GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Ohio, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2024

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Version: 1.0 (December 2024)

This project is funded by the National Institutes of Health, National Institute of Aging, R01 AG030153.

Please cite as "Gateway to Global Aging Data (2024). *Gateway Policy Explorer: Ohio, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2024*, Version: 1.0 (December 2024), University of Southern California, Los Angeles. https://doi.org/10.25553/gpe.ltc.kb.u39"

Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Ohio, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in Ohio are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Ohio, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria. Until 2016 Ohio was a 209(b) state, one of the relatively few states to use more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program for its main eligibility track.

Since 1992, Ohio's Medicaid LTC system has been subject to two major policy reforms: the expansion of Medicaid eligibility for adults through the Affordable Care Act (ACA) in 2014, and the increase in asset eligibility for aged, blind, and disabled beneficiaries in 2016.

Key Dates

First law: 1968

Major changes since 1992: 2014, 2016

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2013

Overview

Long-term care (LTC) benefits in Ohio are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Ohio is administered at the state level by the Ohio Department of Jobs and Family Services (ODJFS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. Ohio is 1 of 9 states that chooses to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program, making it what is known as a 209(b) state. LTC benefits in Ohio are mostly provided through the Medicaid state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Pre-Admission Screening Providing Options and Resources Today - PASSPORT).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the PASSPORT program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the PASSPORT program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and PASSPORT beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Policy changes during this period:

- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration (U.S. Congress, 1996).
- (2006) Ohio implemented a home equity limit that made individuals with home equity above $500,000 ineligible for LTC. From 2011 this standard increases annually with inflation (ORC, 2006).
- (2008) The PASSPORT program added community transition services, which are non-recurring expenses for people who are in the process of transitioning from a nursing facility to a home or community setting (e.g., case management, financial support for moving expenses) (OAC, 2008).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024d)

Ohio Law for Medicaid

- Ohio Revised Code (ORC), Title 51 - Public Welfare (ORC, 2024a)
- Ohio Administrative Code (OAC), Chapter 5160 - Ohio Department of Medicaid (OAC, 2024b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Ohio Medicaid spending on beneficiaries in fiscal year 1992 was 60.63%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Ohio Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Ohio.

Eligibility for Medicaid in Ohio for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) states

  Ohio is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, this was $422 for an individual and $633 for a couple (SSA, 2024b). See Table 2 for historical monthly benefit amounts. Individuals who do not meet this income threshold are able to "spend down" their excess income either by incurring medical expenses that decrease income down below the threshold, or by making monthly payments in the amount of their excess income to the state (OAC, 2014i).
  - Asset requirements: Resources may not exceed $1,500 for an individual and $2,250 for a couple.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - Home equity limit: From 2006, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (ORC, 2006). From 2011, this figure increases annually with inflation.
  - Citizenship/immigration requirements: The applicant must be an Ohio resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be an Ohio resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024c) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Income may not exceed 300% of the monthly federal SSI amount (OMR, 1997). In 1992, this was $1,266. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[5] See Table 3 for historical monthly spousal disregards.

- ◇ Asset requirements: Resources may not exceed $1,500. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.
  - Asset transfer and home equity limit: Same as eligibility track 1b.
- ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
- ◇ Other requirements
  - The applicant must be recieving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., PASSPORT).

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervicel Cancer Program (BCCP): Provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (BCCP, 2024)—from 1994

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Pre-Admission Screening Providing Options and Resources Today (PASSPORT)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 60 (OMFS, 2004). Those applying for the PASSPORT program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Assisted Living Program—from 2006
- Transitions Carve-Out Program—from 2006
- Program for All-Inclusive Care for the Elderly (PACE)—from 2010

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home Health provides (CFR, 1992b; OAC, 2004):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Skilled therapy services: Physical therapy, occupational therapy, and speech-language pathology

See Box 1 for limitations on Home Health services.

Nursing Facility Care

Nursing Facility Care does not provide home care.

PASSPORT

PASSPORT provides (OAC, 2006a):

- Personal care services, which include:
  - ◇ Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - ◇ Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only)
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

Community care

Community care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

PASSPORT

PASSPORT provides Adult Day Health Care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (OAC, 2006a, OAC, 2014h, OAC, 2016b).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, PASSPORT

These programs do not provide residential care.

Nursing Facility Care

Ohio Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (OAC, 2004f, OAC, 2014b, OAC, 2016c). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Ohio's largest home and community-based services (HCBS) program.

Ohio Medicaid provides additional state plan benefits related to LTC (OMR, 1997):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

PASSPORT

PASSPORT provides the following services in addition to those offered under the state plan, unless otherwise noted (OAC, 2006a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services
- Home modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization

- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)—from 2008

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Ohio Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans have more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse or practical nurse under the supervision of a licensed registered nurse (OAC, 2006d, OAC, 2014a, OAC, 2016a). Home health aide services must be provided by a home health aide employed or contracted by the Medicare certified home health agency. Skilled therapy services may be provided by licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants under the direction of a physical therapist, or certified occupational therapy assistants under the direction of a licensed occupational therapist who are contracted or employed by a Medicaid certified home health agency.

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (CFR, 1992).

PASSPORT

The provision of care for program services will vary by authorized service (OAC, 2006a, OAC, 2014h, OAC, 2016b).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary and certified by the individual's attending physician (OAC, 2006d, OAC, 2014a, OAC, 2016a).

Nursing Facility Care, PASSPORT

Applicants must meet a nursing facility level of care (NFLOC) in order to be admitted to a nursing facility (OAC, 2004a, OAC, 2014c, OAC, 2016d). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

A physician must review the plan of care and recertify the order for services every 60 days (OAC, 2006d, OAC, 2014a, OAC, 2016a).

Nursing Facility Care

Nursing facility residents must be reassessed at least every 12 months, or after a significant change in the patient's condition, or more often as needed (OAC, 2004b, OAC, 2014d, OAC, 2016e).

PASSPORT
Participants must be reassessed at least every 12 months (OAC, 2018).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the three largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care
There is no age requirement.

PASSPORT
The individual must be at least age 60 (OMR, 1997, ODJFS, 2013, ODA, 2017).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services
Home health services must be medically necessary based on the individual's diagnosis, prognosis, functional limitations and medical conditions (OAC, 2006d, OAC, 2014a, OAC, 2016a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care, and provided to beneficieries in their residence.

Applicants may be able to receive extended home health services (28 hours per week) if all of the following conditions are met:

- The applicant has a discharge date from an inpatient hospital stay of 3 or more days
- The applicant has a medical condition that temporarily meets a nursing facility level of care (NFLOC)
- The applicant requires medically necessary home health services at least once per week

Nursing Facility Care, PASSPORT
Applicants must be evaluated using the Level of Care Assessment Form (JFS 3697) and meet an NFLOC (OAC, 2004c). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services
Home health services must be medically necessary based on the individual's diagnosis, prognosis, functional limitations and medical conditions (OAC, 2014a, OAC, 2006d, OAC, 2016a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care, and provided to beneficieries in their residence.

Nursing Facility Care, PASSPORT
Applicants must be evaluated using the Level of Care Assessment Form (JFS 3697) and meet a nursing facility level of care (NFLOC) (OAC, 2004c). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)

- The applicant requires hands-on assistance with with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

The JFS 3697 determines level of care using the following items:

- Ability to perform ADLs
- Ability to self-administer medication
- Need for 24-hour supervision
- Use and frequency of skilled nursing services
- Use and frequency of skilled therapy services

Meeting the minimum level of dependence for PASSPORT does not guarantee admission to the program. Program space is limited to a specific number of beneficiaries. When the number of program participants exceeds program capacity, individuals are placed on a wait list. To view the form, see ODJFS (2003). For more detailed information on the JFS 3697 form sections, see Box 2 for Section 3: Level of care assessment summary, which summarizes all level of care items listed above, Box 3 for Section 11: ADLs, and Box 4 for Section 13: Medication administration.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 5 for more information on the PASRR, and Box 6 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (OAC, 2006d).

Nursing Facility Care, PASSPORT

Level of care evaluations must be conducted by a registered nurse or licensed social worker (OAC, 2004c).

Author's note: Authors have not yet identified the exact policy for care needs assessment evaluators for the period 1992 to 2003, but sources from 2004 onwards detail the above criteria, and it's possible that this criteria was in effect during this period.

Benefit limitations

Can you mix LTC benefits?

All Ohio Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program (e.g., PASSPORT). Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the three largest programs.

Medicaid

As required by federal law, Ohio enforces Estate Recovery. The acceptance of Medicaid in Ohio creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (OAC, 2004d).

Home Health Services

There are no copayments or other charges for home health services (OAC, 2006d).

Nursing Facility Care

Beneficiaries in an institution for more than 90 days are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1992, the PNA was $40 per month. See Table 3 for historical spousal impoverishment standards (OAC, 2004e).

PASSPORT

Beneficiaries are expected to contribute all of their income to the cost of care, except for a monthly PNA and any funds protected by the spousal impoverishment rules. The PNA is 65% of the income limit for this group, or 195% of the monthly SSI benefit amount. See Table 3 for historical spousal impoverishment standards (OAC, 2004e).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2014-2015

Policy change in 2014
In 2014, Ohio implemented eligibility track 2c, Medicaid expansion under the Affordable Care Act (ACA). The expansion extended Medicaid coverage to a new population of adults that were previously ineligible for Medicaid. This new population may receive long-term care (LTC), including nursing facility care and home and community-based services (HCBS) programs (OMR, 2014).

Medicaid expansion covers adults between the ages of 19 and 64 with incomes up to 138% of the federal poverty level (FPL). States that have adopted the expansion receive an enhanced federal matching rate (FMAP) for the new population (OMR, 2014).

Other policy changes during this period:

- (2014) The personal needs allowance (PNA) for nursing facility residents increased to $45 per month (ORC, 2014). Previously, the PNA was set at $40 per month.
- (2014) The Ohio Department of Medicaid became the single state agency for the Medicaid program (OMR, 2014)
- (2014) The PASSPORT program added the following benefits to their service package (OAC, 2014h):
  - Consumer-directed personal care services, which allows the beneficiary to hire and manage the caretaker of their choice.
  - Alternative meals, such as meals from restaurants and senior centers.
- (2015) The PNA for nursing facility residents increased to $50 per month (ORC, 2014).

Overview

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Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. Ohio is 1 of 9 states that chooses to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program, making it what is known as a 209(b) state. LTC benefits in Ohio are mostly provided through the Medicaid state plan benefit programs (Home Health Services, Nursing Facility Care, or through federally approved home-and community-based services (HCBS) LTC programs (Pre-Admission Screening Providing Options and Resources Today - PASSPORT).

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Statutory basis

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Ohio Law for Medicaid

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- Ohio Administrative Code (OAC), Chapter 5160 - Ohio Department of Medicaid (OAC, 2024b)

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Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Ohio Medicaid spending on beneficiaries in fiscal year 2014 was 63.02%.See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

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Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Ohio Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Ohio.

Eligibility for Medicaid in Ohio for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) states

  Ohio is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - ◇ Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2014, this was was $721 for an individual and $1,082 for a couple (SSA, 2024b). See Table 2 for historical monthly benefit amounts. Individuals who do not meet this income threshold are able to "spend down" their excess income either by incurring medical expenses that decrease income down below the threshold, or by making monthly payments in the amount of their excess income to the state (OAC, 2015b).
  - ◇ Asset requirements: Resources may not exceed $1,500 for an individual and $2,250 for a couple.
    - ▪ Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - ▪ Home equity limit: The equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (ORC, 2006). This figure increases annually with inflation.
  - ◇ Citizenship/immigration requirements: The applicant must be an Ohio resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2024c) for additional information.
  - ◇ Other requirements

- The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Income may not exceed 300% of the monthly federal SSI amount (OAC, 2015a). In 2014, this was $2,163. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[7] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $1,500. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community.[8] See Table 3 for historical monthly spousal disregards.
    - Asset transfer and home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be recieving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., PASSPORT).
- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the FPL (OMR, 2014). In 2014, this was $1,293 for an individual and $2,405 for a household of 2. See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervicel Cancer Program (BCCP): Provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (BCCP, 2024)

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Pre-Admission Screening Providing Options and Resources Today (PASSPORT)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 60 (ODJFS, 2013). Those applying for the PASSPORT program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Assisted Living Program
- Program for All-Inclusive Care for the Elderly (PACE)
- Transitions Carve-Out Program—until 2014.

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home Health provides (CFR, 1992b; OAC, 2014a; OAC, 2016a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Skilled therapy services: Physical therapy, occupational therapy, and speech-language pathology

See Box 1 for limitations on Home Health services.

Nursing Facility Care

Nursing Facility Care does not provide home care.

PASSPORT

PASSPORT provides (OAC, 2014h; OAC, 2016i):

- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only)
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

Home care services may be participant directed, which means the beneficiary may hire and manage the caretaker of their choice. In Ohio, this is referred to as Consumer-Directed Personal Care (OAC, 2014h; OAC, 2016b).

Community care

Community care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

PASSPORT

PASSPORT provides Adult Day Health Care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (OAC, 2006a, OAC, 2014h, OAC, 2016b).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, PASSPORT

These programs do not provide residential care.

Nursing Facility Care

Ohio Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (OAC, 2004f, OAC, 2014b, OAC, 2016c). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Ohio's largest home and community-based services (HCBS) program.

Ohio Medicaid provides additional state plan benefits related to LTC (OMR, 1997):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids—this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

PASSPORT

PASSPORT provides the following services in addition to those offered under the state plan, unless otherwise noted (OAC, 2014h, OAC, 2016b):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services
- Home modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)
- Alternative meal: Meals from restaurants and senior centers

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Ohio Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans have more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse or practical nurse under the supervision of a licensed registered nurse (OAC, 2006d, OAC, 2014a, OAC, 2016a). Home health aide services must be provided by a home health aide employed or contracted by the Medicare certified home health agency. Skilled therapy services may be provided by licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants under the direction of a physical therapist, or certified occupational therapy assistants under the direction of a licensed occupational therapist who are contracted or employed by a Medicaid certified home health agency.

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (CFR, 1992).

PASSPORT

The provision of care for program services will vary by authorized service (OAC, 2006a, OAC, 2014h, OAC, 2016b).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary and certified by the individual's attending physician (OAC, 2006d, OAC, 2014a, OAC, 2016a).

Nursing Facility Care, PASSPORT

Applicants must meet a nursing facility level of care (NFLOC) in order to be admitted to a nursing facility (OAC, 2004a, OAC, 2014c, OAC, 2016d). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

A physician must review the plan of care and recertify the order for services every 60 days (OAC, 2006d, OAC, 2014a, OAC, 2016a).

Nursing Facility Care

Nursing facility residents must be reassessed at least every 12 months, or after a significant change in the patient's condition, or more often as needed (OAC, 2004b, OAC, 2014d, OAC, 2016e).

PASSPORT

Participants must be reassessed at least every 12 months (OAC, 2018).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the three largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

PASSPORT

The individual must be at least age 60 (OMR, 1997, ODJFS, 2013, ODA, 2017).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services

Home health services must be medically necessary based on the individual's diagnosis, prognosis, functional limitations and medical conditions (OAC, 2006d, OAC, 2014a, OAC, 2016a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care, and provided to beneficieries in their residence.

Applicants may be able to receive extended home health services (28 hours per week) if all of the following conditions are met:

- The applicant has a discharge date from an inpatient hospital stay of 3 or more days
- The applicant has a medical condition that temporarily meets a nursing facility level of care (NFLOC)
- The applicant requires medically necessary home health services at least once per week

Nursing Facility Care, PASSPORT

Applicants must be evaluated using the Level of Care Assessment Form (ODM 3697) and meet an NFLOC (OAC, 2014e, OAC, 2016f). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary based on the individual's diagnosis, prognosis, functional limitations and medical conditions (OAC, 2014a, OAC, 2006d, OAC, 2016a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care, and provided to beneficieries in their residence.

Nursing Facility Care, PASSPORT

Applicants must be evaluated using the Level of Care Assessment Form (ODM 3697) and meet a nursing facility level of care (NFLOC) (OAC, 2014e, OAC, 2016f). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

The ODM 3697 determines level of care using the following items:

- Ability to perform ADLs
- Ability to self-administer medication
- Need for 24-hour supervision
- Use and frequency of skilled nursing services
- Use and frequency of skilled therapy services

Meeting the minimum level of dependence for PASSPORT does not guarantee admission to the program. Program space is limited to a specific number of beneficiaries. When the number of program participants exceeds program capacity, individuals are placed on a wait list. To view the form, see ODM (2014a). For more detailed information on the ODM 3697 form sections, see Box 2 for Section 3: Level of care assessment summary, which summarizes all level of care items listed above, Box 3 for Section 11: ADLs, and Box 4 for Section 13: Medication administration.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 5 for more information on the PASRR, and Box 6 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (OAC, 2014a, OAC, 2016a).

Nursing Facility Care, PASSPORT

Level of care evaluations must be conducted by a registered nurse and certified by a physician (OAC, 2014e, OAC, 2016f).

Benefit limitations

Can you mix LTC benefits?

All Ohio Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program (e.g., PASSPORT). Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the three largest programs.

Medicaid

As required by federal law, Ohio enforces Estate Recovery. The acceptance of Medicaid in Ohio creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (OAC, 2014f).

Home Health Services

There are no copayments or other charges for home health services (OAC, 2014a).

Nursing Facility Care

Beneficiaries in an institution for more than 90 days are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2014, the PNA was $45 per month. See Table 3 for historical spousal impoverishment standards (OAC, 2014g).

PASSPORT

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly PNA and any funds protected by the spousal impoverishment rules. The PNA is 65% of the income limit for this group, or 195% of the monthly SSI benefit amount. In 2014, the PNA was $1,406 per month. See Table 3 for historical spousal impoverishment standards (OAC, 2017a).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2016-2024

Policy change in 2016
In 2016, Ohio transitioned from a 209(b) state to a 1634 state. This meant that rather than making their own state determinations of Medicaid eligibility for individuals receiving Supplemental Security Income (SSI), they now automatically provide Medicaid coverage to SSI recipients determined eligible by the Social Security Administration (SSA). The 1634 transition replaced eligibility track 1b (209(b) states) with eligibility track 1a (Supplemental Security Income recipients). During this transition, Ohio also made the following changes:

- Increased asset limits for the aged, blind, and disabled populations. The asset limit of $1,500 for a single person increased to $2,000, and the asset limit of $2,250 for a married couple (when both are receiving Medicaid) increased to $3,000 (ODM, 2015).

Overview

Long-term care (LTC) benefits in Ohio are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Ohio is administered at the state level by the Ohio Department of Medicaid (ODM), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Ohio are mostly provided through the Medicaid state plan benefit programs (Home Health Services, Nursing Facility Services, or through federally approved home-and community-based services (HCBS) LTC programs (Pre-Admission Screening Providing Options and Resources Today - PASSPORT).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the PASSPORT program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the PASSPORT program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and PASSPORT beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024d)

Ohio Law for Medicaid

- Ohio Revised Code (ORC), Title 51 - Public Welfare (ORC, 2024a)
- Ohio Administrative Code (OAC), Chapter 5160 - Ohio Department of Medicaid (OAC, 2024b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Ohio Medicaid spending on beneficiaries in fiscal year 2016 was 62.47%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Ohio Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Ohio.

Eligibility for Medicaid in Ohio for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2016, the monthly federal benefit amount was $733 for an individual and $1,100 for a couple (SSA, 2024b). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - Home equity limit: The equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (ORC, 2024a). This figure increases annually with inflation.
  - Citizenship/immigration requirements: The applicant must be an Ohio resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2024c) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Income may not exceed 300% of the monthly federal SSI amount (OAC, 2017b). In 2016, this was $2,199. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[9] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $2,000. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
    - Asset transfer and home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.

- Other requirements
  - The applicant must be recieving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., PASSPORT).
- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the federal poverty level (FPL). In 2016, this was $1,366 for an individual and $1,842 for a household of 2. See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervicel Cancer Program (BCCP): Provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (BCCP, 2024)

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Pre-Admission Screening Providing Options and Resources Today (PASSPORT)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 60 (OAC, 2016i). Those applying for the PASSPORT program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Assisted Living Program
- Program for All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home Health provides (CFR, 1992b; OAC, 2014a; OAC, 2016a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Skilled therapy services: Physical therapy, occupational therapy, and speech-language pathology

See Box 1 for limitations on Home Health services.

Nursing Facility Care

Nursing Facility Care does not provide home care.

PASSPORT

PASSPORT provides (OAC, 2014h; OAC, 2016i):

- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only)
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

Home care services may be participant directed, which means the beneficiary may hire and manage the caretaker of their choice. In Ohio, this is referred to as Consumer-Directed Personal Care (OAC, 2014h; OAC, 2016b).

Community care

Community care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

PASSPORT

PASSPORT provides Adult Day Health Care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (OAC, 2006a, OAC, 2014h, OAC, 2016b).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, PASSPORT

These programs do not provide residential care.

Nursing Facility Care

Ohio Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (OAC, 2004f, OAC, 2014b, OAC, 2016c). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Ohio's largest home and community-based services (HCBS) program.

Ohio Medicaid provides additional state plan benefits related to LTC (OMR, 1997):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids—this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

PASSPORT

PASSPORT provides the following services in addition to those offered under the state plan, unless otherwise noted (OAC, 2014h, OAC, 2016b):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant

- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services
- Home modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)
- Alternative meal: Meals from restaurants and senior centers

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Ohio Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans have more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse or practical nurse under the supervision of a licensed registered nurse (OAC, 2006d, OAC, 2014a, OAC, 2016a). Home health aide services must be provided by a home health aide employed or contracted by the Medicare certified home health agency. Skilled therapy services may be provided by licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants under the direction of a physical therapist, or certified occupational therapy assistants under the direction of a licensed occupational therapist who are contracted or employed by a Medicaid certified home health agency.

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (CFR, 1992).

PASSPORT

The provision of care for program services will vary by authorized service (OAC, 2006a, OAC, 2014h, OAC, 2016b).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary and certified by the individual's attending physician (OAC, 2006d, OAC, 2014a, OAC, 2016a).

Nursing Facility Care, PASSPORT

Applicants must meet a nursing facility level of care (NFLOC) in order to be admitted to a nursing facility (OAC, 2004a, OAC, 2014c, OAC, 2016d). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

A physician must review the plan of care and recertify the order for services every 60 days (OAC, 2006d, OAC, 2014a, OAC, 2016a).

Nursing Facility Care
Nursing facility residents must be reassessed at least every 12 months, or after a significant change in the patient's condition, or more often as needed (OAC, 2004b, OAC, 2014d, OAC, 2016e).

PASSPORT
Participants must be reassessed at least every 12 months (OAC, 2018).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the three largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care
There is no age requirement.

PASSPORT
The individual must be at least age 60 (OMR, 1997, ODJFS, 2013, ODA, 2017).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services
Home health services must be medically necessary based on the individual's diagnosis, prognosis, functional limitations and medical conditions (OAC, 2006d, OAC, 2014a, OAC, 2016a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care, and provided to beneficieries in their residence.

Applicants may be able to receive extended home health services (28 hours per week) if all of the following conditions are met:

- The applicant has a discharge date from an inpatient hospital stay of 3 or more days
- The applicant has a medical condition that temporarily meets a nursing facility level of care (NFLOC)
- The applicant requires medically necessary home health services at least once per week

Nursing Facility Care, PASSPORT
Applicants must be evaluated using the Level of Care Assessment Form (ODM 3697) and meet an NFLOC (OAC, 2014e, OAC, 2016f). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services
Home health services must be medically necessary based on the individual's diagnosis, prognosis, functional limitations and medical conditions (OAC, 2014a, OAC, 2006d, OAC, 2016a). Services must be ordered by the beneficiary's physician and performed

in accordance with a written plan of care, and provided to beneficieries in their residence. From 2017 home health services must be provided in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board (OAC, 2017c).

Nursing Facility Care, PASSPORT

Applicants must be evaluated using the Level of Care Assessment Form (ODM 3697) and meet a nursing facility level of care (NFLOC) (OAC, 2014e, OAC, 2016f). An NFLOC is satisfied when an applicant meets one of the following requirements:

- The applicant requires hands-on assistance with at least 2 activities of daily living (ADLs)
- The applicant requires hands-on assistance with with 1 ADL and is unable to self-administer medication
- The applicant requires at least 1 skilled nursing or skilled therapy service
- Due to cognitive impairment, the applicant requires the presence of another person on a 24-hour basis

The ODM 3697 determines level of care using the following items:

- Ability to perform ADLs
- Ability to self-administer medication
- Need for 24-hour supervision
- Use and frequency of skilled nursing services
- Use and frequency of skilled therapy services

Meeting the minimum level of dependence for PASSPORT does not guarantee admission to the program. Program space is limited to a specific number of beneficiaries. When the number of program participants exceeds program capacity, individuals are placed on a wait list. To view the form, see ODM (2014a). For more detailed information on the ODM 3697 form sections, see Box 2 for Section 3: Level of care assessment summary, which summarizes all level of care items listed above, Box 3 for Section 11: ADLs, and Box 4 for Section 13: Medication administration.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 5 for more information on the PASRR, and Box 6 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (OAC, 2014a, OAC, 2016a).

Nursing Facility Care, PASSPORT

Level of care evaluations must be conducted by a registered nurse and certified by a physician (OAC, 2014e, OAC, 2016f).

Benefit limitations

Can you mix LTC benefits?

All Ohio Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program (e.g., PASSPORT). Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the three largest programs.

Medicaid

As required by federal law, Ohio enforces Estate Recovery. The acceptance of Medicaid in Ohio creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (OAC, 2014f).

Home Health Services

There are no copayments or other charges for home health services (OAC, 2014a).

Nursing Facility Care

Beneficiaries in an institution for more than 90 days are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2016, the PNA was $50 per month. See Table 3 for historical spousal impoverishment standards (OAC, 2016h).

PASSPORT

Beneficiaries are expected to contribute all of their income to the cost of care except for a monthly PNA and any funds protected by the spousal impoverishment rules. The PNA is 65% of the income limit for this group, or 195% of the monthly SSI benefit amount. In 2016, the PNA was $1,429 per month. See Table 3 for historical spousal impoverishment standards (OAC, 2017a).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Ohio Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2024)

Fiscal Year	FMAP
1992	60.63%
1993	60.25
1994	60.83
1995	60.69
1996	60.17
1997	59.28
1998	58.14
1999	58.26
2000	58.67
2001	59.03
2002	58.78
2003	60.31
2004	61.44
2005	59.68
2006	59.88
2007	59.66
2008	60.79
2009	71.30
2010	73.47
2011	69.25
2012	64.15
2013	63.58
2014	63.02
2015	62.64
2016	62.47
2017	62.32
2018	62.78
2019	63.09
2020	67.67
2021	69.83
2022	70.30
2023[1]	68.56
2024	64.68

Source: U.S. DHHS (2023)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period. [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Ohio Medicaid Income Limits (1992-2024)

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422	$633	$1,266	$1,899		
1993	434	652	1,302	1,956		
1994	446	669	1,338	2,007		
1995	458	687	1,374	2,061		
1996	470	705	1,410	2,115		
1997	484	726	1,452	2,178		
1998	494	741	1,482	2,223		
1999	500	751	1,500	2,223		
2000	513	769	1,539	2,307		
2001	531	796	1,593	2,388		
2002	545	817	1,635	2,451		
2003	552	829	1,656	2,487		
2004	564	846	1,692	2,538		
2005	579	869	1,737	2,607		
2006	603	904	1,809	2,712		
2007	623	934	1,869	2,802		
2008	637	956	1,911	2,868		
2009	674	1,011	2,022	3,033		
2010	674	1,011	2,022	3,033		
2011	674	1,011	2,022	3,033		
2012	698	1,048	2,094	3,144		
2013	710	1,066	2,130	3,198		
2014	721	1,082	2,163	3,246	$1,341	$1,809
2015	733	1,100	2,199	3,300	1,354	1,833
2016	733	1,100	2,199	3,300	1,366	1,842
2017	735	1,103	2,205	3,309	1,387	1,867
2018	750	1,125	2,250	3,375	1,397	1,893
2019	771	1,157	2,313	3,471	1,437	1,944
2020	783	1,175	2,349	3,525	1,467	1,983
2021	794	1,191	2,382	3,573	1,481	2,004
2022	841	1,261	2,523	3,783	1,564	2,106
2023	914	1,371	2,742	4,113	1,677	2,267
2024	943	1,415	2,829	4,245	1,732	2,350

Source: SSA (2024b), CMS (2024)

Notes: Income limits for individuals and couples are monthly. Income limits at 138% of the FPL began in 2016, corresponding to Ohio's implementation of eligibility track 2c. ACA expansion adults.

Table 3: Ohio Spousal Impoverishment Standards (1992-2024)

Year	Minimum MMNA	Maximum MMNA	Minimum CSRA	Maximum CSRA
1992	$984.20	$1,718.00	$13,740.00	$68,700.00
1993	1,148.75	1,769.00	14,148.00	70,740.00
1994	1,178.75	1,817.00	14,532.00	72,660.00
1995	1,230.00	1,871.00	14,964.00	74,820.00
1996	1,253.75	1,919.00	15,348.00	76,740.00
1997	1,295.00	1,976.00	15,804.00	79,020.00
1998	1,326.25	2,019.00	16,152.00	80,760.00
1999	1,356.25	2,049.00	16,392.00	81,960.00
2000	1,382.50	2,103.00	16,824.00	84,120.00
2001	1,406.25	2,175.00	17,400.00	87,000.00
2002	1,451.25	2,232.00	17,856.00	89,280.00
2003	1,492.50	2,266.50	18,132.00	90,660.00
2004	1,515.00	2,319.00	18,552.00	92,760.00
2005	1,561.25	2,377.50	19,020.00	95,100.00
2006	1,603.75	2,488.50	19,908.00	99,540.00
2007	1,650.00	2,541.00	20,328.00	101,640.00
2008	1,711.25	2,610.00	20,880.00	104,400.00
2009	1,750.00	2,739.00	21,912.00	109,560.00
2010	1,821.25	2,739.00	21,912.00	109,560.00
2011	1,821.25	2,739.00	21,912.00	109,560.00
2012	1,838.75	2,841.00	22,728.00	113,640.00
2013	1,891.25	2,898.00	23,184.00	115,920.00
2014	1,938.75	2,931.00	23,448.00	117,240.00
2015	1,966.25	2,980.50	23,844.00	119,220.00
2016	2,002.50	2,980.50	23,844.00	119,220.00
2017	2,002.50	3,022.50	24,180.00	120,900.00
2018	2,030.00	3,090.00	24,720.00	123,600.00
2019	2,057.50	3,160.50	25,284.00	126,420.00
2020	2,113.75	3,216.00	25,728.00	128,640.00
2021	2,155.00	3,259.50	26,076.00	130,380.00
2022	2,177.50	3,435.00	27,480.00	137,400.00
2023	2,288.75	3,715.50	29,724.00	148,620.00
2024	2,465.00	3,853.50	30,828.00	154,140.00

Source: CMS (2024)

Notes: State sources were not found for all years, but they are subject to the federal minimum and maximum standards. Federal law requires states to set the minimum monthly maintenance needs allowance (MMNA) standard at 150% of the federal poverty level (FPL) for a couple, increasing each year with inflation, except for FY 1992, which was set at 133% of the FPL. MMNAs are calculated using FPLs for each year and are validated by state and federal sources. Some states round to the dollar, which may lead to minor variations between the calculated federal amounts and state-specific standards. For Community Spouse Resource Allowances (CSRAs), the minimum was set at $12,000 and the maximum at $60,000 as of September 30, 1989, increasing each year with inflation. CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U).

Box 1: Ohio Home Health Care Service Limitations

Home Health services are covered if only provided on a part-time and intermittent basis, which means:

- No more than a combined total of 8 hours per day of skilled nursing, home health aid, and skilled therapy services
- No more than a combined total of 14 hours per week of skilled nursing or home health aid services
- Visits are not more than 4 hours each

Source: OAC (2014a)

Box 2: Ohio JFS/ODM 3697 Form: Section 3 - Level of Care Assessment Summary (2003-2024)

Section 3: Level of Care Assessment Summary

- A. Activities of daily living (ADLs) (list total by category)
  - Independent
  - Supervision
  - Assistance
- B. Instrumental activities of daily living (IADLs) (list total by category)
  - Independent
  - Supervision
  - Assistance
- C. Medication Administration
  - Independent
  - Supervision
  - Assistance
- D. Needs 24 hour supervision due to cognitive impairment
- E. Condition
  - Stable
  - Unstable
- F. Skilled nursing services (list/frequency)
- G. Skilled rehabilitation therapy services (list/frequency)

Source: ODJFS (2003)

Notes: Section 3 of the Level of Care Assessment form summarizes the results of Section 11: Activities of Daily Living (ADLs), Section 12: Instrumental Activities of Daily Living (IADLs), and Section 13: Medication Administration. Assessors must also mark the applicant's condition as stable or unstable and list the type and frequency of skilled nursing services and skilled rehabilitation (therapy) services. When the Ohio Department of Medicaid became the single state agency for Medicaid in 2014, the name of the form changed from JFS 3697 to ODM 3697, but the contents of the form stayed the same. Authors were unable to verify the assessment process prior to 2003.

Box 3: Ohio JFS/ODM 3697 Form: Section 11 - Activities of Daily Living (ADL) (2003-2024)

Section 11: Activities of daily living (ADLs)

The form assesses the individual's ability to complete the following ADLs:

- A. Mobility
  - Bed
  - Transfer
  - Locomotion
- B. Bathing
- C. Grooming
- D. Toileting
- E. Dressing
- F. Eating

Each ADL is assessed using the following scale of dependence:

- No help
- Supervision
- Hands on

Sources: The assessor must include the source of information, which may be a physician, medical records, a caregiver, an authorized representative, the assessor, or the applicant.

All durable, assistive, or adaptive equipment used by the applicant must also be listed.

Source: ODJFS (2003)

Notes: The applicant's ability to perform each Activity of daily living (ADL) is categorized according to the following: No help required (Independent) , Supervision required, or Hands-on assistance required. The Source of the information and equipment used by the individual must also be listed. When the Ohio Department of Medicaid became the single state agency for Medicaid in 2014, the name of the form changed from JFS 3697 to ODM 3697, but the contents of the form stayed the same. Authors were unable to verify the assessment process prior to 2003.

Box 4: Ohio JFS/ODM 3697 Form: Section 13 - Medication Administration (2003-2024)

Section 3: Medication Administration
This form assesses the individual's ability to self-administer medication using the following scale of independence:

- No help (independent)
- Supervision
- Hands on

Sources: The assessor must include the source of information, which may be a physician, medical records, a caregiver, an authorized representative, the assessor, or the applicant.

Source: ODJFS (2003)
Notes: When the Ohio Department of Medicaid became the single state agency for Medicaid in 2014, the name of the form changed from JFS 3697 to ODM 3697, but the contents of the form stayed the same. Authors were unable to verify the assessment process prior to 2003.

Box 5: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 6: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1634 State: States known as "1634" states are states that have completed a "1634 agreement" with the Social Security Administration. This agreement determines eligibility for a specific state's Medicaid program for Supplemental Security Income (SSI) recipients, known as categorical eligibility. The agreements are only with states that use SSI criteria to determine Medicaid eligibility, in contrast to "209(b)" states that have their own criteria and do not automatically provide Medicaid coverage to SSI recipients.

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Assisted Living Facility (ALF): A group residence that provides consistent care to older adults (e.g., personal care) that do not require the type of care provided in a nursing facility.

Assisted Living Program (ALP): Provides LTC services for those who reside in an assisted living facility (ALF). Applicants must be at least age 21, require a nursing facility level of care (NFLOC), be eligible for Medicaid, and cover the cost of room and board. Those who apply are not guaranteed care as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Chore Services: Chore services are household tasks necessary to maintain a safe and habitable home environment provided intermittently as needed by a trained homemaker. Chore services include: light cleaning (e.g., washing walls, windows, rugs), pest and rodent control (e.g., spraying the home with over-the-counter supplies, setting traps), simple household repair (e.g., repairing water faucets, unclogging drains), and disposal of garbage.

Community Spouse Resource Allowance (CSRA): Amount of countable assets a spouse residing in the community can retain if their spouse is institutionalized or requires home and community-based long-term care.

Community Transition Service: Non-recurring expenses for people who are in the process of transiitoning form a nursing facility to a less institutional setting. This includes services such as case management and support for moving expenses. Ohio added this benefit to PASSPORT in 2008.

Consumer-directed personal care services: Personal care services provided by an aide that is hired and managed by the recipient.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 1b. 209(b) States: The Social Security Act provides states the authority to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program. States that elect this option are called 209(b) states. Because eligibility for SSI does not guarantee Medicaid eligibility in a 209(b) state, these states do not cover the mandatory SSI Beneficiaries group. Instead, 209(b) states impose more restrictive criteria through the mandatory 209(b) group. A person receiving SSI can still be eligible for Medicaid in the mandatory 209(b) group, but that person must also meet the more restrictive eligibility requirements imposed by the state.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2c. Affordable Care Act (ACA) expansion adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, blind, or disabled: Optional coverage group under Medicaid for individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Homemaker Services: General household activities provided by a trained homemaker when the beneficiary is unable to manage home care for themselves, or when others who are regularly responsible for these activities are temporarily absent. Homemaker services can include assistance with meal planning, meal preparation, grocery purchase planning, assisting consumers with shopping and other errands, laundry, hhouse cleaning, kitchen care, bathroom care, emptying and cleaning bedside commodes, changing bed linens, washing inside windows within reach from the floor, and removing trash.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore

health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home Modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Level of Care Assessment Form (ODM 3697): Used to asses an applicant's level of care needs and evaluate the applicant's medical eligibility for various long-term care services including nursing facility care and home and community-based services. The form collects information on demographics, diagnoses, medications functional abilities, and support systems. Prior to 2014, the form was known as JFS 3697 due to the Ohio Department of Job and Family Services being the Medicaid state agency at that time.

Managed Care Organization (MCO): Health plans that administer Medicaid services and contract with providers to deliver services. MCOs receive a capitated per member per month fee from the state and reimburse providers for services enrollees receive.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy Income Limit (MNIL): The income standard that a Medicaid applicant must spend-down to meet if they are seeking Medicaid eligibility through eligibility track 3a (Medically Needy Aged, blind, or disabled). Typically, this standard is very low.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often

the minimum level of dependence required for long-term care programs.

Ohio Department of Jobs and Family Services (ODJFS): The ODJFS is Ohio's single state agency that administered the state Medicaid program until 2014 when the Ohio Department of Medicaid (ODM) became the single state agency.

Ohio Department of Medicaid (ODM): The ODM is the single state agency that has administered the state Medicaid progrom since 2014.

Ohio Home Care program: This program provides HCBS services for beneficiaries age 59 or less who require an NFLOC and qualify for Medicaid.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Pre-Admission Screening Providing Options and Resources Today (PASSPORT): State program that provides home and community-based services to low income Ohioans that are at least age 60. Beneficiaries must qualify for Medicaid and require a nursing facility level of care.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Program for All-inclusive Care for the Elderly (PACE): A program of managed healthcare for Ohioans age 55 or older who live in an area with a PACE site. Services include primary and specialty care, adult day care, personal care, inpatient hospital care, prescription drugs, physical and occupational therapies, and nursing home care. Medicaid will pay for PACE services for those who qualify for eligibility track 2b. Institutional rules. Beneficiaries may also pay for their own services. As of July 2024, there are 2 PACE sites. Ohio plans to add 6 more sites in 2025 with additonal sites in 2026.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Qualified Income Trust: A Qualified Income Trust (QIT), or Miller Trust, is an irrevocable trust that allows individuals with excess income to qualify for Medicaid benefits. Each month, the beneficiary's excess income is deposited in the QIT, and a designated trustee can use these funds for limited purposes that include the beneficiary's monthly personal needs allowance, residential care facility costs, community spouse allocations, and any other care-related expenses. When the beneficiary passes away, any remaining funds in the account are claimed by the State.

Restorative Nursing: Interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Skilled Therapy Services: Physical therapy, occupational therapy, and speech-language pathology services that require the skills of

and are performed by skilled therapy providers to meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Social Security Disability Insurance (SSDI): Social Security Disability Insurance is a payroll tax-funded federal insurance program of the United States government. It is managed by the Social Security Administration and designed to provide monthly benefits to people who have a medically determinable disability that restricts their ability to be employed.

State Supplemental Payment (SSP): Small supplement to recipients of federal Supplemental Security Income (SSI) and some non-SSI recipients who are low-income persons with disabilities and older adults with limited resources to pay their living expenses.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Transitions Carve-out program: Provides HCBS services for beneficiaries aged at least 60 who require a nursing facility level of care and qualify for Medicaid. Enrollment for the program was only available to those that aged out of the My Home Care program by turning 60. This program operated from 2006 to 2015 when beneficiaries of this program transitioned to the PASSPORT program.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients in some states may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track.

2. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period was 60 months prior to the date of application. In 2006 the look back period was extended to 60 months for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999; OAC 2006e).

3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).

4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024e) for more information on these requirements.

5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the minimum MMNA in Ohio was $984.20 per month, and the maximum was $1,718. This standard increases annually with inflation. See Table 3 for historical MMNAs.

6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $13,740 to $68,700 in 1992. In Ohio, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

7. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2014, the minimum MMNA in Ohio was $1,938.75 per month, and the maximum was $2,931. This standard increases annually with inflation. See Table 3 for historical MMNAs.
8. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $23,448 to $117,240 in 2014. In Ohio, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.
9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2016, the minimum MMNA in Ohio was $2,002.50 per month, and the maximum was $2,980.50. This standard increases annually with inflation. See Table 3 for historical MMNAs.
10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $23,844 to $119,220 in 2016. In Ohio, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

Version information

Current Version: 1.0 (December 2024)

Version History

- 1.0 (December 2024): First Version.