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MEDICAID LEVELS – 2016

Income (Monthly) (in-home care)	
One Person	$825.00 + $20.00 disregard
Two People	$1,209.00
Resources (all services)	
One Person	$14,850.00
Two People	$21,750.00

Maximum Monthly Maintenance Needs Allowance For Community Spouse	$	2,980.50
Minimum Community Spouse Resource Allowance	$	74,802.00 (NYS State)
Maximum Community Spouse Resource Allowance	$	119,220.00 (Federal)
Nursing Home Medicare Co-Pay for Days 21-100[1]	$	161.00
Medicare Part B Premium (standard)	$	104.90
Medicare Part D varies by plan		
Home Equity Limit for Nursing Home Coverage	$	828,000.00

There continues to be a 5 year look back in New York State for nursing home Medicaid in all counties. Any withdrawals or deposits over $2,000.00 or more must be explained, including source (deposit) or purpose of expenditure, as part of the Medicaid application.

Nursing Home Rates By Region – Following are average costs from Department of Health (NYS) for nursing home care in each region of NYS. Districts must use the rate for the region in which the facility is located to calculate Medicaid Penalty Period for gifts and asset transfers made within five (5) years prior to application.

Long Island (Nassau/Suffolk)	$12,633.00
New York City (5 Boroughs)	$12,029.00
Central (Syracuse, Broome, Cayuga, Oswego, etc.)	$9,252.00
Northeastern (Albany, Rensselaer, Saratoga, Schenectady, etc)	$9,806.00
Northern Metropolitan (Westchester, Dutchess, Orange, Rockland, etc.)	$11,768.00
Rochester (Monroe, Ontario, Seneca, etc.)	$11,145.00
Western (Buffalo, Erie, Niagra, Genesee, etc.)	$9,630.00

[1] For many years, Medicare patients might not receive full 100 days in a skilled care facility if it was determined that they were no longer improving or had plateaued in their therapy. This was extremely problematic for persons suffering from chronic conditions such as multiple sclerosis, Alzheimer's disease, Parkinson's disease, ALS, heart disease and stroke. As the result of a recent federal class action lawsuit settlement, Medicare has agreed to abandon the "improvement standard" and revise its policy manual to indicate that coverage does not terminate based upon a patient's potential for improvement, but rather on whether the patient needs skilled care to "maintain" their current condition or "to slow further deterioration". This new analysis will apply not only to continued Medicare coverage at a skilled care facility, but also for continuing to receive physical or occupational therapy as an outpatient or at home.