Medicaid
Questions and Answers
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Introduction

Ohio offers comprehensive, quality health coverage to more than 2 million Ohioans who are elderly, disabled or have low incomes through its Medicaid program.

The Medicaid program serves individuals and families who meet certain income guidelines, including children up to age 21; pregnant women; families; and those people who are 65 or older, who are blind or who have a disability.

Eligibility for health care coverage through Medicaid is determined by the county departments of job and family services (CDJFS). Disability Medical Assistance is available through a state-funded program administered by the Office of Ohio Health Plans for qualified Ohioans who are disabled. However, enrollment in this program is currently closed due to funding constraints.

Health care services covered under Ohio’s Medicaid program include, but are not limited to, the following:

• Most inpatient and outpatient hospital services
• Services of doctors, dentists, optometrists, chiropractors, podiatrists, and other licensed specialists
• Certain prescription drugs
• Eyeglasses, hearing aids, dentures
• Immunizations
• Well-child visits
• Care in a nursing facility
• Mental health, alcohol and drug addiction services

By calling the toll-free Consumer Hotline at 1-800-324-8680 or (TDD) 1-800-292-3572, individuals can receive Medicaid information and assistance; enroll in a Managed Care Plan; apply for health coverage for children and pregnant women; and learn how to receive services. The hotline is open seven days a week. Managed care members should contact the Managed Care Enrollment Center (MCEC) to enroll/receive assistance. That number is 1-800-605-3040.

General Information About Medicaid

Q: What is Medicaid?
A: Medicaid is a health insurance program that provides health care coverage to certain eligible people of all ages.

Q: What is the difference between Medicare and Medicaid?
A: MediCARE is an insurance program that mainly serves people with disabilities or who are 65 or older who have worked and paid into the Social Security System for enough time that they are eligible for medical coverage regardless of their income. Medicare is federally funded and is administered by the Social Security Administration. Medicare cards are red, white and blue in color.

MediCAID is a health care program that serves people of all ages who do not have enough money or health insurance coverage for medical care. Medicaid is funded by both the federal government and the state of Ohio and is administered by the Ohio Department of Job and Family Services.

Q: Who can qualify for Medicaid?
A: Medicaid provides health care coverage to different groups of people who meet certain financial requirements, including:

Covered families and children:
• Children up to age 19
• Children ages 19-21
• Pregnant women
• Families with children under age 19 who participate in the Ohio Works First (OWF) program
• Families who are not eligible for OWF but who meet certain financial requirements
• Youth ages 18-21 who were in foster care on their 18th birthday
• Workers with disabilities

People who are aged, blind or have disabilities:
• Adults aged 65 or older
• Individuals with disabilities, including individuals who are legally blind
• Individuals who are eligible for Medicare can receive help with all or part of their Medicare Part B premiums, co-payments, and/or deductibles

People who need care in a nursing facility or an intermediate care facility for people with mental retardation or developmental disabilities.

Q: How long can I continue to get Medicaid coverage?
A: There is no time limit. You can be covered by Medicaid as long as you continue to meet the eligibility requirements. You do, however, have to recertify your eligibility at regularly scheduled times.

Q: Who can apply for Medicaid coverage?
A: Anyone can apply for Medicaid. The information you give on the application is used to determine whether you are eligible for coverage. Depending on your age, income and health status, you may qualify for health coverage.

Q: I receive Supplemental Security Income (SSI) or Social Security Disability payments. Can I still be covered by Medicaid?
A: It is possible to be covered by both. Someone at your CDJFS can talk with you about your individual circumstances and whether you will be eligible for Medicaid.

Q: I have medical coverage through Medicare or through a commercial health insurance policy (e.g. Blue Cross). Can I be covered by Medicaid, too?
A: Yes, you may have coverage under Medicare or a commercial health insurance policy and still be eligible for Medicaid. In these cases, Medicaid may pay for what isn’t covered by Medicare or your commercial health insurance. You should bring information about your Medicare or commercial coverage when you apply for Medicaid and anytime you visit the doctor, hospital or other medical provider. Medicaid is not considered primary health coverage when there is commercial insurance available. If you have Medicare and are eligible for Medicaid, you will not be enrolled in the managed care plan.

Q: I own my home and live alone. I don’t have enough money to pay my medical bills. Do I have to sell my home before I can qualify for Medicaid?
A: No. As long as you live in your home, it is not counted as a resource when determining your eligibility for Medicaid.

Q: What if my financial resources are more than Medicaid says I can have?
A: Even if your income is too high for you to qualify for regular Medicaid, you may be able to get coverage after you “spend-down” some of your income. (See page 16 for more information about “spend-down.”) If your resources (savings accounts, insurance policies, etc.) are too high to qualify for regular Medicaid, you may still be able to get help under a Medicaid waiver program, which counts income differently than for regular Medicaid. Waiver programs enable people with disabilities or other conditions to receive care in their homes and communities instead of in nursing facilities. Examples of home-delivered services include homemaker, personal care, transportation and counseling services. (See page 13 for more information on waiver programs.)

Q: I am expecting a child, and I can’t afford doctor visits during my pregnancy. Can Medicaid help me?
A: Medicaid can probably help you. You may be eligible for the program within Medicaid called Healthy Start, which offers health care to women who are pregnant and have income below a certain level. You should
apply even if your income is above the eligibility limit because expenses such as child care costs can be deducted, reducing your countable income. The fact that you own a home and a car will not affect your Medicaid eligibility since these resources are not counted.

Because health care during a pregnancy is so important, Medicaid applications for pregnant women are processed very quickly. That way you can go to the doctor as soon as possible.

If you are found eligible, you will stay eligible throughout your pregnancy even if your income increases. If you qualify, your newborn baby will automatically be covered for the first year of his or her life. Your children under the age of 19 may also be eligible. Medicaid will cover medical care for you and your children, including the birth of your baby and doctor visits before and after you have your baby.

Q: My daughter is 15 years old and pregnant. My health insurance at work won’t pay for prenatal care and delivery for my daughter. Can Medicaid help us?
A: You should apply for Healthy Start. Your income will be used in determining your daughter’s eligibility. Because she is under age 18, once the baby is born, the baby’s eligibility for Medicaid will be based on your daughter’s income only.

Q: I have private health insurance, but the coverage isn’t very good. Could Medicaid help me with health care not covered under my private plan? If I am eligible for Medicaid, should I cancel my private health insurance?
A: You may be eligible for Medicaid coverage even if you have other health insurance. Because Medicaid eligibility is based on income, it’s a good idea to keep your private insurance.

Medicaid coverage is very broad and covers many medical services. If you have private health insurance and don’t have to pay anything out of your pocket for the coverage, it wouldn’t be a savings to you to cancel the coverage (for example, if you and your children are covered through a child support arrangement). But some private health insurance policies don’t pay all of your medical costs. Medicaid could help pay for some of these services. Depending on what kind of Medicaid coverage you have, the money you pay for your premiums might be used to reduce your countable income when your Medicaid eligibility is determined.

Q: I have a chronic medical condition. If I can no longer work, can I qualify for medical coverage through Medicaid?
A: If your physical condition is serious and keeps you from working regularly or if you find you are no longer able to work at all, and you have limited financial resources, you may be eligible for Medicaid. Someone at your local CDJFS can help you apply for Medicaid coverage. You should also file an application with the Social Security Administration for benefits.

How Do I Apply for Medicaid?

There are several ways to apply for health coverage through Medicaid. You can call the Medicaid Consumer Hotline at 1-800-324-8680 or (for the hearing impaired) 1-800-292-3572 (TDD). You can discuss your options, or possibly be referred to someone at your CDJFS who can give you an application and talk with you about your need for medical coverage.

No face-to-face interview is required if:
• You’re applying for Healthy Start for your children up to age 19
• If you are between 19 and 21
• You’re a pregnant women applying for Healthy Start or expedited Medicaid
• You’re applying for Healthy Families
• If you are a worker with a disability
You are required to have a face-to-face interview at your CDJFS if you’re applying for other kinds of health coverage, and/or such programs as food stamps or child care. If visiting your CDJFS is difficult because of a disability or other limitation, you should ask whether the county staff can make other arrangements for you. For example, you might be able to complete the application and mail it and copies of required documents to the CDJFS.

You can also choose someone to represent you at the face-to-face interview. You must name this person as your authorized representative. This should be someone who can complete the application for you and provide all the necessary information. Your authorized representative must be at least 18 years old, and can be anyone you choose to act in your behalf, such as your husband or wife, a relative or friend, your legal guardian, or an attorney. You must sign a letter saying that this person is your authorized representative.

Q: How do I apply for Healthy Start or Healthy Families?
A: To apply for coverage, call the toll-free Medicaid Consumer Hotline at 1-800-324-8680 or talk to someone at your local CDJFS. Hotline staff can mail you a blank Healthy Start & Healthy Families application or even help you fill it out over the phone. They will mail you the completed application for your signature and include a checklist so you’ll know what other documents to send to your CDJFS. The hotline can also tell you how to apply for other kinds of Medicaid coverage.

The Healthy Start & Happy Families application is also available at your CDJFS, at Women, Infants and Children (WIC) clinics and at Child and Family Health Services clinics. It also can be found on the Internet at http://jfs.ohio.gov/ohp/consumers/Application.stm.

This application is used for Healthy Start coverage for children up to age 19 and pregnant women, and for Healthy Families coverage for entire families. No face-to-face interview is necessary.

It is also used for pregnant women to apply for Expedited Medicaid. Once you show proof of pregnancy, proof of identity and a statement of your income, an Expedited Medicaid card will be mailed to you. This card will be good for 60 days, while your Healthy Start eligibility is evaluated, to enable you to get the medical care you need as early as possible in your pregnancy. (The Expedited Medicaid card does not cover hospitalization.)

Q: What if I need help filling out the application?
A: You can call the Medicaid Consumer Hotline at 1-800-324-8680 for help in completing your application. Caseworkers at your CDJFS also can help you complete your application for health coverage.

Q: When I apply for Medicaid for myself and my family, what information should I bring with me?
A: If you’re applying for Healthy Start coverage, you’ll need:
• Social Security numbers
• Proof of your identity (driver’s license or other photo identification)
• Proof that you are a U.S. citizen or a registered alien (birth certificate, green card, etc.)
• Proof of your income, such as pay stubs, worker’s compensation letters, income tax forms, etc.

If you’re applying for other kinds of Medicaid coverage, you will also need additional information, such as:
• If you get Social Security, your Social Security award letter and Medicare card
• Car title, if you have a car
• Information about cash on hand, money in checking and savings accounts, savings bonds
• Current value of stocks, life insurance, health insurance
• Information about property you own or are buying
• Medical bills you owe
• Information about medical treatment and medicines you need regularly
• Statement from doctor verifying pregnancy (if applicable)
• Proof you are a U.S. citizen or a registered alien.

Q: When will I find out whether I am eligible for Medicaid? How will I be notified?
A: If you applied for Healthy Start or Healthy Families, you should be notified by letter within about 45 days from the date the CDJFS received your completed application. If you applied as a blind or disabled person (and you aren’t receiving benefits from social security or SSI), determining your eligibility will take longer because your medical condition and medical records need to be reviewed as well as your financial eligibility. Determining your disability usually takes about 90 days from the date you applied. You can always call your county caseworker and ask about the status of your application.

Q: If I'm found Medicaid eligible, when will my coverage start?
A: Your Medicaid coverage is effective the first day of the month in which you applied. In addition, you may have retrospective coverage. This means that if you would have been found eligible for Medicaid anytime in the three months before you applied, Medicaid may pay for medical services you got during those previous three months. Check with your caseworker to find out about your individual circumstances.

Once I’m Eligible, What Can I Expect?

Q: What kind of medical or health care providers can I visit if I have Medicaid coverage?
A: Not all medical or health care providers accept Medicaid so you should ask when you make your appointment. Examples of medical or health care providers who serve Medicaid consumers are doctors, dentists, pharmacists, nurse-midwives, optometrists, podiatrists, chiropractors, physical therapists, psychologists, hospitals, outpatient clinics, nursing facilities, ambulance services, X-ray and laboratory services, home health agencies, intermediate care facilities for persons with mental retardation (ICF-MR), habilitation centers, hospices, medical equipment and supply companies, and family planning clinics.

You may be required to enroll in a managed care plan (MCP), which contracts with Medicaid. If you join an MCP, you must go to a Medicaid provider who has agreed to work with your MCP. If you have questions about enrolling in Medicaid managed care, contact the Managed Care Enrollment Center at 1-800-605-3040.

Q: What is a Medicaid Managed Care Plan (MCP)?
A: Ohio Medicaid contracts with certain managed care plans to serve some Medicaid enrollees who, when enrolled, become “members” of that MCP. An MCP arranges health care for its members through a network of providers. You must get your medical treatment from a doctor who has agreed to work with your MCP or is in the MCP’s network. You will need to choose one doctor or a group of doctors. This allows you to develop a close relationship with your primary care physician. If you or your children need the services of a specialist, your physician will make the referral at no cost to you.

Adults as well as children are entitled to preventive health care through an MCP, in addition to all of the health care services offered through Medicaid. Information about MCPs in your area is available by contacting your CDJFS or by calling the Managed Care Enrollment Center (MCEC) at 1-800-605-3040.

Q: How will my doctor know that I am eligible for Medicaid?
A: You will get a Medicaid card in the mail. If you are enrolled in Medicaid managed care, the card will be called a “member card,” and it will come from the Managed Care Plan. MCP member cards may be
good for more than one month so keep it in a safe place. If more than one member of your household is enrolled, your family may receive a card for each person enrolled.

If you are not enrolled in a Medicaid Managed Care Plan, you will get a regular Medicaid card in the mail each month. The card will show the names of everyone in your household who is eligible for Medicaid. You will get a new card in the mail every month for as long as you are eligible for Medicaid. You must have a current card to get medical services. Be sure to show the card to your provider before you get a medical service.

Q: Do all providers accept Medicaid? How can I find a doctor?
A: No. You should find out if a provider accepts the card and if the medical service is covered before you get the service. Your CDJFS may have information about which local providers accept the Medicaid card. The Medicaid Consumer Hotline can also provide you with a list of providers in your area.

If you are enrolled in Medicaid managed care, your MCP will send you a list of providers who have agreed to see patients enrolled in that MCP. You can also call the customer service number on your card and ask whether you can see a certain provider or for help in finding a provider.

Q: Do I have to pick just one doctor to be my regular doctor?
A: Unless you are in an MCP, you don’t have to pick one doctor to be your regular doctor. Picking a primary doctor is still a good idea because:

- You won’t have to give your medical history every time you visit.
- You won’t have to have duplicative examinations, tests and X-rays.
- Your doctor will have all records of the medicines you are taking, which will help prevent any side effects of taking drugs that shouldn’t be taken at the same time.
- Sometimes you may be able to get advice over the phone from your regular doctor, because the doctor knows you.
- It is usually easier and faster to get an appointment with a doctor who is your regular doctor.
- Your regular doctor may decide that you need to see a specialist, and can arrange an appointment with the specialist for you.

If you are enrolled in Medicaid managed care, you will be required to choose one doctor to manage your care (your PCP). If you don’t choose a PCP, one will be chosen for you.

Q: I am sick and need to see a doctor, but I can’t drive or take a bus. I have no one who can take me to the doctor. Can Medicaid help?
A: Yes, Medicaid can cover transportation to get medical services. But you should plan in advance unless it is an emergency. If you are enrolled in Medicaid managed care, contact your MCP and ask for help with medical transportation. If you are not in Medicaid managed care, contact your CDJFS and ask for help. Your caseworker will talk with you about what kind of transportation is best for you and will explain how this service works. You must ask for transportation services at least 10 business days before you need to travel, unless your visit is urgent or an emergency.

The medical transportation service is not for Medicaid consumers who have family or friends who can take them to the doctor. If family or friends have been taking you to your medical appointments in the past, you must explain why they can no longer do so. If you have been able to use public transportation or your own car to go to your medical appointments in the past, you must explain why you can no longer use that transportation.

Q: Is there a limit on the number of prescriptions I can have filled?
A: There is no limit for prescriptions you can receive through managed care. Your managed care plan must cover all drugs covered by Medicaid, however, the prior authorization requirements may be different.

In general, as long as your doctor thinks you need the medicine and gives you a
What services does Medicaid cover?

In general, Medicaid provides comprehensive coverage for medically necessary health services through two benefit packages.

The **Basic Health Package** covers a wide range of services, including doctor visits, hospital care, prescription drugs, preventive health care, dental care, transportation, vision services, and mental health and substance abuse treatment services. Even if a service is not generally covered, it may be if your doctor can show that it is medically necessary and asks Medicaid for approval.

Coverage in the Basic Health Plan is available to all Medicaid enrollees whether they are enrolled in Medicaid managed care or traditional fee-for-service Medicaid.

The **Long-Term Care Health Package** offers several options to Medicaid-covered individuals who are elderly, blind or have disabilities and meet additional criteria. Most people receiving services under the Long-Term Care Health Plan are in nursing homes or an ICF-MR. There is also a home health care option that allows eligible people to receive care in their homes. Individuals receiving benefits in the Long-Term Care Health Package also get the coverage offered by the Basic Health Package, regardless of whether in an institution or at home.

Some individuals qualify for both Medicaid and Medicare benefits. Medicare is the federally funded program that provides health insurance to people age 65 and over and those who have permanent kidney failure and certain people with disabilities. Medicaid may pay for some or all of an individual’s Medicare insurance premium payments. Eligibility for Medicare premium payments is determined by the CDJFS based on several factors, including income. For more information about enrollment in Medicare and Medicaid and the Medicare premium assistance program, visit [http://jfs.ohio.gov/OHP/consumers/7103intro.stm](http://jfs.ohio.gov/OHP/consumers/7103intro.stm).

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Coverage in the Basic Health Plan is available to all Medicaid enrollees whether they are enrolled in Medicaid managed care or traditional fee-for-service Medicaid.

The **Long-Term Care Health Package** offers several options to Medicaid-covered individuals who are elderly, blind or have disabilities and meet additional criteria. Most people receiving services under the Long-Term Care Health Plan are in nursing homes or an ICF-MR. There is also a home health care option that allows eligible people to receive care in their homes. Individuals receiving benefits in the Long-Term Care Health Package also get the coverage offered by the Basic Health Package, regardless of whether in an institution or at home.

Some individuals qualify for both Medicaid and Medicare benefits. Medicare is the federally funded program that provides health insurance to people age 65 and over and those who have permanent kidney failure and certain people with disabilities. Medicaid may pay for some or all of an individual’s Medicare insurance premium payments. Eligibility for Medicare premium payments is determined by the CDJFS based on several factors, including income. For more information about enrollment in Medicare and Medicaid and the Medicare premium assistance program, visit [http://jfs.ohio.gov/OHP/consumers/7103intro.stm](http://jfs.ohio.gov/OHP/consumers/7103intro.stm).

Q: Does Medicaid keep track of how many times I go to the doctor or the number of prescriptions I have filled?

A: Yes. Computers at the Ohio Department of Job and Family Services keep track of how many people use Medicaid services, who they are, how many times they visit a doctor, how many different doctors they visit, how many different pharmacies they go to for prescriptions, what prescriptions they have filled, and what brings them to visit a doctor. If a person with no serious or chronic illness visits a lot of different doctors and has a lot of prescriptions filled, this might show misuse or overuse of Medicaid services. This information also helps Medicaid understand if there are certain services that are available to consumers that are not being used.

Q: Is there a limit on the number of times I can go to the doctor?

A: There is no limit to the number of times a member can see the doctor under a managed care plan if it is medically necessary.

If you are not in an MCP, Medicaid will cover up to 24 doctor visits in a calendar year. These visits may be to one doctor or to different doctors. Some visits, such as those for serious illness, pregnancy-related visits and well-child visits are not counted toward the 24-visit limitation.

Q: What are HEALTHCHEK services?

A: HEALTHCHEK is the name given to Ohio’s prescription, Medicaid should pay for your medicine. But you should always tell a doctor what other drugs you are taking because combining certain drugs can be harmful to your health. Some drugs are not covered. If your doctor prescribes a drug that is not covered, your doctor and pharmacist can discuss another drug that can be substituted.

Q: What are HEALTHCHEK services?

A: HEALTHCHEK is the name given to Ohio’s prescription, Medicaid should pay for your medicine. But you should always tell a doctor what other drugs you are taking because combining certain drugs can be harmful to your health. Some drugs are not covered. If your doctor prescribes a drug that is not covered, your doctor and pharmacist can discuss another drug that can be substituted.
Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. HEALTHCHEK includes prevention and treatment services for children and teens. The basic services, which are provided through Ohio’s Medicaid program, are screening services, vision services, dental services, hearing services, behavioral health and other rehabilitative services, and other medically necessary services.

The HEALTHCHEK screen services package includes a complete unclothed physical exam; medical history; nutritional and developmental assessments; dental, eye and hearing checks; and health education. Other health care services, including treatment, may be provided for children with disabilities or chronic care needs and as a follow-up to a screening service.

**Q:** When should my child get a HEALTHCHEK screening exam?
**A:** Your child should receive a HEALTHCHEK screening exam as often as once a calendar year up to his or her 21st birthday. All babies should be examined at birth. During the first two years of life, regular exams are important to your child. Good medical care during these first two years will give your child a healthy start in life.

**Q:** Are shots included in the HEALTHCHEK screening exam?
**A:** Yes. The doctor will determine what shots (immunizations) your child needs, such as shots against polio, whooping cough, measles, mumps, diphtheria, hepatitis B and tetanus (lockjaw).

**Q:** What dental services are provided as part of the HEALTHCHEK program?
**A:** Dental checkups are part of the HEALTHCHEK program and cover teeth cleaning and examination, as well as treatment for cavities and other problems identified during the examination. Children may receive a dental examination beginning at age 2 or earlier if a dental problem is identified. Regular dental checkups are important and are covered every six months. Tooth decay is one of the common problems of childhood. Many people lose their teeth as adults because dental problems that began in childhood were not treated.

**Q:** Will the HEALTHCHEK program cover my child’s eyeglasses and other vision services?
**A:** Yes. The HEALTHCHEK program provides vision services to find and treat vision problems, including a complete eye examination, eyeglasses and other necessary services. Vision services may be obtained every 12 months and are provided by ophthalmologists and optometrists who are eligible to offer Medicaid services. If you are enrolled in an MCP, check with your MCP about vision services, providers and frame selection.

**Q:** What hearing services are provided as part of the HEALTHCHEK program, and how often can they be provided?
**A:** Although your children may have had their hearing checked during the HEALTHCHEK screening exam, the program provides other hearing services to find and treat hearing problems. These services may include a complete hearing exam, hearing aids and other necessary services. Hearing services may be obtained if a hearing problem is suspected by the family, doctor, teacher or any other professional, and may be provided by audiologists who are eligible to offer Medicaid services.

If you are enrolled in an MCP and suspect that your child may need a hearing assessment, check with your child’s PCP.

**Pregnancy Services**

**Q:** I’m pregnant and should see a doctor now, but I don’t have a Medicaid card. Is there a way for me to see a doctor without having to wait?
**A:** You could be eligible for a Medicaid card very quickly if your family income is below a certain level and you can show identification and proof of your pregnancy. Under
Expedited Medicaid, all other eligibility requirements are postponed or put off until later, so that you can get this “quick” card. The Expedited Medicaid card is good for 60 days for all Medicaid-covered services except inpatient hospital services. To continue your eligibility for Medicaid, you will have to provide additional documentation.

Q: I think I might be pregnant. Will Medicaid pay for my visits to my doctor or clinic?
A: If you already have Medicaid coverage and you become pregnant, the medical care you need during your pregnancy, including regular checkups and your hospital stay during delivery, are covered. If you are pregnant and not on Medicaid, and you don’t have money to pay for regular checkups during your pregnancy, you should apply for Medicaid as soon as you know you are pregnant. To be eligible for Medicaid, your pregnancy will have to be verified by a doctor or qualified medical provider.

Q: What if I don’t have a doctor to verify my pregnancy and provide regular checkups during my pregnancy?
A: Your CDJFS or the Medicaid Consumer Hotline (1-800-324-8680) can help you find a doctor if you don’t have one. If you do not already receive Medicaid services or are having problems finding medical care, you can call the Help Me Grow Helpline toll-free at 1-800-755-GROW. Someone there can help you find out where to have a free or low-cost pregnancy test and where to find a doctor or clinic for prenatal care. Regular medical checkups throughout your pregnancy are important to your health and to the health of your unborn child. Regular prenatal care gives your child a head start on a healthy life.

If you are enrolled in an MCP, you should contact your Primary Care Physician to confirm your pregnancy. You can then decide to go to any prenatal provider on the MCP’s panel who is taking new patients. Check with your MCP to determine your options.

Q: I’m having problems with my pregnancy. The doctor even thinks I might go into labor too early. What else can Medicaid do for me during my pregnancy?
A: You can get special services along with your regular checkups, both before and after the baby arrives. This can include learning how to take care of yourself while you are pregnant, learning good eating habits, and learning how to tell if you are going into labor too soon. The CDJFS also offers special help to make sure you get the medical care you need. If you are enrolled in Medicaid managed care, contact your MCP for special help during your pregnancy.

Q: What if I need help getting to the doctor when I’m pregnant?
A: Talk with your caseworker about your transportation problem or any other problems you might have that might keep you from going to the doctor or clinic. In many cases, pregnant women can get free transportation to the doctor or clinic.

If you are enrolled in an MCP, talk to your doctor or the MCP’s member services office about transportation.

Q: Can adults get preventive care, too?
A: Medicaid covers the following preventive health care services for adults: immunizations; family planning office visits and services; routine dental examinations; eye examinations and eyeglasses; annual chest X-rays for patients in nursing facilities; and female examinations that include an annual breast exam, Pap smear and pelvic exam. Routine physicals for adults are not covered.

All MCPs must cover all medically necessary Medicaid-covered services. They are also required to cover annual physical exams. For more information, check with your Primary Care Physician or call your MCP.

Q: If I can’t get an appointment with a doctor right away, should I go to a hospital emergency room?
A: That depends. The hospital emergency room is not intended to take the place of a doctor’s office. An emergency room is for emergencies, like severe bleeding, difficulty breathing, loss of consciousness, broken bones, heart attack – or any medical problem that could be life-threatening if not treated right away. Going to an emergency room for a minor medical problem such as a cold, sore throat or diaper rash is not an appropriate use of the emergency room. It is also very costly!

Each MCP has a toll-free telephone number that is available 24 hours a day, 7 days a week that you can call if you’re not sure whether you should go to an emergency room. They may refer you to an urgent care center in your area instead of the emergency room.

If you are enrolled in an MCP, check with your PCP or your MCP member services department.

Q: Will my prescriptions be covered by Medicaid?
A: Yes. Medicaid generally expects the pharmacist to dispense generic drugs unless your medical problem requires you to take the name-brand drug and your doctor specifies that information on the prescription.

Q: Does Medicaid pay for over-the-counter drugs?
A: Generally, Medicaid does not pay for nonprescription or over-the-counter drugs. However, certain over-the-counter drugs are covered if you have a prescription from your doctor. Insulin for diabetics is an example of an over-the-counter drug that is covered by Medicaid.

Many MCPs do pay for over-the-counter drugs for their members. If you join an MCP, you may want to check to see if you can receive coupons or vouchers for over-the-counter drugs at no cost.

Q: Medicaid paid for new upper and lower dentures for me about two years ago. I recently misplaced them and can’t find them anywhere. Will Medicaid pay to have them replaced?
A: Dentures are expected to last for quite some time. That’s why it is so important to take care of your dentures. Medicaid can’t pay to replace dentures so soon after you got them. Only in very unusual circumstances could dentures be replaced so soon – for example, if a person was in an accident and suffered personal injury that resulted in damaged or broken dentures.

If you are enrolled in an MCP, please check with your MCP member services department or in your member handbook to see if the MCP pays for dentures more often.

Q: I got new eyeglasses a year ago, and Medicaid paid for them. I dropped them, and both lenses broke. Can I get a new pair with my Medicaid coverage?
A: Medicaid routinely pays for replacement of lenses or frames, but there is a limit on the number of complete new pairs of glasses that are covered.

If you are at least 21 years old but younger than 60, you can have one vision exam and one complete pair of glasses every two years. If you are younger than 21 or 60 or older, you can have one vision exam and one complete pair of glasses every year. If you are enrolled in an MCP, you will at a minimum have the same coverage as Medicaid, however, your MCP may be willing to provide additional coverage. Check with your member services department or your member handbook.

Q: Are contact lenses covered by Medicaid?
A: Contact lenses need to be pre-approved by Medicaid before they are ordered. Your eye doctor will ask for approval from Medicaid. Contact lenses are approved only under certain circumstances, such as to correct vision after cataract surgery or to correct vision that can’t be corrected with eyeglasses.

If you are enrolled in an MCP, coverage may be different. Check with your MCP member services or your member handbook.

Q: I have read in the paper and heard on TV that women should be checked for breast cancer and should have a Pap smear every
year to detect cancer of the uterus. Are these checkups covered by Medicaid?
A: Yes. Medicaid covers one Pap smear a year. Mammograms (an X-ray to detect breast tumors) are covered only for women over 35 unless your doctor orders them because you have a breast problem or you are at high risk of having a breast problem.

If you are enrolled in an MCP, your PCP or gynecologist can talk to you about these tests.

Q: Do I have to get approval from Medicaid before I can be admitted to the hospital?
A: Many non-emergency hospital admissions require prior approval before you can be admitted to the hospital. Your doctor should contact the independent review agency in your area to get approval for a non-emergency hospital admission under Medicaid. Then, the review agency must decide within three working days after the doctor asks for approval. If you are enrolled in an MCP, your MCP must approve your admission to a hospital.

Emergency hospital visits need not be prior approved. Check your MCP’s member handbook for its policy on emergency hospital visits.

Q: Do all hospital admissions require this pre-screening?
A: No, all hospital admissions do not require pre-admission screening. Circumstances when pre-admission screening is not required include the following:

- Emergency and maternity admissions
- Admissions for procedures or surgeries that cannot be safely performed on an outpatient basis
- When the patient is already in the hospital for a medically necessary condition and can receive the elective care during the same hospital stay
- When the patient’s application for Medicaid is pending at the time of hospital admission or the patient applies for Medicaid after he or she is in the hospital
- When the patient was already in the hospital but is transferred to another hospital

- When the patient was admitted to the hospital under Medicare Part A service (although Medicare requires its own pre-admission screening)
- When the patient is enrolled in an MCP under contract to the department. If you are enrolled in an MCP, the MCP will determine your need for hospital admission.

Q: What does “outpatient basis” mean?
A: This means that the medical procedure is done in a medical office or hospital where you don’t have to stay overnight. Also, some medical tests can be given to you on an outpatient basis before you are admitted to the hospital. This can cut down on the time you have to be in the hospital.

Q: My husband is out of work, and our family receives assistance through the Ohio Works First (OWF) program. We think our family is big enough now, and we can’t afford to have any more children. Will Medicaid cover sterilization?
A: Yes, as long as the man or woman is at least 21 years old, voluntarily asks for sterilization, is legally capable of providing informed consent to this procedure, and gives consent 30 days before the procedure. Sterilization is also covered for women on Healthy Start.

If you are enrolled in an MCP, you should contact your PCP or the MCP’s member services.

Q: Does Medicaid cover abortions?
A: The only circumstances in which Medicaid will pay for an abortion is if the life of the mother would be endangered if the fetus were carried to term, or if the pregnancy is the result of rape or incest.

Q: Does Medicaid cover treatment for drinking problems and substance abuse?
A: Yes. Medicaid covers some alcohol and substance abuse services. The Consumer Hotline can also refer you to other agencies in your community that can help. Call 1-800-324-8680.

If you are enrolled in an MCP, your PCP or your MCP member services department
can tell you how to obtain substance abuse and/or treatment services.

Q: Does Medicaid pay if someone is mentally ill and has to be hospitalized?
A: Yes. Medicaid pays for psychiatric hospitalizations in general hospitals for anyone on Medicaid who needs it. Medicaid pays for hospitalizations in state and private psychiatric hospitals for people under 22 and 65 or older. Check with your doctor, your local Alcohol, Drug Addiction and Mental Health (ADAMH) board or the Consumer Hotline.

If you are enrolled in an MCP and you need psychiatric hospitalization, you should contact your PCP or your MCP member services department to learn how to obtain services.

Q: Does Medicaid pay for mental health counseling?
A: Yes. Medicaid pays for counseling in a variety of settings, including community mental health centers, outpatient hospitals, and psychologists’ and psychiatrists’ offices. If your community has an ADAMH board, someone there can refer you to a counselor. If your community has an ADAMH board, someone there can refer you to a counselor or you can call the Consumer Hotline.

Q: Does Medicaid pay for organ transplants?
A: Medicaid covers medically necessary kidney transplants without the need for the attending physician to get prior approval. Other types of transplants – such as heart, lung, heart-lung, liver, bone marrow and pancreas transplants – are covered only if a doctor first contacts and receives approval from Medicaid.

If you are enrolled in an MCP, check with your PCP or your MCP member services department.

Q: I’ve been out of work for 18 months. I know I can’t find a job because I look older than I really am. Does Medicaid pay for cosmetic treatment?
A: Medicaid covers any procedure that is medically necessary. If the only purpose of treatment is to improve your appearance, Medicaid won’t pay. It does not cover face lifts or hair transplants.

Q: I have to go into a nursing home. If Medicaid pays for my care, does the state choose the nursing facility for me?
A: Nursing facilities offer different levels of care. Your caseworker can refer you to the Area Agency on Aging or the Department of Aging Ombudsman for information on choosing a nursing home. Medicaid does not choose the nursing facility for you. You will need to check with individual facilities to find one with a vacancy.

Q: My husband has to go into a nursing home, probably for the rest of his life. We don’t have the money to pay the nursing home. Will we have to sell our home before he can get Medicaid?
A: No. You won’t have to sell your home as long as you continue to live there while your husband is in the nursing facility.

Q: But what happens after my husband dies? Will I have to sell my home to pay back the money Medicaid paid for his care while he was in the nursing home?
A: No. You do not need to sell your house as long as you are living there.

Q: I’m not married, I have no dependent children living with me, and I own my home. I have to go into a nursing home. I’m not sure for how long. Do I have to sell my home before Medicaid will pay for my care?
A: No. If you are in the nursing facility for less than 13 months and will be returning to live in your home, your home won’t be counted in determining your eligibility for Medicaid. But if you have to stay in the nursing facility longer than 13 months, you might have to put the house up for sale.

Q: I need to go into a nursing home. I have
$8,000 in the bank. I know this is too much money to have in my savings and still qualify for Medicaid. I would like to give the money to my grandson so he can buy a new car. Can I get Medicaid if I do this?
A: If you give the money to your grandson, you may be ineligible for a period of time for nursing home payments. Talk to a caseworker at the CDJFS or talk to an attorney before you give away or transfer your money or property.

Q: My mother is in the hospital now. When she is released, she will go into a Medicare-certified skilled nursing facility. I understand that Medicare will pay for her care in this nursing facility for only a short time. She will probably have to be there a very long time. How will she pay for her care?
A: If your mother has to go into a skilled nursing facility and requires a skilled level of care, Medicare will pay for only a certain number of days. Your mother should apply for Medicaid right away and not wait until Medicare coverage runs out.

Q: My mother is in a nursing facility in another state, and that state pays for her care. My father died recently and now she is all alone there. I want to bring her here to be near me. Can she get Medicaid in Ohio if she has never lived here?
A: Yes, if she meets income and resource tests. There is no requirement that says your mother had to live in Ohio previously. A caseworker in the state where your mother lives now should contact your CDJFS to discuss a plan for your mother’s care. Everyone concerned will attempt to work out a plan that will be in your mother’s best interest.

Q: I have to go into a nursing home for the rest of my life. I have three grown children who are pretty well off financially. Does Ohio law make them pay for my care in the nursing home?
A: No. Your children have no obligation under Ohio law to pay for your care in a nursing facility.

Q: My husband has inoperable cancer, and the doctor told us that he has at most two or three months to live. We both want those last months to be as comfortable as possible with some quality time. We have heard about hospice services. Can you tell me more about hospice care?
A: Hospice services provide supportive care for terminally ill patients who don’t want extraordinary measures taken to prolong their lives. Ohio’s Medicaid program has a hospice benefit available to people with terminal illnesses who elect to be admitted into the hospice program. Coverage includes medical and nursing services, short-term inpatient hospital care, respite care, and bereavement counseling for the family.

Q: My aunt’s doctor told her that her illness can’t be cured and that she has only a few months to live. If she has to go into a nursing home, would she be able to receive hospice care? Or is hospice care available only to people who are at home?
A: The hospice program is for people on Medicaid who are expected to live less than six months, to provide them with appropriate services in the final stages of illness, to ease their pain, and to prepare them and their family for dying and grieving. Your aunt can receive hospice care at home. If 24 hour nursing care or respite is needed, the hospice can arrange for her to receive hospice services in a Medicaid-participating nursing facility. If your aunt is already a resident in a Medicaid-participating nursing facility, she can elect hospice services and the facility will help make the arrangements with a Medicaid-participating hospice.
someone to come in to help me with my bath. But I don’t have the money to pay for this. Can Medicaid help me so I can stay in my own apartment and not have to go into a nursing home?

A: Medicaid has different levels of home care services available, depending on your needs, medical condition and income. Home health, private duty nursing and skilled therapies are available through the Medicaid state plan. Skilled therapy includes physical, occupational, and speech and language therapy.

State plan home health services will meet the basic home care needs of most consumers who need up to 14 hours per week of nursing and/or daily living services.

If you need more home health services than are available through the Medicaid state plan, you may be eligible for a Medicaid home- and community-based services waiver. Waivers are designed to help people with disabilities or other chronic medical conditions remain at home instead of having to go to a hospital, nursing facility or ICF-MR. Waiver programs have a different income eligibility standard than regular Medicaid, since those who are eligible for waiver programs often need services that are not usually covered by Medicaid. This includes services such as personal care, homemaker services, adult day care and respite care. Depending on their needs, individuals can also receive such services as adult day care, home-delivered meals, home modifications (such as bath rails and wheelchair ramps), supplemental adaptive and assistive devices (such as hearing aids or walkers), and out-of-home respite for caregivers.

If you want more information about home- and community-based waiver programs, call the Consumer Hotline at 1-800-324-8680 or talk with your caseworker at your local CDJFS.

Q: What is PACE, and who does it cover?
A: PACE is the Program of All-inclusive Care for the Elderly. It offers health care services to adults age 55 and older who meet certain level-of-care needs for nursing home placement, who are enrolled in Medicaid and Medicare, and who live in a designated geographic area in either the Cleveland or Cincinnati metropolitan area. PACE services are coordinated by local agencies. In Cleveland, this agency is the Benjamin Rose Institute, and in Cincinnati it is the Tri Health Senior Link. These agencies act as MCPs for the project. PACE participants can receive services through day health centers, in their own homes, or in other medical facilities when needed.

Q: Can anyone who needs home care services get on a waiver?
A: No. The waiver programs have only a certain number of openings. Also, there is a limit of how much money can be spent on each person, and individuals must meet specific requirements. For more information on the waiver programs and how to apply, contact your Area Agency on Aging for assistance.

Q: My 9-year-old daughter is dependent on a ventilator as the result of a bicycle-car accident. She was recently moved from a hospital to a less restrictive environment in a nursing facility. Although she receives excellent care around the clock, my husband and I would prefer to have her home with us. However, if we did move her home, I was told that we would lose my daughter’s Medicaid benefits because our income is too high.
A: Unless your daughter is accepted into a waiver program, where your potential income is not counted, she could lose her Medicaid coverage.

Q: What is respite care?
A: If you are caring for your daughter at home, and you need someone to come in to relieve you for a short time, this service is called respite care. It is covered under the waiver program. The person who provides the respite care must be an approved Medicaid provider, such as a registered nurse or an LPN.
Who Pays the Bills?

Q: Does Medicaid pay for all of my health care costs, or do I have to pay something, too?
A: If a health care service is covered under Medicaid, you may be required to pay a small co-payment for certain services. Be sure to get your services from a Medicaid provider who accepts Medicaid patients. If you’re a member of a MCP please contact the member service department to determine if a co-pay is required.

You may have to pay some portion of your medical care before Medicaid will cover your bills if you are on “spend-down.” (See “Spend-down” on page 16.)

Q: I have some medical bills that I couldn’t afford to pay before I got on Medicaid. Will Medicaid pay those old bills for me?
A: If you would have been eligible for Medicaid any time within the three months before you actually applied, and if you are found to be eligible for Medicaid, Medicaid may pay the health care bills you got during those previous three months. These bills could also be used to offset your spend-down for future months, as long as you still owe on them. When you talk with the caseworker, be sure to take along the bills you can’t pay to see if they can be covered by Medicaid or applied to your spend-down amount.

Q: What if I get very sick when I am out of town or out of the state and need medical treatment right away? Will Medicaid pay?
A: It depends on your situation. If treatment can’t be delayed and if the medical service is covered under Ohio’s Medicaid program, yes. Be sure to show the medical provider your medical assistance identification card. Sometimes, though, an out-of-state provider will not accept your Ohio Medicaid card and will require that you pay for the services.

Q: What if a doctor or hospital sends a bill directly to me?
A: Contact the people who sent you the bill and give them your Medicaid number (and your Medicare number if you have one). In most cases, you should not have to pay. If you are on spend-down, you may be responsible for all or part of the bill. If the doctor did not accept you as a Medicaid patient or if you signed off to receive a non-covered service and pay for it, you are responsible for the bill. If you are enrolled in an MCP, contact your MCP member services department.

Q: My doctor told me Medicaid didn’t pay all of my bill, and he sent me a bill for the rest. I don’t have the money to pay it. What should I do?
A: When doctors agree to accept patients covered by Medicaid, they also agree to accept the amount Medicaid pays. You cannot be charged for a service, unless it was a service that Medicaid does not cover and you agreed in writing to pay for it before it was done. Sometimes there is a mistake on the bill, and the doctor can explain it to Medicaid and it will be corrected. Sometimes the doctor’s bill is higher than the amount Medicaid can pay for the service. But you do not have to pay anything for a service covered by Medicaid.

If the doctor continues to ask you to pay, call the Medicaid Consumer Hotline at 1-800-324-8680 for help.

If you are enrolled in an MCP and go to an emergency room for care and the MCP determines there was no emergency, you may be required to pay for some of the emergency room services. If you disagree with the MCP’s determination, you may file a grievance with the MCP or request a state hearing.

Q: If I have to go into the hospital, does Medicaid pay for a certain number of days or for the entire time I have to be in the hospital?
A: Your care will be paid by Medicaid for as long as it is medically necessary for you to be in the hospital. This is also true if you are enrolled in an MCP.
Q: If I keep my private health insurance and I have to go into the hospital, who pays the bill: my private health insurance or Medicaid?
A: If you have any other health insurance available to you, this must be used before Medicaid will pay anything. Medicaid may pay for services your private insurance doesn’t cover. Be sure to give your health care provider all your health insurance information so it can bill the other insurance first.

Q: My doctor told me the best hospital for gallbladder surgery is in another state. Will Medicaid pay for my surgery?
A: Medicaid does not normally cover services out of state that can be provided in Ohio. If your doctor believes the best care would be provided in another state, he or she will have to contact Medicaid first to get approval. If you are enrolled in an MCP, the MCP will tell you where it will authorize care. If you disagree with what the MCP tells you, you can file a grievance with the MCP.

Q: My doctor told me I need an operation. I’d like to have another opinion. Will Medicaid pay for an opinion from another doctor?
A: Yes, Medicaid will pay for a second opinion. Having an operation is serious, and you should feel certain it is the right thing to do. If you are enrolled an MCP, check with your member services or member handbook to find out how the MCP covers this.

Q: I have Medicaid coverage. But when I went to get eyeglasses, I was told I had to pay a deposit. Is that true?
A: No. The provider should not ask you to pay a deposit if you are on Medicaid. If you paid a deposit, Medicaid cannot pay you back.

Q: I have to have an operation. I applied for Medicaid, but I was told I couldn’t get Medicaid because I am out on strike. Where can I get help with my hospital bill?
A: Strikers can get Medicaid. Only individuals who receive medical assistance through the Disability Medical Assistance program are unable to receive medical services.

Q: My Social Security check is stretched to the limit. I don’t know what I would do if I had to go into the hospital and have to pay the deductible amounts for doctor and hospital bills.
A: People who are elderly or have a disability who receive Medicare and are entitled to hospital insurance benefits under Medicare Part A, and whose income and resources are below certain levels, might be eligible for benefits as Qualified Medicare Beneficiaries (QMBs) or Specified Low-Income Beneficiaries (SLMBs). Your home is not counted as a resource in determining your eligibility.

If you qualify as a QMB, you will be eligible for help in paying your monthly Medicare premiums as well as deductibles for doctor and hospital bills and co-insurance for certain medical services. You can apply for help with your Medicare expenses through your CDJFS.

Q: Can you explain Medicaid spend-down?
A: If you are elderly, legally blind or have a disability and your income is more than the specified level for regular Medicaid, you may still be eligible for coverage under the spend-down provision. Briefly, here is how spend-down works. Your caseworker will tell you the amount of your monthly income that is over the specified level for regular Medicaid eligibility. That amount becomes your “spend-down” amount and is the amount you are responsible for incurring in medical expenses each month before you can become eligible for Medicaid.

After you have incurred medical expenses each month that are equal to or more than your spend-down amount, you will receive a Medicaid card that is good from the date you reached your spend-down amount through the rest of that month. Medical expenses incurred before you get your medical card cannot be billed to Medicaid; they are your responsibility. The medical card entitles you to covered health services under Medicaid for the rest of that month at no cost to you.
What If I Have a Complaint?

Q: I applied for Medicaid, but I was told I am not eligible. I don’t agree with this.
A: If you don’t agree with any decision or action of the CDJFS, you have the right to ask for a state hearing. Ask for a hearing by contacting your CDJFS, or by writing to the Ohio Department of Job and Family Services, State Hearings, 30 E. Broad Street, 32nd Floor, Columbus, Ohio 43215-3414.

Q: My income is too high for me to be eligible for Medicaid. I am HIV-positive, and I need some medications to help manage my disease. I can’t afford to pay for these drugs. Is there any program that can help?
A: Yes. Even if you do not qualify for Medicaid, federally approved drugs are available through two programs from the Ohio Department of Health. If you have health insurance but cannot meet the monthly insurance premium, you may qualify for the HIV Health Insurance Premium Program (HIPP) program. The HIV Drug Program can also provide medications to individuals with AIDS/HIV. For more information about these programs, call 1-800-777-4775.

Q: My doctor says I need to go into the hospital, but the review agency won’t approve it. What should I do?
A: Your doctor can appeal by asking the review agency to reevaluate its decision. The review agency must give your doctor its answer no later than 15 days after your doctor asked for the second review. If your doctor doesn’t ask for this approval from the review agency and puts you in the
hospital anyway, your doctor takes the risk that he or she and the hospital won’t get paid. But you can’t be billed if this happens. If you are enrolled in an MCP, the MCP must prior authorize your admission to the hospital.

Q: What can I do if the review agency again says that I don’t need to go into the hospital?
A: If you don’t agree with this decision, you have the right to ask for a state hearing. Contact your CDJFS, or write to the Ohio Department of Job and Family Services, State Hearings, 30 E. Broad Street, 32nd Floor, Columbus, Ohio 43215-3414.

Q: How can I appeal a decision about my health care and services?
A: If any medical care is denied, reduced or terminated, you can ask for a state hearing. If you are enrolled in an MCP and the MCP denies, reduces or terminates health services and you disagree, you can file a grievance with the MCP and/or request a state hearing.

Q: My father is in a nursing home, and Medicaid is paying for his care, but I’m not satisfied with the care he is getting. Is there anything I can do?
A: You should talk over the problem with the administrator or social services staff member in the nursing facility, or with your father’s caseworker in the CDJFS. You also have the right to find another Medicaid-covered nursing facility to move him to. If the problem is not resolved to your satisfaction, contact the Ohio Department of Health, Complaint Intake Hotline, at 1-800-342-0553 or Ohio’s Office of the State Long-Term Care Ombudsman at 1-800-282-1206. (These are toll-free numbers.) The office of the Long-Term Care Ombudsman is in the Ohio Department of Aging, 50 W. Broad Street, Columbus, Ohio 43215-3414.

Where can I get more information?

If you have questions, or would like more information about the health care coverage described here, you can call the Ohio Consumer Hotline at 1-800-324-8680. People with hearing problems can call the TDD 1-800-292-3572. The hotline is staffed from 7 a.m. to 8 p.m. on weekdays, and from 8 a.m. to 5 p.m. on weekends.

You can also call your local CDJFS weekdays during regular business hours. Or visit the Ohio Department of Job and Family Services on the Internet at: http://www.jfs.ohio.gov/ohp/.

Toll-Free Numbers

Ohio Department of Aging
Long-Term Care Services, Monday-Friday 8 a.m. to 5 p.m. ........................................... 1-800-266-4346
Ombudsman ............................................................................................................................... 1-800-282-1206

Ohio Department of Health
Complaint Intake Hotline ........................................................................................................ 1-800-324-0553
Help Me Grow Helpline ........................................................................................................... 1-800-755-GROW (4769)
HIV Drug Program ................................................................................................................... 1-800-777-4775

Ohio Department of Job and Family Services
Medicaid Consumer Hotline ................................................................................................. 1-800-324-8680
TDD ........................................................................................................................................ 1-800-292-3572

Ohio Managed Care Enrollment Center ..................................................................................... 1-800-605-3040

Ohio Legal Services .................................................................................................................... 1-800-589-5888

Federal Government Medicare ................................................................................................ 1-800-MEDICARE (633-4227)
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