

Making Sense of Medicaid

No Wrong Door - November Lunch & Learn

Kerrie Deer
JFS Training Supervisor
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Agenda

12:00 - 12:45 PM

- What is Medicaid
 - How to Qualify - Who Qualifies
 - Making Referrals to JFS
 - Medicaid Categories
 - Countable Income
 - Managed Care Benefits
 - Q&A
-

What is Medicaid?



A healthcare program that assists over 3 million Ohio residents daily, including children, pregnant women, adults, aged individuals, and individuals with disabilities



A joint program, funded primarily by the federal government, run at the state level by the Ohio Department of Medicaid (ODM), and administered on the county level



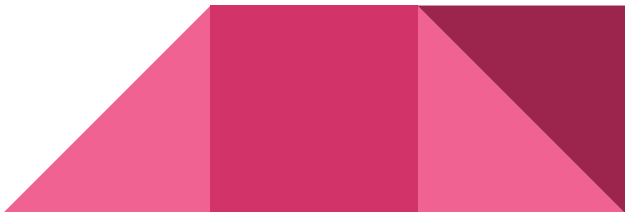
Provides medical assistance to low-income Ohioans based on a variety of eligibility requirements

- Financial eligibility is determined by comparing an individual's or household's income to the Federal Poverty Level (FPL)

What is Medicaid?

Ohio Medicaid provides a comprehensive package of healthcare treatments and services, depending on the type of Medicaid received

There are many different types of Medicaid – not all of them offer the same coverage or have the same financial eligibility requirements. We group the types of Medicaid within three ‘main’ categories:

- MAGI (Modified Adjusted Gross Income) Medicaid,
 - ABD (Aged, Blind, Disabled) Medicaid, and
 - LTC (Long Term Care) Medicaid
- 

How to Qualify – Who Qualifies?

Submit an Application

The eligibility determination process starts with an application

You can submit an application by coming into JFS at 1115 Gilman Ave in Marietta,

by logging into

<https://www.benefits.ohio.gov>

,

or by calling (740) 373-5513 and requesting an application be mailed to you

Meet eligibility requirements

To be eligible for coverage, you must first meet some general conditions of eligibility, such as:

Be an Ohio resident,

Be a US citizen or have a qualifying immigration status, and,

Have or apply for a Social Security Number*

Meet financial requirements

Even if you are not sure that you or your family will qualify for coverage, you should still apply!

Your eligibility worker will explore all categories of Medicaid you could be eligible for when making a determination

JFS Referrals

If you are assisting a family who states they do not have Medical coverage and they indicate a need for healthcare, you can refer them to Job & Family Services and encourage them to apply for Medicaid

You can let them know they can apply via one of the ways discussed on the previous slide

After they apply, they may receive a letter asking for more information. If they need help in obtaining the requested information, they should ask their caseworker for assistance. Once all the needed information and verifications are provided, an eligibility determination can be made and they will receive a Notice of Action on their application typically within 30 days from the application submission date



Medicaid Categories

MAGI Medicaid

MAGI Medicaid - Who Qualifies?

What are the Financial Requirements?



Parents

Parents and caretaker relatives with children under the age of 18 in their physical custody up to the 90% FPL



Pregnant Women

Pregnant women through 12 months postpartum up to the 200% FPL



Deemed Newborns

Babies born to women receiving or eligible for Medicaid at the time of birth



Children

Children, under age 19, with creditable insurance up to the 156% FPL

Children with no creditable insurance up to the 206% FPL



Adults

Adults aged 19-64, not eligible for Medicare

*If they have children under 18, children must be insured (Medicaid or private) up to the 133% FPL

19/20 yr old- Ribicoff Kids up to the 44% FPL

MAGI Medicaid - Who Qualifies?

What are the Financial Requirements?



Individuals aged 65
or older if eligible
under:

- MAGI Parent/
Caretaker
-



Dual eligible,
or individuals receiving
both Medicaid and
Medicare, if eligible
under:

- MAGI Parent/Caretaker
 - MAGI Pregnant Women
 - MAGI Child
-



Individuals
determined to be
blind or disabled by
the SSA and not yet
in receipt of
Medicare



Individuals seeking
Long Term Care
(LTC) services

MAGI Medicaid - Who Qualifies? What are the Financial Requirements?

MAGI stands for Modified Adjusted Gross Income. 'Adjusted Gross Income' may be a familiar term to you if you have ever filed taxes. Individuals potentially eligible for MAGI Medicaid are subject to IRS rules when we are determining what household income is countable in your Medicaid budget

Typically if the income is taxable, it counts in your budget. Child support, Workers' Compensation, SSI and VA benefits are not taxable and are not included. The exception to this is Retirement, Survivors, and Disability Insurance (Social Security benefits). While not taxable, this income type is added back into the Medicaid budget

Portions of an individual's income that goes toward paying 'pre-tax' expenses are excluded as countable income – this could be something like an employer health coverage premium, a 401k contribution, qualifying employer childcare, or self-employment expenses



MAGI Medicaid - Who Qualifies?

What are the Financial Requirements?

MAGI Income

- Federal Poverty Level (FPL)
- 5% Disregard

Categories

- MAGI Parent/Caretaker Relative = 90% FPL
- MAGI Adult = up to 133% FPL
- MAGI Pregnant = 200% FPL
- MAGI Child = up to 156% FPL
- CHIP Child = up to 206% FPL
- Ribicoff Kids (19 & 20-year-old individuals) = 44% FPL
- Transitional Medical Assistance (2nd 6-month period) = 185% FPL

Medicaid Categories

Aged, Blind, Disabled Medicaid

ABD Medicaid - Who Qualifies?

What are the Financial Requirements?

ABD Medicaid categories are programs that provide healthcare coverage consisting of primary and acute-care benefit packages for aged adults and people with disabilities

An individual must have a limiting physical factor to be eligible for one of the categories under ABD. An individual would meet the L PF if they are considered:

Aged

- 65 years or older
- Determined by CDJFS

Blind

- Visual acuity of 20/200 or less in the better eye with correcting glasses, or a limited visual field of twenty degrees or less in the better eye

Disabled

- Physical/mental impairment or severe functional limitations that inhibit work and has lasted or will last not less than 12 months or result in death

ABD Medicaid - Who Qualifies?

What are the Financial Requirements?

Applicable Categories of ABD Medicaid include:

- SSI Recipient - Aged, Blind, or Disabled
- Categorically Needy - Aged, Blind, or Disabled
- Medicaid Buy In for Workers with Disabilities - MBIWD
- Specialized Recovery Services - SRS
- Medicare Premium Assistance Programs

*Not an all-inclusive list



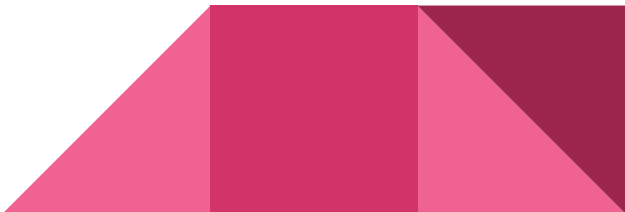
ABD Medicaid - Who Qualifies?

What are the Financial Requirements?

Countable Income for ABD is determined by combining all gross income, then subtracting all excluded income per OAC 5160:1-3-03.1 (It's a long list)

A few types of excluded income sources include AmeriCorps, Student financial assistance, Foster Care payments, SSI Payments, VA Aid and Attendance and housebound allowances, Federal housing or home energy assistance, impairment related work expenses, blind work expenses, and $\frac{1}{2}$ of all earned income received in a month

ABD Medicaid has a resource limit, so in addition to verifying income, CDJFS must also verify a household's countable assets



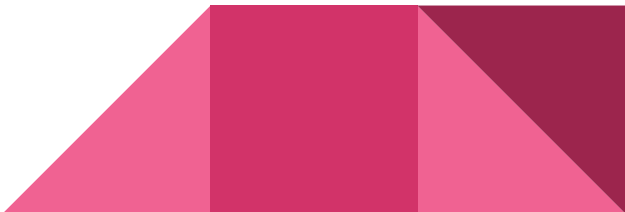
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Categories with Income 'Exceptions'

Not all Medicaid programs are subject to the same budgeting methodologies as their overall eligibility category. Some examples of this include

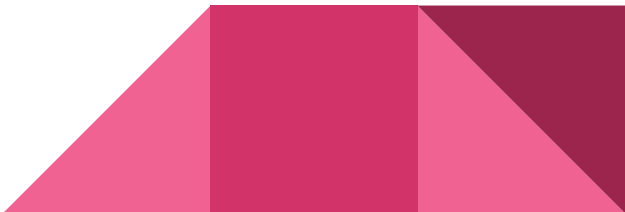
Transitional Medicaid - TMA

Former Foster Care - FFC

Breast and Cervical Cancer Project - BCCP

Medicaid Buy-In for Workers with Disabilities - MBIWD

Specialised Recovery Services - SRS



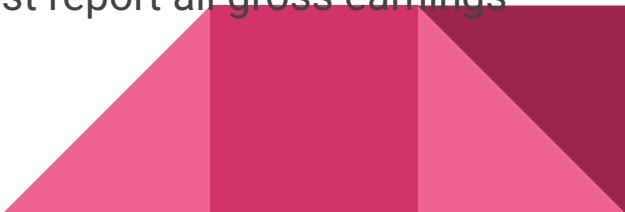
Categories with Income 'Exceptions'

Transitional Medicaid is received with two 6-month periods of eligibility. TMA can be received when an individual already receiving MAGI Parent/Caretaker Medicaid has an increase in earned income that puts them over the MP/C income limit

The first 6 month period does not have an income test; this is so that the parent has time to enroll in employer health coverage if it's offered to them or to find other low-cost insurance available without losing their current coverage

The second 6-month period is subject to an income limit of 185% of the FPL

TMA has reporting requirements where the parent/caretaker must report all gross earnings every 3 months



Categories with Income 'Exceptions'

Former Foster Care Medicaid is for individuals younger than age 26 who were in Foster Care at the time of their 18th birthday and aged out

An individual must have been in receipt of Foster Care Medicaid at the time of aging out of Foster Care, and this coverage would have been managed by the PCSA

FFC Medicaid does not have an income test



Categories with Income 'Exceptions'

Breast and Cervical Cancer Project - BCCP Medicaid is an optional category of Medicaid providing full Medicaid benefits to certain individuals who need treatment for breast or cervical cancer, breast or cervical pre-cancerous conditions, and/or breast or cervical early-stage cancer

The administration of BCCP Medicaid is coordinated by ODM and the Ohio Department of Health. It is not managed at the county-level. For information on how to enroll, go online at Medicaid.Ohio.gov/BCCP or call the ODH at 1-844-430-2227

In addition to breast and cervical cancer screenings, other diagnostic services are available, including mammograms, pap tests, office visits, and biopsies. Case management services are also available

An individual must be under age 65 and be uninsured.
There is otherwise no income or resource test for BCCP



Categories with Income 'Exceptions'

Medicaid Buy-In for Workers with Disabilities is for individuals aged 16+ who are blind or disabled and who are working and paying taxes on those wages

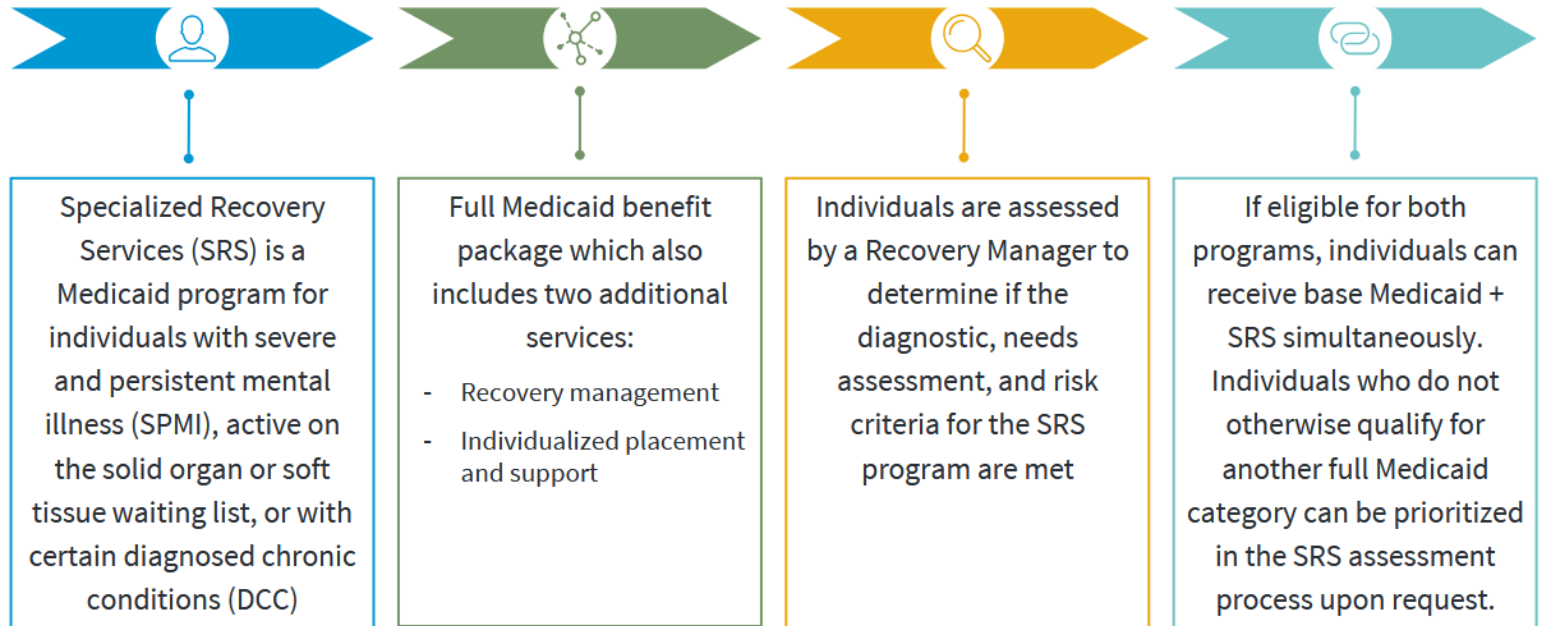
The income limit for MBIWD at this time (2025) is 250% of the FPL, and does have additional exclusions to apply. The resource limit for MBIWD is also higher than other ABD programs; at this time (2025) it is \$15,210

Only the individual's income is included when determining eligibility, but resources for the individual and their spouse are combined when looking at the resource limit



Categories with Income 'Exceptions'

What is the Specialized Recovery Services (SRS) Program?

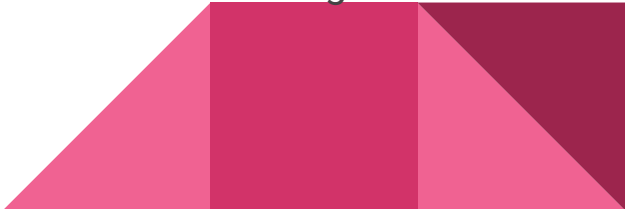


Categories with Income 'Exceptions'

To be eligible for SRS, you must:

- Be aged 21+
- Meet the definition of disability as used by SSA
- Meet the clinical diagnostic, needs assessment, and risk criteria
 - Must have a severe and persistent mental illness (SPMI), be active on the solid organ or soft tissue waiting list, or have a diagnosed chronic condition (DCC)
- Reside in the community
- Meet specific financial criteria
 - Have countable income at or below 150% of the FPL with up to \$944 disregarded in addition to ½ of all earned income excluded, for individuals not otherwise eligible for full Medicaid

There is no resource limit



Ohio Medicaid

2025 Monthly Financial Eligibility

Children, Families, and Adults

Family Size	Parents/Caretaker Relatives	Adults (age 19-64)	Children with Insurance	Pregnant Women	Children without Insurance
	90% FPL	133% FPL	156% FPL	200% FPL	206% FPL
1	\$1,174	\$1,735	\$2,035	\$2,609	\$2,687
2	\$1,587	\$2,345	\$2,750	\$3,525	\$3,631
3	\$1,999	\$2,954	\$3,465	\$4,442	\$4,575
4	\$2,412	\$3,564	\$4,180	\$5,359	\$5,520
5	\$2,824	\$4,173	\$4,895	\$6,275	\$6,464
6	\$3,237	\$4,783	\$5,610	\$7,192	\$7,408
7	\$3,649	\$5,393	\$6,325	\$8,109	\$8,352
8	\$4,062	\$6,002	\$7,040	\$9,025	\$9,296
9	\$4,474	\$6,612	\$7,755	\$9,942	\$10,240
10	\$4,887	\$7,221	\$8,470	\$10,859	\$11,185
11	\$5,299	\$7,831	\$9,185	\$11,775	\$12,129
12	\$5,712	\$8,440	\$9,900	\$12,692	\$13,073

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Ohio Medicaid

2025 Monthly Financial Eligibility

Aged, Blind, or Disabled Individuals

	Medicare Premium Assistance Programs				
Family Size	Qualified Medicare Beneficiary (QMB)	Specified Low-Income Medicare Beneficiary (SLMB)	Qualified Individuals (QI-1)	Medicaid for Aged, Blind, or Disabled Individuals	Medicaid Buy-In for Workers with Disabilities (MBIWD)
	100% FPL	120% FPL	135% FPL	SSI Benefit Rate	250% FPL
1	\$1,305	\$1,565	\$1,761	\$967 Individual	\$3,261
2	\$1,763	\$2,115	\$2,380	\$1,450 Couple	
3	\$2,221	\$2,665	\$2,999		
4	\$2,680	\$3,215	\$3,617		
5	\$3,138	\$3,765	\$4,236		
6	\$3,596	\$4,315	\$4,855		
7	\$4,055	\$4,865	\$5,474		
8	\$4,513	\$5,415	\$6,092		
9	\$4,971	\$5,965	\$6,711		
10	\$5,430	\$6,515	\$7,330		
11	\$5,888	\$7,065	\$7,949		
12	\$6,346	\$7,615	\$8,567		

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Managed Care benefits

Ohio has 7 Managed Care Entities

In Ohio, most individuals who have Medicaid must join a managed care plan to receive their health care. Managed care plans are health insurance companies that are licensed by the Ohio Department of Insurance and have a provider agreement with the Ohio Department of Medicaid to provide coordinated health care to Medicaid beneficiaries

These managed care plans work with hospitals, doctors and other health care providers to coordinate care and to provide the health care services that are available with an Ohio Medicaid card

If you have Medicaid, and are in a managed care plan, you need to get most of your health care from health care providers that work with your managed care plan

AmeriHealth Caritas

1-833-625-6446

Anthem BCBS

1-844-430-0341

Buckeye Health Plan

1-866-246-4358

Caresource

1-866-206-0554

Humana Healthy Horizons

866-376-4827

Molina Healthcare

888-275-8750

United Healthcare Community Plan

1-800-542-8630

How can you Choose a Health Plan?

When selecting a plan, you should choose the best health plan suited to your needs. All managed care plans offer the same 'main' health benefits, and all of them have value-added services unique to each MCO

Visit the Ohio Medicaid Consumer Hotline Portal at <https://members.ohiomh.com> where you can login and make a plan selection

Call the Ohio Medicaid Consumer Hotline at 800-324-8680

You can select a plan within 90 days of being approved for Medicaid, anytime during annual open enrollment (Nov 1 - Nov 30), or any time during the year if you have Just Cause



All plans must offer:



- Inpatient, outpatient, and physician services
- Laboratory and x-ray services
- Screening, diagnosis, and treatment services for children under 21 under Healthchek
- Immunizations
- Contraceptive services and counseling
- Podiatry and Chiropractic services



- Home health and private duty nursing services
- Blood glucometers and blood glucose test strips
- Behavioral health services, including treatment for mental health and substance use disorders
- Physical, occupational, developmental, and speech therapy
- Nursing facility services



- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
- Durable medical equipment and supplies
- Respite services for eligible children
- Hospice
- Telehealth
- Coverage for mom and baby for 12 months following delivery
- Prescription drugs

All plans must offer:



Dental services

- o For members 21 and older - one cleaning per calendar year.
- o For members under 21 years old – one cleaning every six months and, in extreme cases with prior authorization, braces.
- o For pregnant members – two cleanings per calendar year.
- o Dentures, fillings, extractions, crowns, medical



Vision Care

- o For members under 21 years old – one exam and eyeglasses every 12 months.
- o For members 21 to 59 years old - one exam and eyeglasses every 24 months.
- o For members over 60 years old – one exam and eyeglasses every 12 months.



Transportation

Necessary transportation by ambulance or wheelchair van, without regard to distance.

- o Necessary transportation by standard vehicle (e.g., taxicab, sedan) when the nearest network provider is located at least 30 miles away.
- o For OhioRISE members, necessary transportation by standard vehicle, without regard to distance.
- o If the member exhausts the value-added transportation benefit, the health plan works with the member to transition them to their county non-emergency medical transportation (NEMT), if possible.

MCO

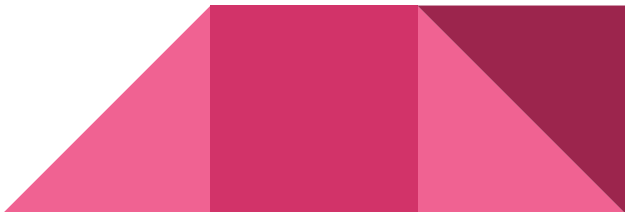
You can view additional services offered by each plan by going to

<https://medicaid.ohio.gov/families-and-individuals/mcare/Managed%20Care> or ohiomh.com

You can get help in finding a provider by going to www.ohiomh.com/home/findaprovider

You can also view all Managed Care plans and their offered services through OHM's Managed Care Comparison Guide found here

<https://ohfiles.blob.core.windows.net/public/OhioMHWebsite/Documents/Ohio%20Medicaid%20Managed%20Care%20Health%20Plan%20Comparison%202026.pdf>



Thanks!

Any Questions?

