

Revision: HCFA-PM-86-20 (BERC)  
SEPTEMBER 1986

ATTACHMENT 3.1-B  
Page 1  
OMB No. 0938-0193

*Jeanne Carroll*  
↑ ↑ responsibility

State/Territory: OHIO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): None

The following ambulatory services are provided.

The State of Ohio does not have a medically needy program.

\*Description provided on attachment.

TN No. 86-34  
Supersedes  
TN No. NEW

Approval Date JAN 23 1987

Effective Date OCT 01 1986

HCFA ID: 0140P/0102A

DEC 15 1986

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): NONE

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided:  No limitations  With limitations\*

2.a. Outpatient hospital services.

Provided:  No limitations  With limitations\*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic--(which are otherwise covered under the Plan).

Provided:  No limitations  With limitations\*

3. Other laboratory and X-ray services.

Provided:  No limitations  With limitations\*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided:  No limitations  With limitations\*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*

Provided:

c. Family planning services and supplies for individuals of childbearing age.

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 91-20  
Supersedes 86-34 Approval Date 1-16-92 Effective Date 10/1/91  
TN No. 86-34 HCFA ID: 7986E

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4)

Provided:  No limitations  With limitations

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): NONE

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, ~~a skilled~~ nursing facility, or elsewhere.

Provided:  No limitations  With limitations\*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 91-20  
Supersedes 86-34 Approval Date 1-16-92 Effective Date 10/1/91  
TN No. 86-34 HCFA ID: 7986E

State/Territory: OHIO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): None

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' Services  
 Provided:  No limitations  With limitations\*
- b. Optometrists' Services  
 Provided:  No limitations  With limitations\*
- c. Chiropractors' Services  
 Provided:  No limitations  With limitations\*
- d. Other Practitioners' Services  
 Provided:  No limitations  With limitations\*
7. Home Health Services
- a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.  
 Provided:  No limitations  With limitations\*
- b. Home health aide services provided by a home health agency.  
 Provided:  No limitations  With limitations\*
- c. Medical supplies, equipment, and appliances suitable for use in the home.  
 Provided:  No limitations  With limitations\*
- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.  
 Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 86-34  
Supersedes  
TN No. NEW

Approval Date JAN 23 1987 Effective Date OCT 01 1986

HCFA ID: 0140P/0102A

DEC 16 1986

State/Territory: OHIO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): None

8. Private duty nursing services.  
 Provided:  No limitations  With limitations\*
9. Clinic services.  
 Provided:  No limitations  With limitations\*
10. Dental services.  
 Provided:  No limitations  With limitations\*
11. Physical therapy and related services.
- a. Physical therapy.  
 Provided:  No limitations  With limitations\*
- b. Occupational therapy.  
 Provided:  No limitations  With limitations\*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.  
 Provided:  No limitations  With limitations\*
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.  
 Provided:  No limitations  With limitations\*
- b. Dentures.  
 Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 26-34  
Supersedes  
TN No. NEW

Approval Date JAN 23 1987

Effective Date OCT 01 1986

HCFA ID: 0140P/0102A

DEC 16 1986

State/Territory: OHIO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): None

c. Prosthetic devices.

Provided:  No limitations  With limitations\*

d. Eyeglasses.

Provided:  No limitations  With limitations\*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

Provided:  No limitations  With limitations\*

b. Screening services.

Provided:  No limitations  With limitations\*

c. Preventive services.

Provided:  No limitations  With limitations\*

d. Rehabilitative services.

Provided:  No limitations  With limitations\*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided:  No limitations  With limitations\*

b. Skilled nursing facility services.

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 86.34  
Supersedes  
TN No. NEW

Approval Date JAN 23 1987 Effective Date OCT 01 1986

HCFA ID: 0140P/0102A

DEC 16 1986

State/Territory: OHIO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): None

c. Intermediate care facility services.

Provided:  No limitations  With limitations\*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

Provided:  No limitations  With limitations\*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided:  No limitations  With limitations\*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided:  No limitations  With limitations\*

17. Nurse-midwife services.

Provided:  No limitations  With limitations\*

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 86-34  
Supersedes  
TN No. NEW

Approval Date JAN 23 1987

Effective Date OCT 01 1986

HCFA ID: 0140P/0102A

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): NONE

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

         Provided:          With limitations\*

         Not provided.

- b. Special tuberculosis (TB) related services under section 1902 (z)(2)(F) of the Act.

         Provided:          With limitations\*

         Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period at the pregnancy ends and for any remaining days in the month in which the 60th day falls.

         Provided: <sup>+</sup>          Additional coverage <sup>++</sup>

- b. Services for any other medical conditions that may complicate pregnancy.

         Provided: <sup>+</sup>          Additional coverage <sup>++</sup>

         Not provided.

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): NONE

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21. Certified pediatric or family nurse practitioners' services.

         Provided                               No limitations  
         With limitations\*                       Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

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TN No. 94-16  
Supersedes      Approval Date 7-7-94      Effective Date 4-1-94  
TN No. 91-20

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): NONE

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided:  No limitations  With limitations\*

Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

Provided:  No limitations  With limitations\*

b. Services of Christian Science nurses.

Provided:  No limitations  With limitations\*

c. Care and services provided in Christian Science sanatoria.

Provided:  No limitations  With limitations\*

d. Skilled nursing facility services provided for patients under 21 years of age.

Provided:  No limitations  With limitations\*

e. Emergency hospital services.

Provided:  No limitations  With limitations\*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

Provided:  No limitations  With limitations\*

TN No. 87-18  
Supersedes  
TN No. 86-34

Approval Date 8-20-87

Effective Date 4-1-87

HCFA ID: 1042P/0016P

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): NONE

- 24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited to Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

         Provided                        X   Not Provided

- 25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

         Provided:                               State Approved (Not Physician) Services Plan Allowed

                  Services Outside the Home Also Allowed

                  Limitations Described on Attachment

  X   Not provided.

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TN No. 94-28  
 Supersedes          Approval Date 1-10-95 Effective Date 10-1-94  
 TN No. NEW

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically  
Needy

27. Program of All-inclusive Care for the Elderly (PACE) services, as described in  
Supplement 4 to Attachment 3.1-A.

\_\_\_ Election of PACE: By virtue of this submittal, the State elects PACE as an  
optional State Plan service.

\_\_\_ No election of PACE: By virtue of this submittal, the State elects to not add  
PACE as an optional State Plan service.

TN No. 02-011

Approval Date 7-18-02

Effective Date 11-01-02

Supersedes

TN No. NA/New Page