Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

Nursing Facility Bulletin 195

DATE: November 2025

TO: Nursing Facilities Participating in MassHealth

FROM: Mike Levine, Undersecretary for MassHealth

RE: **Specialized Ventilator-Dependent Service Programs and Add-ons**

Background

MassHealth is issuing this bulletin under 101 CMR 206.10(2): *Ventilator Add-on* and 206.10(3): *Communication-limited Resident Ventilator Add-on*. It applies to nursing facilities seeking to establish and/or maintain a program for specialized ventilator-dependent (SVD) services and to receive and/or maintain approval from the Executive Office of Health and Human Services (EOHHS) to provide SVD services to qualify for member-specific ventilator add-on payments and communication-limited resident ventilator add-on payments.

Sections A and C of this bulletin do not apply to nursing facilities that have previously established such a program and received approval via an award resulting from their response to the Request for Applications (RFA) for Nursing Facilities to Provide Specialized Ventilator-Dependent Services. Those facilities have already received the necessary approval and may continue to bill for the ventilator and communication-limited resident ventilator add-ons at the rates in 101 CMR 206, provided all criteria in Sections B and D are met.

Under 101 CMR 206.10(2)(c) and 101 CMR 206.10(3)(c), to receive the member-specific ventilator add-on and the communication-limited resident ventilator add-on, respectively, a nursing facility must be approved by EOHHS to provide SVD services in accordance with processes established in written EOHHS guidance, which includes this bulletin. The facility must also maintain a program for SVD services in accordance with the requirements in this bulletin.

This bulletin establishes the process for a nursing facility to receive EOHHS approval to provide SVD services and establishes the requirements for a nursing facility to maintain a program for SVD services. A nursing facility that meets the requirements in this bulletin will be qualified to receive the member-specific add-ons in 101 CMR 206.10(2) and (3) provided that it also meets the additional regulatory criteria in 101 CMR 206.10(2) or (3), as applicable, and the criteria listed under "Member-Specific Criteria for the Ventilator and Communication-Limited Resident Ventilator Add-ons" in this bulletin.

A. Qualifying Criteria to Request EOHHS Approval to Provide SVD Services

To be approved by EOHHS to provide SVD services, a nursing facility must do all of the following.

1. Be a licensed Massachusetts nursing facility (unless operated by a department, agency, board, or commission of the Commonwealth of Massachusetts).
2. Be enrolled as a nursing facility provider (currently, Provider Type 09) with MassHealth.
3. Be deemed a qualified provider of nursing facility and SVD services by submitting a completed Appendix A: Specialized Ventilator-Dependent Services Approval Request Form and receiving approval from EOHHS. EOHHS will determine whether facilities are qualified in consultation with the Bureau of Health Care Safety and Quality within the Massachusetts Department of Public Health as to compliance, quality, and related performance indicators.
4. Provide a plan describing how it will provide SVD services as described in the "Requirements for Maintaining an SVD Services Program" section of this bulletin.
5. Be accredited by the accreditation body identified by the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organization.
6. Document Medicare certification for all beds intended to be used in delivering SVD services to eligible MassHealth members who meet the eligibility criteria listed in the "Member-Specific Criteria for the Ventilator and Communication-Limited Resident Ventilator Add-ons" section of this bulletin.
7. Have an established, formalized relationship with a pulmonary specialist or specialists.

B. Requirements for Maintaining an SVD Services Program

A nursing facility approved by EOHHS to provide SVD services must maintain a program through which the facility can provide all of the following SVD services, staff members, and equipment.

1. All medically necessary services in 130 CMR 456: *Long Term Care Services*.
2. All medically necessary respiratory care services.
3. An appropriately trained clinical staff with the necessary expertise and competencies to support the care and treatment of ventilator-dependent patients.
4. Access to, and a contractual relationship with, pulmonary specialists and hospitals to assist the facility staff.
5. A program director for the SVD services program.
6. 24/7 respiratory coverage on site by a respiratory therapist, registered nurse, or licensed practical nurse with the expertise and competencies to support the care and treatment of patients receiving SVD services.
7. All medically necessary ventilator equipment and supplies.

In addition to appropriately training its existing staff, the approved nursing facility must obtain sufficient additional staff members to meet the following requirements.

Staff Person	Minimum Qualifications and Specialized Training	Responsibilities
SVD Services Program Manager	Licensed respiratory therapist with experience in managing ventilator care and services, or a registered nurse or licensed practical nurse with the expertise and competencies to support the care and treatment of ventilator-dependent patients.	Overall performance and functioning of the program and direction of the unit's day-to-day activities. This will include, but is not limited to, the following. • Develop, monitor, and supervise the SVD services program. • Design and conduct all staff training related to ventilator equipment and services. • Supervise respiratory therapists. • Assess and approve all admissions. • Develop the ventilator and respiratory care portion of each member's care plan. • Act as liaison with pulmonary specialists. • Participate in interdisciplinary care plan meetings. • Participate in discharge plan development and follow-up for each member.
Respiratory Therapist	Licensed respiratory therapist with experience working with ventilator and tracheotomy patients, or a registered nurse or licensed practical nurse with relevant work experience.	Direct care services for patients receiving SVD services.

Each quarter, the approved nursing facility must complete and submit to the MassHealth Office of Long Term Services and Supports a Quarterly Participant Report (Appendix B of this bulletin) for each member receiving SVD services. If MassHealth determines that a member no longer meets the eligibility requirements in this bulletin, the nursing facility must stop billing for ventilator and communication-limited resident ventilator add-on payments for that member.

C. How to Request EOHHS Approval to Provide SVD Services

Email a Specialized Ventilator-Dependent Services Approval Request Form (Appendix A of this bulletin) to InstitutionalPrograms@mass.gov.

Facilities will only be allowed to bill MassHealth ventilator add-on payments and communication-limited resident ventilator add-on payments after they receive approval to provide SVD services, which will occur once EOHHS reviews and approves their Specialized Ventilator-Dependent Services Approval Request Form and completes an onsite visit to the facility.

D. Member-Specific Criteria for the Ventilator and Communication-Limited Resident Ventilator Add-ons

According to 101 CMR 206.10(2) and (3), a nursing facility that is approved by EOHHS to provide SVD services, and maintains a program for SVD services, may only receive the ventilator add-on or the communication-limited resident ventilator add-on for MassHealth members who meet all of the following criteria.

- MassHealth is their primary payer for nursing facility services at the time of admission.
- They require ventilator services at least daily (ventilator add-on), or they require ventilator services at least daily *and* cannot communicate without specialized communication technology that relies on eye movements; for instance, this applies to certain individuals with advanced amyotrophic lateral sclerosis (ALS) (communication-limited resident ventilator add-on).
- The facility is not receiving the tracheostomy add-on described in 101 CMR 206.10: *Other Payment Provisions* for them.

Additionally, in order for a facility to receive the ventilator add-on or the communication-limited resident ventilator add-on for a MassHealth member, the member must meet the following criteria.

- They have been initially screened for nursing facility placement pursuant to 130 CMR 456.407: *Clinical Authorization of Nursing Facility Services* by MassHealth's screening agent, and they meet MassHealth nursing facility clinical eligibility criteria as defined in 130 CMR 456.409: *Clinical Eligibility Criteria*;
- They have a long-term ventilator-dependent condition. A ventilator-dependent condition requires the member to need a vent for a portion of the day, but not necessarily an entire 24-hour period.
- They need specialized respiratory services due to ventilator dependence that are not normally or routinely provided as standard services in nursing facilities.
- If they are deemed incompetent or their medical conditions warrant their being deemed incompetent, they have a guardianship and/or Rogers order in place before receiving SVD services.

E. Payment for the Ventilator Add-on and Communication-Limited Resident Ventilator Add-on

To bill for the ventilator and communication-limited resident ventilator add-ons, the approved facility will need to establish two additional MassHealth provider identification / service locations (PID/SLs). MassHealth will combine the add-ons with the current nursing facility

standard rate to create two new nursing facility rate schedules. MassHealth will provide billing guidelines and instructions on obtaining the new MassHealth PID/SLs when EOHHS approves the facility.

F. Enforcement

Any nursing facility that receives a ventilator or communication-limited resident ventilator add-on is subject to audits, inspections, and requests for information or documentation by MassHealth about its compliance with the criteria in this bulletin and 101 CMR 206.10(2) and 206.10(3).

If a nursing facility is found to be noncompliant with the criteria in this bulletin or 101 CMR 206.10(2) or 206.10(3), MassHealth may recoup the paid ventilator and communication-limited resident ventilator add-ons as an overpayment, pursuant to 130 CMR 450.237: *Overpayments: Determination*.

Additionally, if MassHealth confirms that a nursing facility has made false or misleading representations through the submissions required by this bulletin, MassHealth may pursue sanctions against the provider under 130 CMR 450.238: *Sanctions: General*. MassHealth will also refer the provider to the Medicaid Fraud Division of the Massachusetts Office of the Attorney General, as appropriate.

MassHealth Website

This bulletin is available on the MassHealth Provider Bulletins web page.

Sign up to receive email alerts when MassHealth issues new bulletins and transmittal letters.

Questions?

- Call MassHealth at (800) 841-2900, TDD/TTY: 711
- Email us at provider@masshealthquestions.com

APPENDIX A

SPECIALIZED VENTILATOR-DEPENDENT SERVICES APPROVAL REQUEST FORM

INSTRUCTIONS

Fully complete and sign this request form (if applying for multiple nursing facilities, submit one copy for each facility) and email it, along with all other required documentation, to InstitutionalPrograms@Mass.gov.

GENERAL INFORMATION

1. Name of nursing facility

_____

2. Address of nursing facility

_____

3. Contact person for application

   Name

   _____

   Title

   _____

   Address

   _____

   Telephone

   _____

4. Nursing facility provider numbers

   a. Medicaid

   _____

   b. Medicare

   _____

ADMINISTRATIVE AND CLINICAL QUALIFICATIONS

1. Is the applicant nursing facility in Massachusetts?

   Yes _____ No____

2. Is the applicant nursing facility Medicare certified?

   Yes _____ No____

3. Is the applicant nursing facility licensed by the Massachusetts Department of Public Health (DPH)?

   Yes _____ No____

4. Total number of DPH licensed beds: _____

PROVIDER-SPECIFIC CRITERIA

Attach the following required documentation.

1. A cover letter that includes the following.
    1. The name, address, telephone number and email address of the person who should be contacted about any aspect of the applicant's submission.
    2. The names and titles of all key personnel, including but not limited to the administrator, the director of nursing, the director of social services, and the admissions director.
2. A written plan describing in detail the program and the special services that will be provided to members who need specialized ventilator-dependent (SVD) services. Applicants should refer to the program requirements listed in this bulletin and specifically discuss how their proposal will meet all the program elements in it. This plan should be sufficient to substantiate that the applicant's program or anticipated program meets all applicable Massachusetts Department of Public Health standards and protocols. The plan shall include, at a minimum, a description of each of the following areas of the applicant's program.
    a. SVD program standards (including but not limited to clinical standards; medical standards; goals; objectives; outcomes; size; in-house or contracted services; forms, tools, and assessments; and quality assurance systems);
    b. SVD program job descriptions and staffing ratios;
    c. All written policies and procedures about the SVD program, including but not limited to the following.
        1. Staffing: mix and qualifications.
        2. Coordination of human and material resources.
        3. Education and training programs.
        4. Quality assurance program.
        5. Documentation and reporting of program activities.

3. A copy of each of the following documents.
    a. Most recent Massachusetts Department of Public Health survey and certification review and findings.
    b. Most recent Joint Commission on Accreditation of Healthcare Organizations certificate and related findings, if any.
    c. Medicare certification of designated ventilator program beds.
4. Confirmation that the nursing facility has a completed MassHealth Program Nursing Facility Provider Contract.

ACKNOWLEDGMENT

All required information, as well as all required supporting documentation, must be current, complete, and accurate. The applicant must attach all additional information and/or documentation that is necessary to update, complete, or correct the application. In addition, once an applicant executes an agreement with MassHealth, it has a continuing obligation under that agreement to promptly submit all additional information and/or documentation to reflect any changes to previously submitted documentation and/or information related to this form.

I, _____, hereby certify that the information submitted in this Specialized Ventilator-Dependent Services Approval Request Form, is current, complete and accurate.

THIS APPLICATION IS SIGNED UNDER THE PAINS AND PENALTY OF PERJURY.

_____ _____

Signature of authorized facility representative Date

_____

Name and title (printed)

APPENDIX B

QUARTERLY PARTICIPANT REPORT

FOR INDIVIDUALS RECEIVING SPECIALIZED VENTILATOR-DEPENDENT SERVICES

The facility must continue to meet the qualifying criteria, which will be determined by clinical staff within the MassHealth Office of Long Term Services and Supports. The facility must submit the following report on each member for whom it receives a ventilator add-on or communication-limited resident ventilator add-on to InstitutionalPrograms@mass.gov quarterly.

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____

Member identification number _____

Sex _____

Provider _____

Location _____

CHANGES SINCE LAST REPORT

Please check applicable box and provide an explanation.

☐ Benefits in addition to MassHealth
Hospitalizations ☐ Type ☐ Length of stay ☐ Treatments provided

☐ Changes to member's care plan related to respiratory therapy treatments (please describe)
☐ Other (please describe)

COMMENTS/OTHER RELEVANT INFORMATION

Has the member's functional status worsened or improved in the last 90 days? __ Yes ____ No

Explain.

_____

_____

_____

_____

Has the member's respiratory status worsened or improved in the last 90 days? __ Yes ____ No

Explain.

_____

_____

_____

_____

Has the length of time on the ventilator increased or decreased in the last 90 days? _ Yes _ No

Explain.

_____

_____

_____

_____

Summarize the care and services provided, including the respiratory services, and the member's respiratory functional status.

_____

_____

_____

_____

Additionally, submit the following documentation for the current month: medical doctor orders, treatment sheets, respiratory notes, and medication administration record (MAR).

Report submitted by

Name and title _____

Phone number _____

Date _____