services on 3/29/96 to address the transfer and trust provisions of OBRA 93. It sets forth a directive for the local Departments of Social Services to follow in determining eligibility for nursing home Medicaid benefits.

a. This ADM continues to apply unless otherwise stated in 06 OMM/ADM-5, which is the directive that was issued to implement the Deficit Reduction Act of 2005 (42 USC 1396p (c) (1) (B) (I)).

3. Penalty period calculated by dividing the amount of the transfer by the Medicaid regional rate. Each year Medicaid publishes the average rate of

nursing home care for each region. The 2020 regional rate for Nassau and Suffolk Counties is $13,407.

4. Penalty period commenced on the first day of the month following the month of the transfer.

5. Penalty period could run while person did not require care.

6. Permits the last minute "rule of halves" planning.

7. The length of the penalty period is unlimited.

C. Transfers made after February 8, 2006 are governed by the Deficit Reduction Act of 2005 which is found at SSL § 366 5 (e). See also 42 USC 1396p (c) (1) (B) (I).

1. The look-back period has been extended to 60 months for all transfers.

2. Penalty period method of calculation is not changed.

   a. Transfer divided by Medicaid regional rate = penalty period.

3. Commencement of the penalty period for transfer made on or after February 8, 2006 has significantly changed.

   a. Penalty period starts on the first day of the month after the transfer

OR

the date the institutionalized individual is otherwise eligible for

AND receiving nursing facility services, whichever is later.

   b. Thus, the elements for the start of the penalty period are:

      (1) Applicant is receiving nursing facility services.

AND

(2) Applicant is otherwise eligible (except for the penalized transfer).

(a) Resources at or below $15,750.

(b) Income below the private pay rate for nursing home

(c) Medicare coverage has been exhausted.

4. The establishment of the start of the penalty period is done by submitting a Medicaid application and receiving a Medicaid denial. Depending upon the length of the penalty, the applicant may need to reapply when the penalty period is over.

5. Once the penalty period has commenced it continues to run even if the person no longer resides in a nursing home or continues to be eligible for Medicaid.

6. Multiple transfer are added together.

a. All transfers during the look-back period are totaled and the sum is divided by the Medicaid regional rate to determine the penalty period. This is true even if each individual transfer did not equal a full month penalty.

b. The penalty begins when the applicant is receiving nursing home care and is otherwise eligible.

D. Exempt Transfers SSL § 366 5 (e)(4).

1. Certain transfers are exempt and do not cause a penalty period:

a. Transfer of exempt property other than a homestead.

b. Transfers between spouses.

c. Transfers to a blind or disabled child, or a trust for the sole benefit of such child.

d. Transfers to authorized SNT.

(1) Trust for sole benefit of disabled applicant under age 65.

(2) Trust for sole benefit of any disabled individual under age 65.

e. Transfer made for a purpose exclusively other than to qualify for Medicaid.

f. Denial of eligibility would cause undue hardship.

2. In addition to the above, the transfer of a homestead is also exempt if the transfer is to:

(1) An adult child who has resided in the home for at least 2 years and has been a care giver to the applicant.

(2) A sibling of the applicant who has resided with the applicant for at least 1 year and has an equity interest in the home.

(3) A minor child (any resource can be transferred to a blind or disabled child).

MEDICAID CHANGES IN THE 2020-21 NEW YORK STATE BUDGET

I. Transfer of Assets for Community-Based Long-Term Care Services

A. Overview

1. The New York State Budget for its fiscal year 2020-21 amended the eligibility provisions for community-based long-term care services to add a look-back period and a penalty period on the transfer of assets by the applicant or the applicant's spouse. (SSL § 366 5 (e)).

2. Although federal law permits a state to impose a penalty period on long-term community-based care services, this is the first time that New York State has done so.

3. Long-term care services are defined as "home health care services, private duty nursing services, personal care services, assisted living program services and such other services for which medical assistance is otherwise available under this chapter which are designated as long-term care services and the regulations of the department." (SSL § 366 5 (e) (1) (xii)).

   a. This includes MLTC services and CDPAP.

4. The look-back and penalty provisions are effective for applications for community-based long-term care services submitted on or after October 1, 2020.

B. Look-back Period

1. The look-back period is 30 months from the date that the applicant applies for community-based long-term care services. (SSL § 366 5 (e) (1) (vi)).

C. Penalty Period

1. The penalty period method of calculation is the same as the method of calculation for nursing home care. (SSL § 366 5 (e) (3)).

   a. Transfer divided by Medicaid regional rate = penalty period.

   b. The regional rate is the Medicaid nursing home regional rate. There is no separate regional rate for community-based long-term care services.

2. Instead of adding a new section of the statute to implement the imposition of transfer penalties for community-based long-term care services, the transfer penalty provisions were added in SSL § 366 5 (e), which is the section of the statute that implemented the Deficit Reduction Act of 2005. Prior to the amendment for community-based long-term care services, this section of the statute applied to transfers made on or after February 8, 2006 with respect to eligibility for nursing home services.

   a. Adding the transfer of assets provisions to this section of the statute created uncertainty with respect to community-based long-term care services as to which transfers are penalized and when the commencement of the penalty period begins to run.

D. Transfers Made Prior to October 1, 2020

1. Based upon a literal reading of the statute, for applications submitted on or after October 1, 2020, transfers that were made in the 2 ½ year period prior to October 1, 2020 would be penalized.

a. Guidance from the Department of Health or a legislative change is needed in order to clarify that only transfers made on or after October 1, 2020 are to be penalized.

E. Commencement of the Penalty Period

1. The statute states that the penalty begins to run on the "... first day the otherwise eligible individual is receiving services for which medical assistance coverage would be available based on an approved application for such care but for... the transfer of assets.

a. The statute works for nursing home care because, at the time of application, the applicant is already in a nursing home and receiving services. Thus, the penalty period can commence in the month of application or during the retroactive 3 month period.

b. The statute, however, does not work for community-based long-term care services. The applicant for community-based long-term care services does not begin to receive services until after going through the assessment process and being determined eligible for home care services. An applicant cannot pay privately for MLTC or CDPAP. As a result, the statute may impose an infinite penalty

period for community-based long-term care services. The applicant cannot commence receiving services until determined eligible for the services, and cannot be determined eligible for the services until receiving Medicaid.

c. Guidance from the Department of Health or a legislative change is needed in order to clarify that the penalty period commences to run on the first day of eligibility for services, not receipt of services.

F. Transfer of a Homestead

1. For transfers by an **institutionalized individual**, the statute exempts transfers of a home to a (a) spouse, (b) child under the age of 21 years or blind or disabled, (c) sibling with an equity interest who resided in the home for a period of at least one year immediately to institutionalization, or (d) a child who resided in the home for at least 2 years before the date of institutionalization and who provided care to the parent. (SSL § 366 5 (e) (4) (I)).

2. The statute was not amended to include a transfer by a person applying for community-based long-term care services.

3. Since the home is an exempt resource while the applicant resides and it, the transfer of the home is not necessary in order to be eligible to receive community-based long-term care services. Accordingly, the transfer of the home to anyone while the applicant resides in it should be an exempt

transfer because it is a transfer made exclusively for a purpose other than to qualify for Medicaid. (SSL § 366 5 (e) (4) (iii) (B)).

G. Gift Loan Planning

1. The provisions of the statute for annuities and loans were not amended. Thus, the gift loan planning strategy should work for applications for community-based long-term care.

2. The difficulty will be in determining the first month that the person is "otherwise eligible" and the private pay rate of care.

H. Pooled Trusts

1. The provisions of the statute for pooled trusts were not amended. For persons under 65, these trusts qualify as supplemental needs trusts and transfers of income to the trust are exempt. For persons 65 years of age and older, transfers to the pooled trusts are exempt from penalty as long as the funds are paid for such person's expenses. (CMS Manual § 3259.7 (B) (2)).

I. Undue Hardship

1. The provisions of the statute for undue hardship were not amended. DOH policy on undue hardship waivers is set forth in 06 OMM/ADM-5.

2. This Administrative Directive provides that "[u]ndue hardship cannot be claimed: …if after payment of medical expenses, the individual's or couple's income and/or resources are at or above the allowable Medicaid exemption standard for a household of the same size."

a. While this provision may be appropriate for an institutionalized individual, it is not appropriate for an individual residing in the community. An institutionalized individual receiving nursing facility services has all of their needs provided for by the facility. They receive medical care, food and shelter. That is not the case for an individual residing in the community. It is unrealistic to believe that a person residing in the community in New York State can provide for all of their nonmedical needs with only $875 per month.

b. If this provision of the Administrative Directive were to apply to applications for community-based long-term care services, it would make undue hardship waivers unavailable for almost every individual. Most individuals have income of more than $875 per month.

c. Guidance from DOH, including a directive that the provision of the Administrative Directive that prevents the claim for an undue hardship waiver by an individual whose income or resources, after the payment of medical expenses, exceeds the allowable Medicaid exemption standard be limited to applications for nursing facility services.

J. Immediate Need Applications

1. Immediate need applications are required to be processed within 7 days. It is unrealistic to require DSS to process applications, including a 30 month look-back period, within 7 days.

2. DOH should direct that applicants for immediate needs may attest to transfers instead of requiring submission of documentation.

II. Non-financial Eligibility Changes

A. Activities of Daily Living

1. Effective for applications submitted on or after October 1, 2020, in order to be eligible for personal care services, other than personal emergency response services, the applicant must require at least limited assistance with physical maneuvering with more than 2 activities of daily living, or, for individuals with a dementia or Alzheimer's diagnosis, at least supervision with more than one activity of daily living. (SSL § 365-a subd. 2)).

2. The statute does not define the terms "physical maneuvering" or "activity of daily living."

III. Pending Legislation

A. Bills have been introduced in both the Senate and the Assembly to clarify some of the provisions of the changes that were made in the budget.

B. Transfer of Assets S. 8337 and A. 10489

1. Clarifies that only transfers on or after October 1, 2020 will be subject to the look-back period for community-based long-term care services.
2. Defines the start date for the penalty as the first day the otherwise eligible individual is functionally eligible for services for which medical assistance would be available based on an approved application instead of when the applicant is receiving such services.
3. Permits applicants for immediate need to attest to the fact that no transfers of assets were made within the look-back.
4. Prohibits the transfer penalty where transferred funds were used for the applicant's benefit.

C. Activities of Daily Living S.08403 and A. 10486

1. Expands the category of people who qualify for personal care services using the lower threshold of more than one activity of daily living to include persons with traumatic brain injury, other cognitive impairments, developmental disabilities, blindness, or other visual impairment.

TO:	Local District Commissioners, Medicaid Directors
FROM:	Lisa Sbrana, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2020 Medicaid Levels and Other Updates
EFFECTIVE DATE:	January 1, 2020
CONTACT PERSON:	Local District Support Units Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the income levels and figures used to determine Medicaid eligibility, effective January 1, 2020.

Due to the 1.6 percent (%) cost of living adjustment (COLA) for Social Security Administration (SSA) payments effective January 1, 2020, figures used to determine Medicaid eligibility must be updated. With an increase in the Supplemental Security Income (SSI) benefits level, the Medically Needy income and resources levels will also be adjusted accordingly.

The standard monthly premium for Medicare Part B enrollees will be $144.60 for 2020, an increase of $9.10 from $135.50 in 2019. Most Medicare beneficiaries will pay this amount. An estimated 4% of Medicare beneficiaries will pay less than the full Part B standard monthly premium amount in 2020. Due to the SSA 1.6% COLA, some beneficiaries who were held harmless against Part B premium increases in 2019 will pay the full monthly premium of $144.60 in 2020. This is because the increase in their Social Security benefits will be greater than or equal to the increase in their Part B premium.

The “hold harmless” provision does not apply to the following beneficiaries whose Part B premium will increase to $144.60 in 2020:

- beneficiaries who do not receive Social Security benefits;
- those who are directly billed for their Part B premium;
- new Medicare Part B beneficiaries;
- those who have Medicare and Medicaid, and Medicaid pays the premiums; and
- those who pay an Income-Related Monthly Adjustment Amount (IRMAA).

A chart with the 2020 Medicaid levels is attached. Medicaid Budget Logic (MBL) is programmed to use these figures when a “From” date of January 1, 2020, or greater is entered. Also attached is a chart with the updated reduction factors for calculating Medicaid eligibility under the Pickle Amendment.

Note: Budgets with a “From” date of January 1, 2020, or later, that utilize a Federal Poverty Level (FPL) must be calculated with the 2019 Social Security benefit amount and Medicare Part B premium amount until the 2020 FPLs are available on MBL. Upstate districts are instructed to update Social Security benefit amounts and Medicare Part B premium amounts for budgets that do utilize a FPL at the next contact with the consumer or at recertification, whichever occurs first. In New York City, the 2019 Social Security benefit amounts and Part B premium should be used until Phase Two of Mass Re-budgeting.

The following figures are effective January 1, 2020.

1. Medically Needy Income and Resources Levels.

HOUSEHOLD SIZE	MEDICALLY NEEDY INCOME LEVEL		RESOURCES
	ANNUAL	MONTHLY	
ONE	10,500	875	15,750
TWO	15,400	1,284	23,100
THREE	17,710	1,476	25,013
FOUR	20,020	1,669	28,275
FIVE	22,330	1,861	31,539
SIX	24,640	2,054	34,800
SEVEN	26,950	2,246	38,064
EIGHT	29,260	2,439	41,325
NINE	31,570	2,631	44,588
TEN	33,880	2,824	47,850
EACH ADD'L PERSON	2,310	193	3,263

2. The Supplemental Security Income federal benefit rate (FBR) for an individual living alone is $783/single and $1,175/couple.
3. The allocation amount is $409, the difference between the Medicaid income level for a household of two and one.
4. The 249e factors are .970 and .150.
5. The SSI resource levels remain $2,000 for individuals and $3,000 for couples.
6. The State Supplement is $23 for an individual living with others.
7. If an individual paid Medicare taxes for less than 30 quarters, the individual's cost for Medicare Part A is $458. If an individual paid Medicare taxes for 30-39 quarters, the standard Part A premium is $252. For individuals who paid Medicare taxes for 40 quarters or more, there is no cost for Medicare Part A.
8. The standard Medicare Part B monthly premium for beneficiaries with income less than or equal to $85,000 is $144.60.
9. The Maximum federal Community Spouse Resource Allowance is $128,640.
10. The Minimum State Community Spouse Resource Allowance is $74,820.
11. The community spouse Minimum Monthly Maintenance Needs Allowance (MMMNA) is $3,216.00.
12. Maximum Family Member Allowance remains $705 until the FPLs for 2020 are published in the Federal Register.
13. Family Member Allowance formula number remains $2,114 until the FPLs for 2020 are published in the Federal Register.
14. Personal Needs Allowance for certain waiver participants subject to spousal impoverishment budgeting is $409.
15. Substantial Gainful Activity (SGA) is: Non-Blind $1,260/month, Blind $2,110/month and Trial Work Period (TWP) $910/month.
16. SSI-related student earned income disregard limit of $1,900/monthly up to a maximum of $7,670/annually.
17. The home equity limit for Medicaid coverage of nursing facility services and community-based long-term care is $893,000.

18. The special income standard for housing expenses that is available to certain individuals who enroll in the Managed Long Term Care program (See 12 OHIP/ADM-5 for further information) vary by region. For 2020, the amounts are: Northeastern $483; Central $436; Rochester $444; Western $386; Northern Metropolitan $1,032; Long Island $1,361; and New York City $1,451. All regions had an increase from the 2019 figure.

Please direct any questions to the Local District Support Unit at 518-474-8887 for Upstate and 212-417-4500 for NYC.