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# Community Medicaid

## What Is The Community Medicaid Program?

The Community Medicaid program pays most medical expenses for low-income individuals. There are two programs for which you may qualify, MAGI-based Medicaid and Community Medicaid for aged, blind or disabled individuals (ABD Community Medicaid). If your household income is below 138% of the Federal Poverty Guidelines, $1,677 in 2023 for an individual, you are younger than age 65 and not covered by Medicare, you will qualify for MAGI-based Medicaid. The income limit increases depending on your household size. There are no resource limits. If you are blind or disabled or age 65 or older and Medicare eligible, your income and resources must meet the limits for ABD Community Medicaid.

## What Medical Services And Equipment Will Medicaid Pay For?

Some Medicaid services are limited by dollar amount, number of visits per year or setting in which they can be provided. Other limitations may apply and some services must be authorized by Medicaid before they can be delivered by a Medicaid provider (prior authorization). A Medicaid provider is one that has contracted with the Ohio Department of Job and Family Services to accept Medicaid payment for medical goods and services. Medicaid coverage includes:

- Dental
- Emergency
- Family Planning
- Healthcheck
- Hospital
- Medical Equipment
- Mental Health
- Pregnancy
- Pregnancy
- Preventative Health
- Professional Medical Services
- Private Duty Nursing
- Substance Use Disorder Treatment
- Transportation
- Vision

## What Home Care Services Are Available?

Medicaid-covered home health care services include part-time or intermittent skilled nursing or home health aide care, skilled therapies and related services when certified by your treating physician. Providers of home health services must be a Medicare Certified Home Health Agency.

## What Are The Financial Eligibility Requirements?

If you are over 65 or blind or disabled, your countable monthly income must not exceed the SSI rate $914 for an individual and $1,371 for a couple. (2023) Countable income means the applicant's gross earned and/or unearned income, minus $20 from certain types of the applicant's unearned income, minus the first $65 of the applicant's earned income, and minus any other applicant income exclusions. A married applicant living with an ineligible spouse will usually be credited with some or all of the ineligible spouse's income minus any income exclusions applicable to the ineligible spouse's income.

**Resources:** Countable resources at or below $2,000, for an individual, and $3,000 for a couple. If you can legally access the resource, convert it to cash and use it for support, then it is an available resource. Some resources are not counted:

a) The home;
b) Household goods and personal property;
c) An irrevocable burial contract;
d) Burial plots;
e) Life insurance with a face value of $1,500 or less;
f) One vehicle, if used for transportation; and
g) Certain income-producing property.

### Will I Be Eligible If I Give Away Resources?

Yes, you will be eligible for Community Medicaid if you gift some or all of your resources to family or friends or sell them for less than fair market value. However, you will be ineligible for Medicaid payment of your long-term, if needed, depending on when you gave away the resource. The length of time you are ineligible depends on the total amount of the gift(s). If you have given some of your resources away or sold them for less than fair market value consult an attorney before applying for Medicaid.

### Will Medicaid Pay Medical Bills I Received Before I Applied?

Medicaid will pay your unpaid bills for Medicaid-covered services during the three months prior to the month of application. But only if you were Medicaid-eligible in each of those three months. Your medical expenses cannot be expenses covered by a third party, such as Medicare, an insurance company or workers' compensation.

### How Long Will I Be Eligible For Medicaid?

Your initial Medicaid application with your County Department of Job and Family Services (CDJFS) is valid for one year from date of application. Every twelve months after your initial application, your CDJFS will require you to renew your Medicaid eligibility.

### What Is MyCare Ohio?

MyCare Ohio is the Medicaid managed care program designed for Ohioans who receive both Medicaid and Medicare benefits, also known as dual eligible beneficiaries. Ohio has 29 counties where, with limited exceptions, all Medicaid dual eligible beneficiaries must enroll in a MyCare Ohio Managed Care Plan. Each Ohio region has multiple MyCare Ohio providers. When you enroll in Community Medicaid, with some exceptions, if you are 18 or older, eligible for Parts A, B, and D of Medicare as well as full Medicaid benefits, and reside in a plan demonstration county, you must choose a MyCare Ohio plan. The MyCare Ohio plan must provide all your medical, behavioral, and long-term services and supports covered by Ohio Medicaid. If you do not make a choice, a MyCare Ohio plan will be selected for you and you will have 90 days to change your MyCare Ohio plan, if you wish. Medicaid benefits will only be available through your chosen MyCare Ohio Managed Care Plan.

### Do I have to enroll in Medicare Managed Care Too?

Although enrollment in the Medicaid managed care is required, the Medicare managed care is not. However, your CDJFS will automatically include your Medicare benefits in your MyCare Ohio Managed Care plan when you are enrolled in Medicaid unless you choose to opt-out of such enrollment and remain with your Medicare plan. If you wish to opt-out of Medicare Managed Care, follow the instructions on the MyCare Ohio notice you receive on how to opt out. If you are already

enrolled in Medicare Managed Care, you must call 1-800-MEDICARE or the Ohio Medicaid Consumer Hotline at 1-800-324-8680 and tell them you want to drop your Medicare MyCare Ohio Managed Care plan and return to your prior Medicare plan.

## Is Medicare MyCare Ohio Managed Care Good or Bad?

Switching from your Medicare plan to a Medicare MyCare Ohio Managed Care plan has both good and bad aspects and requires careful analysis of how the pros and cons will affect your individual healthcare needs. Get help with your choice by contacting the Ohio Department of Insurance's Ohio Senior Health Insurance Information Program (OSHIIP) and talk to a health insurance expert at 1-800-686-1578.

## What Can I Do If My Medicaid Application Is Denied?

If your application for Medicaid is denied, you can appeal the decision in writing or by calling the Ohio Department of Job and Family Services within 90 days of the date the notice was mailed. If your Medicaid services are reduced or ended, you must request a state hearing within 15 days of the date the notice was mailed in order for your Medicaid services to continue while your appeal is pending. After the state hearing, further administrative appeal 29 and court review 30 are available.

*Pro Seniors helps older Ohioans solve legal and long-term care problems and fight Medicare fraud. Our Legal Helpline provides free legal information and advice for Ohio residents aged 60 and older.*
*This fact sheet provides general information, not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Helpline or consult an attorney in elder law.*

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