What is Medicaid?

Most people read a page like this in a hurry, and usually after something has already happened: a fall, a stroke, a diagnosis, or a phone call from a hospital saying a parent cannot safely go home. The fear that comes with it usually arrives as the same question. Are we going to lose the house and everything they saved?

This page cannot answer that for your family, because the answer turns on facts nobody knows yet: who owns what, whose name is on it, whether there is a spouse still at home, what has been given away and when, and what level of care is actually needed. What it can do is explain how the system is built, in plain terms, so that you understand the vocabulary before you sit down with anyone, and so you are less likely to do something in the first frightened week that is hard or impossible to undo.

Medicare and Medicaid are different programs that happen to sound alike

Many families arrive believing Medicare will pay for a nursing home. Generally it will not, at least not for long. Clearing that up is the most useful thing this page can do.

Medicare is federal health insurance. People qualify by age, or by disability or certain medical conditions, not by financial need. A retired person with substantial savings and a retired person with almost nothing both qualify. It pays for hospital care, doctors, and, after a qualifying inpatient hospital stay that meets a minimum length set by the program, a limited period of skilled nursing or rehabilitation.

Two details about that coverage catch families out. Time spent in a hospital under observation status is generally not inpatient time, even though the bed and the hallway look identical, so it may not count toward the qualifying stay. And some Medicare Advantage plans handle the hospital stay requirement differently from original Medicare, which means the plan's own rules matter. In every case the coverage is tied to skilled care and to recovery, and it runs out. It was never built to pay for someone to live in a facility for years because they can no longer be alone safely.

Medicaid is a joint federal and state program for people with limited income and resources. Unlike Medicare, it does pay for long-term custodial care: the ordinary daily help with bathing, dressing, eating, medication and supervision that most families are actually facing. The other ways of paying are narrower than people hope. A long-term care insurance policy pays if one was bought years ago and it covers the care actually needed. Certain veterans benefits help those who meet their own separate tests. Otherwise families pay privately, and for many households that is what eventually leads them to Medicaid.

Two further distinctions matter. Medicare is a federal program, and its core rules do not change from state to state. **Medicaid is administered by each state within federal rules, so Ohio's rules are not Pennsylvania's or Florida's.** Advice from a relative who went through this in another state can be wrong here, in ways that are not obvious until it is too late. And the two programs are not alternatives: many people in nursing facilities have both, with Medicare covering medical care and Medicaid covering the cost of the facility.

It is also worth knowing that Medicaid in Ohio is not only a nursing home program. Ohio runs home and community based waiver programs intended to support care at home or in assisted living for people who would otherwise need facility care. These programs have their own eligibility rules and their own limits, and they are not a substitute for facility care in every case. If staying at home is the goal, that should be part of the first conversation rather than an afterthought.

Means tested is the whole difference

Medicare asks how old you are. Medicaid asks what you have. That is what "means tested" means, and it is why a Medicaid application feels invasive in a way that enrolling in Medicare never did. Expect requests for bank statements going back years, deeds, life insurance policies, annuity contracts, retirement account statements, and an explanation for transfers that may have seemed unremarkable at the time.

Long-term care Medicaid in Ohio generally turns on three separate questions:

Level of care. Does the person medically and functionally need the level of care being requested. This is an assessment, not a financial test.

Income. Is monthly income within the applicable limit, or capable of being handled under the rules that apply when it is not.

Resources. Are countable resources within the applicable limit as of the date that matters.

Failing any one of the three is enough. It is possible to prepare carefully for one test and be caught by another.

How Ohio treats income

Income means what arrives each month: Social Security, a pension, an annuity payment, rental income, a required distribution from a retirement account. Ohio sets a monthly income limit for nursing facility Medicaid. That figure is published and it changes, so it is not printed here.

Being over the limit is not automatically the end of the conversation. Ohio allows the use of a **qualified income trust**, often called a Miller trust, which is a particular kind of account that income is directed into each month, under rules governing both what goes in and what may be paid out. The mechanism is unforgiving about paperwork and timing. It generally has to exist and be funded correctly month after month, and a trust that is drafted wrongly, or funded late, does not repair the month it missed.

There is a related point that surprises many people. Qualifying does not mean the income is kept. Once someone is receiving Medicaid in a facility, most of their monthly income generally goes to the facility as their share of the cost. A personal needs allowance is retained, and certain deductions are allowed, which commonly include health insurance premiums and, where it applies, an allowance for a spouse still at home. The amounts and the permitted deductions are set by rule rather than by agreement with the facility. It is better to learn that now than at the first billing cycle.

How Ohio treats resources: countable and exempt

The resource test divides everything the household owns into two piles. **Countable** resources are counted against the limit. **Exempt** resources are not counted, though exempt is not the same as protected forever, which is a distinction worth holding onto.

Countable resources typically include checking and savings accounts, certificates of deposit, brokerage accounts, retirement accounts, cash value in whole life insurance, a second vehicle, real estate other than the residence, and money held jointly with someone else, which is frequently counted in full to the applicant unless the facts show otherwise. Retirement accounts deserve their own mention, because a great many people assume they are untouchable. They are frequently countable, and the fact that withdrawing from one triggers tax or a penalty does not by itself put it out of reach.

Resources commonly treated as exempt include the primary residence within limits described below, generally one vehicle, household goods and personal effects, certain prepaid and irrevocable funeral and burial arrangements, and term life insurance with no cash value. Several of those categories carry their own dollar limits and their own technical requirements, particularly the burial and funeral items. The categories are narrower and more technical than the plain words suggest, and whether a specific asset fits is a fact question, not a matter of what it is called.

One correction worth making early, because it causes real damage: **a trust is not automatically protective.** A standard revocable living trust, the kind many people set up to avoid probate, generally does nothing for Medicaid eligibility purposes, because the assets in it remain within the person's control. Certain irrevocable arrangements are treated differently, and they carry serious tradeoffs. It is also worth checking what you actually have rather than what it is called at home, because families often describe an irrevocable trust as revocable, and the reverse, and the difference is the whole point.

The house

The primary residence is usually the thing families are most afraid of, and the answer is more nuanced than either of the two stories people tend to hear.

The home is generally not a countable resource while a spouse or certain dependent relatives live in it. Where the applicant lives alone in a facility, the home may still be treated as exempt in some circumstances, including where an intent to return home is documented in the way the rules require, though whether that treatment holds depends on the facts rather than on the statement alone. Federal rules also set an equity limit above which the home exemption stops applying, and that limit generally does not apply where a spouse or certain dependent relatives are living in the home. None of this means the house is permanently safe, and none of it means Medicaid takes the house the day someone is admitted. Both of those beliefs are common and both lead to bad decisions.

When one spouse needs care and the other is still at home

This is the situation where the rules are most protective, and where a panicked decision costs the most.

Federal spousal impoverishment rules exist precisely so that a husband or wife who is still living in the community is not left destitute by the other's care. In broad terms, the at-home spouse, usually called the **community spouse**, is allowed to keep a share of the couple's countable resources up to a limit, and may be entitled to receive part of the institutionalized spouse's monthly income if their own income falls below a floor. Both of those figures are set by rule, they adjust over time, and they are not printed here.

Three mechanical points matter more than most families realize:

The couple's countable resources are generally counted together, regardless of whose name is on what. "It is only in my name" is not a Medicaid answer. Neither, usually, is a prenuptial agreement.

The count is taken as of a particular date, generally tied to the start of a continuous stay in a hospital or nursing facility that lasts at least the minimum length the rules specify, rather than the date you eventually file the application. That date is often earlier than families expect, because a hospital stay that runs straight into a nursing facility stay can be part of the same continuous period. Spending done before that date and spending done after it are treated very differently.

The amounts the community spouse may keep are not always fixed in stone. There are processes for seeking more in particular circumstances, and they have their own requirements and deadlines.

If there is a spouse at home, that fact alone usually justifies getting advice before anything is moved, sold, retitled or spent.

The look-back period

When someone applies for long-term care Medicaid, the state does not only look at what they own today. It reviews financial history going back a fixed period set by federal law, called the **look-back period**. Transfers made for less than fair market value during that window are examined and may be penalized.

This page does not print the length of the look-back, for the same reason it does not print the dollar figures: the rules are detailed and they are worth confirming as they stand on the day you need them rather than as they stood when a web page was written. Ask whoever is helping you to state the current period. What matters for planning is the shape of it. The window runs for years, which is long enough that gifts made well before anyone in the family was thinking about a nursing home can still be squarely within range.

What counts as a transfer is broader than most people expect. It is not only handing over a large check. It can include:

Deeding the house to a child, or selling it to family for a nominal amount.

Adding a child's name to a deed or a bank account.

Paying a grandchild's tuition or wedding.

Helping a child with a down payment or a car.

Regular informal cash gifts, including small ones, over a period of years.

Paying a family member for caregiving without a written arrangement that meets the requirements.

Here is a confusion that does real damage. The annual amount a person can give away without filing a federal gift tax return is a **tax** rule. It has nothing to do with Medicaid. Gifts well inside that tax figure are still transfers for Medicaid purposes, and a gift that creates no tax consequence at all can still create a Medicaid problem. The two systems are simply not speaking to each other, and assuming otherwise is one of the more expensive mistakes available.

What a penalty period is

A penalized transfer does not usually produce a fine or a demand for the money back. It produces a **penalty period**: a stretch of time during which the person is not eligible for Medicaid payment of long-term care, even though they otherwise meet the requirements.

The length is calculated, not chosen. In general terms, the total value of the penalized transfers is divided by a figure the state publishes to represent the average private pay cost of nursing facility care, and the result is a period of ineligibility. Larger gifts produce longer penalties.

The part that causes real harm is the timing. **A penalty period generally does not begin on the date of the gift. It begins when the person is otherwise eligible and in need of the care**, which is to say when the rest of the money is already gone. That is why a transfer made in panic can backfire. The family gives assets away to protect them, spends the remainder on care, applies, and discovers there is now a period with no Medicaid, no assets, and a facility bill. The money is with the children, sometimes already spent or exposed to a divorce, a lawsuit or a creditor, and getting it back is neither simple nor certain.

Adding a child's name to the house or to an account carries its own separate costs beyond Medicaid, which nobody mentions at the kitchen table. It can expose the asset to that child's creditors and to divorce proceedings. It can also have income tax consequences: as a general rule, property inherited at death receives a new tax basis, while property given away during life does not, so a lifetime transfer can leave a capital gains bill that the family never saw coming. How that works out depends on how the transfer was structured and what the property is worth, which is a question for a tax professional on the specific facts. A step that felt free can turn out to have been expensive in more than one direction.

What happens to the house after death

There is one more piece that belongs in an honest page, because leaving it out makes the picture look rosier than it is. Ohio, like every state, operates a Medicaid **estate recovery** program. After the death of someone who received Medicaid-funded long-term care, the state may seek reimbursement from their estate, and in practice the home is often the main asset involved.

Two things are worth understanding before assuming the home is out of reach. What counts as the "estate" for recovery purposes is defined by statute, and in Ohio it is not necessarily limited to assets that pass through probate, so a survivorship deed or a transfer on death designation does not automatically settle the question. And exempt during the application is not the same as exempt afterwards: an asset that was not counted while the person was living can still be within reach of recovery later.

That is not the same thing as Medicaid taking the house during life, and it is not the same as the house being seized. There are exceptions and limits, including protections that generally apply while a surviving spouse is living, protections for certain children, and a process for claiming undue hardship. But a family that assumes the home is safe simply because it was exempt during the application is working from an incomplete picture, and the time to look at that is before the deed is changed, not after.

Planning ahead and crisis planning are two different things

Planning ahead

Planning done well before care is needed, outside the look-back window, has the widest range of options available to it. It is also the only kind that can be done calmly, with time to weigh tradeoffs, look at tax consequences, and consider whether any of it is worth doing at all.

That last point deserves saying plainly. Advance planning is not automatically right. It usually involves giving up control of assets, and control is worth something, particularly to someone who may go on living independently for many more years. For some households the cost and the loss of flexibility are not repaid by the benefit. You should hear that assessment honestly before you spend anything.

Crisis planning

Crisis planning is what happens when care is needed now or has already started. The options are narrower. If an approach is described as making past gifts simply disappear, that is a reason for more questions rather than fewer, because the look-back rules do not stop applying because someone says they do.

Narrower is not the same as nonexistent. Depending entirely on the facts, lawful approaches may include restructuring resources into forms that are treated differently, permitted spending on legitimate needs rather than gifts, use of the spousal protections described above, and recognizing that federal law exempts certain transfers from penalty altogether. Those exceptions generally include transfers to a spouse and transfers to a child who meets the disability standard. In defined circumstances they also include a transfer of the home to a child who lived in the home for a minimum period immediately before the parent moved to a facility and who provided a level of care that meets the standard in the rules, or to a sibling who already holds an equity interest in the home and who lived there for a required period beforehand. Each of those exceptions has strict requirements and has to be evidenced, and the documentation is usually where they fail rather than the family story.

Crisis planning also includes something less dramatic but often more valuable: getting the application right, with complete records, so that it is not denied over a missing statement or a transfer nobody thought to explain.

When to call an attorney

Not every family needs one. These are the points where a mistake is hardest to undo:

Before any asset is given away, sold below value, or retitled, including adding a name to a deed or an account. Retitling is among the most common and least recoverable missteps, because it is usually done with good intentions and discovered much later.

When there is a spouse still living at home. The protections are real and the missteps are costly.

Before signing nursing facility admission paperwork, particularly where a family member is asked to sign as a responsible party or to guarantee payment personally. Federal rules generally prohibit a facility from requiring a third party to guarantee payment personally as a condition of admission, but admission packets do not always make that clear, and signing in the wrong capacity can create an obligation that was never required in the first place.

When the power of attorney is about to be used for anything beyond routine banking. Many powers of attorney do not authorize gifting or Medicaid planning at all, and under Ohio law a document that is silent on those powers generally does not grant them.

When a denial, a penalty notice, or an adverse determination arrives. Appeal rights carry deadlines, the deadline usually runs from the date on the notice rather than the date you opened it, and the notice itself is where that period is stated.

When the household includes a business, a farm, rental property, an annuity, or assets in more than one state.

When income is above the limit, or when someone has been told to set up a qualified income trust.

When a family member has been providing unpaid care and there is any thought of compensating them.

When someone has already made transfers within the look-back period. Earlier is better.

Some situations can be improved and few are improved by waiting.

What this page is, and what it is not

This is general educational information about how Medicaid long-term care rules are structured in Ohio. It is not legal advice. Reading it does not create an attorney and client relationship, and neither does contacting the firm, so please do not send confidential information until a relationship has been agreed in writing. Nothing here is a prediction about any particular household, and nothing here is a promise that anyone will qualify for a benefit, keep a particular asset, or avoid a particular cost.

Three honest limits are worth repeating. First, these rules are detailed, they change, and the published figures behind them adjust over time, which is why this page describes mechanisms rather than numbers, and why it should be read as current only as of the date it was published. Second, federal law sets much of the structure but Ohio's own rules and procedures fill it in, so material written for another state may not apply here. Third, and most importantly, eligibility turns on the specific facts of a specific household: the titling, the dates, the documents, the family's circumstances, and what has already been done. Two families with similar sounding finances can reach very different outcomes. The purpose of this page is to orient you well enough to ask good questions, not to tell you what to do.

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