



MEDICAID QUESTIONS & ANSWERS



Ted Strickland, Governor

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An Equal Opportunity Employer and Service Provider

Ohio Department of Job and Family Services

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This booklet reflects Medicaid policy in effect at the time of printing.

Introduction

Ohio offers comprehensive, quality health coverage to more than 2 million low-income Ohioans through its Medicaid program.

The Medicaid program serves individuals and families who meet certain income guidelines, including: children up to age 19 (Healthy Start); 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 for qualified disabled Ohioans through a state-funded program administered by the Office of Ohio Health Plans.

Health care services covered under Ohio's Medicaid program include:

- Most inpatient and outpatient hospital services
- Most services of doctors, dentists, optometrists, 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
- and much more

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.

General Information About Medicaid

What is Medicaid?

Medicaid is like health insurance. It provides health coverage to certain eligible people of all ages who do not have the money or sufficient health insurance coverage for medical care.

What is the difference between Medicare and Medicaid?

Generally, the difference is that Medicare is an insurance program mainly serving people with disabilities or who are 65 or older who have worked and earned qualifying quarters and are now eligible for medical coverage regardless of their income. Medicare is federally-funded and administered by the Social Security Administration.

Ohio's Medicaid program is a health coverage program serving certain eligible low-income 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.

Who can qualify for Medicaid?

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

Pregnant women

Families with children under age 19 who participate in the Ohio Works First (OWF) program are automatically covered by Medicaid

Families who are not eligible for OWF may still qualify for Medicaid if they meet the financial requirements.

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.

How long can I continue to get Medicaid coverage?

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.

How Can I Be Covered by Medicaid?

Who can apply for Medicaid coverage?

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.

I receive Supplemental Security Income (SSI). Can I still be covered by Medicaid?

Yes, it is possible to be covered by both. Someone at your county department of job and family services can talk with you about your need for help with your medical expenses.

I have medical coverage through Medicare. Can I be covered by Medicaid, too?

Yes, you may be eligible for both Medicare and Medicaid. Medicaid may pay what Medicare does not cover. If you are eligible for Medicare and Medicaid, you need to bring both your Medicare and Medicaid cards to the doctor, hospital, or other medical provider.

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?

No. As long as you live in your home, it is not counted as a resource to you when determining your eligibility for Medicaid.

What if my financial resources are more than Medicaid says I can have?

Even if your income or resources are too high for you to qualify for regular Medicaid, you may get help under a waiver program, which has a less restrictive eligibility standard than regular Medicaid. Waiver programs enable people with disabilities or other conditions that reduce function to remain at home (instead of having to go into a nursing facility) by providing home-delivered services, such as a homemaker, personal care, transportation, counseling. (See page 21 for more information on waiver programs.)

I'm expecting my second child and there is no way I can afford doctor visits during my pregnancy, let alone pay a doctor and the hospital after the baby is born. I own my home and a car and I pay for child care. I have no money left over at the end of the month. Is there any help for someone in my situation?

Yes. If you are pregnant and your income is below a certain level, you may be eligible for health coverage through Healthy Start. If you meet the income limits based on family size (counting your unborn child), and allowing for your child care expenses, then you can receive Healthy Start coverage for you and your children. The fact that you own a home and a car does not make you ineligible for Healthy Start, since these resources are not included.

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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?

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 county department of job and family services. 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 the state ombudsman at 1-800-282-1206. (These are toll-free numbers.) The office of the ombudsman in Ohio is in the Department of Aging, 50 West 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 7a.m. to 8p.m. on weekdays, and from 8 a.m. to 5p.m. on weekends.

You can also call your local county department of job and family services 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

State of Ohio

Department of Aging

Ombudsman (800)282-1206

Department of Health

Complaint Intake Hotline (800)324-0553

Help Me Grow Helpline (800)755-GROW(4769)

HIV Drug Program (800)777-4775

Department of Job and Family Services

Consumer Hotline (800)324-8680

(800)292-3572-TDD

Ohio Legal Services

(800)589-5888

Federal Government Medicare

(800)Medicare

(800)633-4227

If you are eligible for Healthy Start, you will remain 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 for Healthy Start.

The Medicaid card that will be issued to you 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. If you enroll in an Medicaid Managed Care Plan (see page 8), the MCP will send you your medical card.

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?

You should apply for Healthy Start. Your income will be used in determining your daughter's eligibility for Healthy Start. Because she is under age 18, once the baby is born, the baby's eligibility for Medicaid will be based on any income that your daughter has, not on your income.

Right after I made the last payment on my car, I lost my job. I had to drop my private health insurance because I couldn't afford to pay the premium out of my unemployment check. Now I find I have to go into the hospital. Can I get Medicaid if I own a car?

In most cases, a car will not effect your eligibility. In other cases it depends on the value of the car and your circumstances. Contact your county department of job and family services to see if you qualify for Medicaid benefits.

I have private health insurance. Can I also get medical coverage through Medicaid? Should I cancel my private health insurance?

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). The private health insurance may not pay all of your medical costs, and Medicaid could help pay for covered 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.

I have AIDS. If I can no longer work, can I qualify for medical coverage through Medicaid?

Yes. If your physical condition 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 the county department of job and family services can help you apply for Medicaid coverage. If you become eligible, a full range of medical services will be available to you, including outpatient and inpatient hospital care, physician services, laboratory services, drugs, home health care, and hospice care.

You will also want to file an application with the Social Security Administration for benefits.

How Do I Apply?

How do I apply for Medicaid?

There are several ways to apply for health coverage through Medicaid. You can call the 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 county department of job and family services 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're a pregnant women who is applying for Healthy Start or expedited medicaid;
- if you apply for Healthy Families

You are required to have a face-to-face interview at your county department of job and family services if you're applying for other kinds of health coverage, and/or such programs as food stamps or child care.

I am not able to get to the county department of job and family services to apply for Medicaid. Can someone else apply for me or can I apply by mail?

Yes. If you cannot come in person, your county department of job and family services can mail you an application, which you may complete and return to them, with copies of the required verifications.

If a face to face interview is required, another way to apply is to choose someone to go to the county department of job and family services for you. This person is your authorized representative. This should be someone who can complete the application for you and who can 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, an attorney. You must sign a letter saying that this person is your authorized representative.

How do I apply for Healthy Start or Healthy Families?

To apply for coverage, call the toll-free Consumer Hotline at 1-800-324-8680, or talk to someone at your local CDJFS. Hotline staff can mail you a blank two-page 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 county department of job and family services. The Hotline can also tell you how to apply for other kinds of Medicaid coverage.

The two page Healthy Start & Happy Families application is also available at your county department of job and family services, Women, Infants and Children (WIC) clinics and Child and Family Health Services clinics and on the Internet at: <http://jfs.ohio.gov/ohp/consumers/Application.stm>

What If I Have A Complaint?

I applied for Medicaid, but I was told I am not eligible. I don't agree with this.

If you don't agree with any decision or action of the county department of job and family services, you have the right to ask for a state hearing. Ask for a hearing by contacting your county department of job and family services, or writing to the Ohio Department of Job and Family Services, State Hearings, 30 East Broad Street, 32nd Floor, Columbus, Ohio 43215-3414.

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?

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 (HIPPP) 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.

My doctor says I need to go into the hospital, but the review agency won't approve it. What should I do?

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 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 authorize your admission to the hospital.

What can I do if the review agency again says that I don't need to go into the hospital?

If you don't agree with this decision, you have the right to ask for a state hearing. Contact your county department of job and family services, or write to the Ohio Department of Job and Family Services, State Hearings, 30 East Broad Street, 32nd Floor, Columbus, Ohio 43215-3414.

How can I appeal a decision about my health care and services?

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.

Social Security check to the nursing home as partial payment for my care. Medicaid will pay the rest. Will I be able to have any spending money for things I might want to buy?

If you have arranged for your Social Security check to be sent directly to the nursing facility, the nursing facility must see that you get a minimum of \$40 a month for your personal needs. The caseworker will explain how much you will be able to keep for what is called a Personal Needs Allowance (PNA).

What do I have to pay for with my Personal Needs Allowance?

Medicaid pays for your room and board in the nursing facility, for the use of necessary equipment and furnishings, and for your daily nutritional needs. It also pays for all medical care items, including aspirin and ointments. The personal needs you would have to pay for are clothing and other items that you want because of personal preference, such as a manicure or having your hair cut and styled. If you are asked to pay for an item that you think the nursing facility should provide, call your caseworker in the county department of job and family services to make sure that it is your responsibility to pay for that particular item. If you are unable to call yourself, your authorized representative can call for you.

This application is used for Healthy Start coverage for children up to age 19 and pregnant women; and 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 explored, 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.)

What if I need help in filling out the application?

You can call the Consumer Hotline at 1-800-324-8680 for help in completing your application. Caseworkers at your county department of job and family services can also help you complete your application for health coverage.

When I apply for Medicaid for myself and my family, what information should I bring with me?

If you're applying for Healthy Start coverage, you'll need:

- Social Security numbers and proof of citizenship

- Proof of all income

Note: If you're mailing this information to your county department of job and family services, please send **copies** - (do not send the originals.)

If you're applying for other kinds of Medicaid coverage, you will also need the following additional information.

- 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)

Once You're Eligible - What Can You Expect?

What kind of medical or health care providers will see me if I have Medicaid coverage?

Examples of medical or health care providers 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 the Mentally Retarded (ICF-MR) habilitation centers, hospices, medical equipment and supply companies, and family planning clinics. The health care provider you choose must be enrolled as a Medicaid provider.

In some counties you may have to join or have the option of joining 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.

What is a Medicaid Managed Care Plan?

A Managed Care Plan (MCP) arranges health care for its members through a network of providers. You must get your medical treatment from a doctor who works with your MCP, or is in the MCP's network. With most MCPs, you will need to choose one doctor or a group of doctors as your Primary Care Physician (PCP). This allows you to develop a close relationship with your PCP. If you or your children need the services of a specialist, your PCP 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 are available by contacting your county department of job and family services or by calling the Consumer Hotline at 1-800-234-8680.

How will my doctor know that I am eligible for Medicaid?

Every month, your family will get a Medicaid card in the mail. This 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. If you join an MCP, you will get a member card from the MCP instead of a Medicaid member card. MCP member cards may be good for more than one month. Do not throw away your MCP card at the end of the month, since it may be good for more than one month.

Do all providers accept the Medicaid card?

No. You should find out if a provider accepts the card and if the medical service is covered before you get the service. Your county department of job and family services may have information about which local providers accept the Medicaid card. Call the Consumer Hotline for a list of providers in your area.

If you are enrolled in an MCP, the MCP will send you a list of providers who have agreed to see patients enrolled in that MCP.

You can talk with the hospital to see if you can work out a payment plan. Check with your union to see if there are funds available to help you.

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.

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 county department of job and family services.

Can you explain spend-down?

If you are aged or blind or disabled and your income is more than the specified level for regular Medicaid, you may be eligible 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 "spenddown" amount, and is the amount you are responsible for incurring in medical expenses each month before you can become eligible. Medicaid will pay for covered services after eligibility is established.

After you have incurred medical expenses each month which equal the same or more than that of 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. Those 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.

For example:

Your caseworker tells you that your spend-down amount is \$50. On March 3, you go to the doctor and the bill is \$30. On March 4, you go to the pharmacy for a prescription and the bill is \$24. The next day, you take these two medical receipts totaling \$54 to your caseworker. You have met your March spenddown. Medicaid will cover \$4, and you will qualify for a Medicaid card from the date you reached your spend-down amount through the end of that month, March 31.

You are responsible for getting your medical receipts to your caseworker at the county department of job and family services every month. It is to your benefit to bring in these medical receipts to your caseworker as early in the month as possible.

When I go into a nursing home, I heard I will have to turn over my monthly

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 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.

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?

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.

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?

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.

My doctor told me the best hospital for gallbladder surgery is in another state. Will Medicaid pay for my surgery?

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 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 or request a state hearing.

My doctor told me I need an operation. I'd like to have another opinion. Will Medicaid pay for an opinion from another doctor?

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 in an MCP, check with your member services or member handbook to find out how the MCP covers this.

I have Medicaid coverage. But when I went to get eyeglasses, I was told I had to pay a deposit. Is that true?

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.

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?

Do I have to pick just one doctor to be my regular doctor?

Unless you are in a Managed Care Plan, you don't have to, but it's still a good idea. There are several reasons why:

- You don't have to give your medical history every time you visit. Seeing one doctor helps eliminate duplication of examinations, tests, and x-rays.
- Seeing one doctor helps prevent medicines being prescribed by different doctors, which may have harmful effects when taken in combination.
- 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.
- Having a regular doctor is not only good for you and your family, it helps lower the cost of health care.

Remember, if you are enrolled in an MCP you must choose one doctor to manage your care (your Primary Care Provider).

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?

If you are unable to get to an appointment for services covered by Medicaid, contact your county department of job and family services for help. When you call or visit the office, a 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 working days before you need to travel, unless there are circumstances beyond your control.

This service is not for those who have family or friends who can provide free transportation. If family or friends have been taking you to your medical appointments in the past, there must be a good reason 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, there must be a good reason why you can no longer use that transportation. If you are enrolled in an MCP, call member services to check on transportation available through the MCP.

Is there a limit on the number of prescriptions I can have filled?

No, as long as the doctor thinks you need the medicine and gives you a prescription. 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.

If you are in a Managed Care Plan, call the plan for information about which prescriptions are covered and if there are limits on the number of prescriptions you can have filled.

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

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 us misuse or overuse of Medicaid services. These records are reviewed to determine whether the medical services used are needed or not. The information is also available to MCPs.

This information also helps Medicaid understand if there are certain services that are available to consumers that are not being used.

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

If you are in an MCP, you should check with the MCP about the plan limits.

If you are not in an MCP, you can have 24 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.

If you have more than 24 visits in a calendar year, your health care use will be monitored by the department. If the department finds that anyone is misusing or overusing medical services, he or she may be enrolled in the Primary Alternative Care and Treatment program, known as PACT.

What is the PACT program?

The PACT program helps Medicaid control the misuse of health care. People enrolled in PACT are eligible for all health care services covered under Medicaid; however, they must receive all routine medical treatment from one doctor and must have all their prescriptions filled at one pharmacy. If you are enrolled in PACT, you will be issued a special Medicaid member card with the names of your doctor and pharmacy printed on it. If your regular doctor decides that you need to see a specialist, the appointment with the specialist will be made for you. You can still use the PACT card for services that your regular doctor does not provide, such as going to a dentist or having your eyes tested.

Does Medicaid pay for all of my health care costs and, or do I have to pay something, too?

If the health care service is covered under Medicaid, you may be required to pay to pay a small co-payment for certain services. Be sure to get your services from a Medicaid provider who accepts Medicaid patients.

You may have to pay some portion of your medical care before Medicaid will cover your bills (see **Spend-down - page 25**) if you are on “spend-down”.

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?

If you would have been eligible for Medicaid any time within the three months before you actually apply and are found eligible for Medicaid, Medicaid may pay the bills for health care 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 these bills.

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.

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?

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.

What if a doctor or hospital sends a bill directly to me?

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 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.

My doctor told me Medicaid didn’t pay all of his bill, and he sent me a bill for the rest. I don’t have the money to pay it. What should I do?

When doctors agree to accept patients under 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 in the bill, and the doctor

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, I was told that we would lose my daughter's Medicaid benefits because our income is too high.

Unless your daughter is accepted into a waiver program, where your potential income is not counted, she would lose her Medicaid coverage.

What is respite care?

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. 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?

What Benefits Does Medicaid Offer?

What kinds of services are covered by Medicaid?

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 provided either through Medicaid providers using a Medicaid Member Card or, in some counties by a Medicaid Managed Care Plan (MCP). Both cover the same health services.

The **Long-Term Care Health Package** offers several options to Medicaid-covered individuals who are aged, 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 Intermediate Care Facility for Mental Retardation. 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 Part A or Part B coverage. Categories of coverage are identified as Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB) and Additional Low Income Medicare Beneficiaries (ALMB). Eligibility is determined by the CDJFS based on several factors, including income.

Basic Health Package Coverage

HEALTHCHEK

What are HEALTHCHEK services?

HEALTHCHEK is a group of prevention and treatment services for children and teens which are provided through Ohio's Medicaid program. The basic services 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.

When should my child get a HEALTHCHEK screening exam?

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.

Are shots included in the HEALTHCHEK screening exam?

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).

What dental services are provided as part of the HEALTHCHEK program?

Dental checkups are part of the HEALTHCHEK program and cover teeth cleaning and examination, and 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.

Will the HEALTHCHEK program cover my child's eyeglasses and other vision services?

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.

What hearing services are provided as part of the HEALTHCHEK program and how often can they be provided?

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 primary care provider.

There are three levels of home care services available, depending on your needs, medical condition, and income. All three include "core" services--nursing, daily living and skilled therapy. Skilled therapy includes physical, occupational and speech and language therapy.

- 1) **The Core Benefit Package** is designed to meet the basic home care needs of most consumers who need up to 14 hours of nursing and/or daily living services a week.
- 2) **The Core Plus Benefit Package** meets the home care needs of consumers who need more than 14 hours of daily living and/or nursing services a week.
- 3) **The Waiver Benefit Package** is designed to help people with disabilities or other medical conditions remain at home (instead of having to go to a nursing facility) by providing home-delivered services, such as a homemaker, personal care, transportation and counseling. The waiver program has a higher 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 live in southwest Ohio, you might be eligible for a demonstration project called PACE -- Program of All-inclusive Care for the Elderly.

If you want more information about home and community-based waiver programs, call the Consumer Hotline at 1-800-324-8680.

What is PACE - and who does it cover?

PACE is a demonstration project offering health care services to adults over 60 who meet certain level-of-care needs for nursing home placement, are eligible for Medicaid, and live in a designated four-county service area of southwestern Ohio. All health care services are coordinated through Tri-Health Senior Link, which acts as the managed care provider for the project. PACE participants can receive services through a Day Health Center, in their own home, or in another medical facility when needed.

Can anyone who needs home care services get on a waiver?

No. The waiver program has 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 county department of job and family services or call the Consumer Hotline at 1-800-324-8680.

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

here to be near me. Can she get Medicaid in Ohio if she has never lived here?

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 county department of job and family services 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.

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?

No. Your children have no obligation under Ohio law to pay for your care in a nursing facility.

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 just what they are?

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.

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?

The hospice program is for people on Medicaid who are expected to live less than six months, to provide them with in-home services in the final stages of illness, to ease their pain, and to prepare them and their family for dying and grieving. If, however, your aunt should go into a Medicaid participating nursing facility, she would be eligible for hospice services if there is a written agreement (approved by Medicaid) between the nursing facility and the hospice.

Community Long-Term Care Health Plan Coverage

Home Health Care and Community-Based Waiver Programs

My doctor told me to think about going into a nursing home. I have a small apartment and I know that I could take care of it and myself if I had a wheelchair and someone to come in to help me with my bath. But I don't have the money to pay for this. Can I get any help from Medicaid so I can stay in my own apartment and not have to go into a nursing home?

Basic Health Plan Coverage

PREGNANCY SERVICES

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?

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 "quick" 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.

During the period of Expedited Medicaid, an individual is not eligible to be enrolled in an MCP.

I think I might be pregnant. Will Medicaid pay for my visits to my doctor or clinic?

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. For you to be eligible for Medicaid, your pregnancy will have to be verified by a doctor or qualified medical provider.

What if I don't have a doctor to verify my pregnancy and provide regular checkups during my pregnancy?

If you have Medicaid coverage, your county department of job and family services 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 to 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 must check with your Primary Care Provider (PCP) 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.

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?

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 county department of job and family services also offers special help to make sure you get the medical care you need.

What if I need help getting to the doctor when I'm pregnant?

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.

Basic Health Plan Coverage

OTHER SERVICES COVERED BY MEDICAID

Can adults get preventive care, too?

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.

Preventive care services vary among the Medicaid Managed Care Plans. Some MCPs offer preventive health care for adults as well as children, including routine physicals. For more information, check with your primary care provider or call your MCP.

If I can't get an appointment with a doctor right away, should I go to a hospital emergency room?

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!

If the department finds that anyone not in an MCP is misusing or overusing emergency room services, he or she may be enrolled in the PACT program (see page 10).

Each MCP has a toll-free telephone number 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 in an MCP and go to an emergency room when it is not necessary, you could be charged for the visit.

Will my prescriptions be covered by Medicaid?

Yes. Medicaid generally expects the pharmacist to dispense generic drugs unless your medical problem

services can give you names of nursing facilities that provide the type of care you need. Medicaid does not choose the nursing facility for you. You will need to check with individual facilities to find one with a vacancy for you.

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?

No. You don't have to sell your home as long as you continue to live there while your husband is in the nursing facility.

All right, I understand that. 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?

No. You do not need to sell your house as long as you are living there.

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?

No. If you are in the nursing facility for less than six months and will be returning to live in your home, your home won't be counted in determining your eligibility for Medicaid. If, however, you have to stay in the nursing facility longer than six months, you might have to put the house up for sale.

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?

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 county department of job and family services or talk to an attorney before you give away or transfer your money or property.

My mother is in the hospital now. When she is released, she will go into a Medicare-certified skilled 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?

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.

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

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

Does Medicaid pay if someone is mentally ill and has to be hospitalized?

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 are in need of psychiatric hospitalization, you should contact your primary care provider or your MCP member services to learn how to obtain services.

Does Medicaid pay for mental health counseling?

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 Alcohol, Drug Addiction and Mental Health (ADAMH) Board, they can refer you to someone who can help. Or call the Consumer Hotline.

Does Medicaid pay for organ transplants?

Medicaid will cover medically necessary kidney transplants, without the need for the attending physician to get prior approval. But heart, lung, heart-lung, liver, bone marrow, and pancreas transplants will be covered only if the doctor first contacts and receives approval from Medicaid.

If you are enrolled in an MCP, check with your primary care provider or your MCP member services.

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?

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.

Long-Term Care Health Plan Coverage

Nursing Facilities

I have to go into a nursing home. If Medicaid pays for my care, does the state choose the nursing facility for me?

Nursing facilities offer different levels of care. The caseworker in the county department of job and family

requires you to take the name brand drug and your doctor specifies that information on the prescription.

Does Medicaid pay for over-the-counter drugs?

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.

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?

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 which 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.

I got new eyeglasses a year ago, and Medicaid paid for them. I dropped them the other day and both lenses broke. Can I get a new pair with my Medicaid coverage?

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, however, there is a medical reason for new glasses or a comprehensive vision exam sooner than the one-year or two-year periods, your eye doctor must first get approval from Medicaid. If you are enrolled in an MCP, the coverage may be greater. Check with your MCP member services or your member handbook.

Are contact lenses covered by Medicaid?

Contact lenses need to be approved by Medicaid before the lenses are ordered. Your eye doctor will ask for approval from Medicaid. Contact lenses are approved only under these circumstances: 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.

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?

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 it 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 primary care provider or gynecologist can talk to you about these tests.

Does Medicaid cover the drug AZT?

Yes, If you are covered by Medicaid, you are eligible to receive any drug approved by the Food & Drug Administration that is prescribed for you for the treatment of HIV/AIDS, including AZT.

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.

If I am covered by Medicaid, does my doctor have to get approval from Medicaid before I can be admitted to the hospital?

Most non-emergency hospital admissions under Medicaid require pre-admission certification. This means that your doctor has to get 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.

In an emergency, pre-admission certification is not required.

If I am covered by Medicaid, does my doctor have to get approval from Medicaid before I can be admitted to the hospital?

See page 17 for information about when and how to use the emergency room.

If you are enrolled in an MCP, your doctor or MCP must approve your admission to a hospital. Check your MCP's member handbook for its policy on emergency admissions.

What is the reason for this review for hospital admissions?

These reviews are necessary to make sure that the care Medicaid consumers get is appropriate. A number of medical procedures done on an inpatient basis in the hospital can just as safely and effectively be done on an outpatient basis or in a doctor's office.

Do all hospital admissions require this pre-admission screening?

No, all hospital admissions don't require pre-admission screening. Circumstances when pre-admission screening is not required include:

- Emergency and maternity admissions
- Admissions for procedures or surgeries that cannot be safely performed on an outpatient basis
- The patient is already in the hospital for a medically necessary condition and can receive the elective care during the same hospital stay
- 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
- The patient was already in the hospital but is transferred to another hospital
- The patient was admitted to the hospital under Medicare Part A service (although Medicare requires its own pre-admission screening)
- The patient is enrolled in a Managed Care Plan (MCP) under contract to the department. If you are enrolled in an MCP, the MCP will determine your need for hospital admission.

What is meant by outpatient basis?

This means that the medical procedure is done in a setting 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.

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?

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 primary care provider or the MCP's member services.

What about abortions?

The only circumstances under 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 a result of an act of rape or incest.

Does Medicaid cover treatment for drinking problems and substance abuse?

Yes. Medicaid covers some alcohol and substance abuse services. The Consumer Hotline can also refer you to other agencies in your community which can help. Call 1-800-324-8680.