NURSING FACILITY VENTILATOR DEPENDENT CARE (VDC) SERVICES ADDENDUM TO PROVIDER APPLICATION AND AGREEMENT

Please enter the requested information, print, sign and mail the Addendum along with the requested documentation to:

Division of Medicaid
Attn: Provider Enrollment
550 High Street, Suite 1000
Jackson, MS. 39201

Facility Name ____

Address/City/State and ZIP ____

NPI # ______________________________ ***Medicaid Provider ID #*** _______________________

Administrator Name ____

Email _________________________ ***Phone*** _____________________ ***Fax*** ___________________

By completing this Ventilator Dependent Care (VDC) Addendum, the above named nursing facility (NF) is requesting consideration to participate in the VDC services program for NFs to receive a VDC established reimbursement per diem rate in addition to its standard per diem reimbursement rate. Approval of participation must be received from the Mississippi Division of Medicaid (DOM) and Mississippi State Department of Health-Health Facilities Licensure and Certification (MSDH-HFLC). The effective date will be the date that DOM approves the VDC Addendum.

This Addendum verifies that the NF, ______________________________ , anticipates being in compliance on ______ / _____ / 20_____ with Miss. Admin. Code, Title 23: Medicaid, Part 207: Institutional Long-Term Care, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care, and Long-Term Care federal and state regulations for Nursing Facilities and Institutions for the Aged or Infirm. The NF will provide the documentation included in this Addendum to appropriate federal, state and local representatives upon request. These representatives include federal and state health surveyors which ensure the NF is adhering to the aforementioned Miss. Admin. Code and federal and state regulations.

DOM reserves the right to approve the Addendum at its discretion based on:

1) *Geographic coverage,*
2) *Market saturation, and/or*
3) *Ability of the NF to demonstrate compliance with certification requirements.*

The approval of the Addendum is dependent upon:

1) *Successful completion of an Addendum and submission of required documents,*
2) *Establishment of policies to support the operations of VDC services,*
3) *Successful completion of an on-site visit by MSDH-HFLC, and*
4) *Completion by the NF of all other required documents applicable to providing VDC services as requested by DOM or MSDH-HFLC.*

DOM will close an Addendum for VDC services if the provider fails to submit any requested information or documentation within thirty (30) days of a request by DOM. Once closed, the NF is not eligible to re-apply for three (3) months.

PART I: Attach the following documentation to the completed Addendum:

1. Total number of designated VDC beds that correspond with the required staffing ratios as stated in Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care.

2. Description of the equipment used for VDC and emergency resources including, but not limited to, generator, batteries, back-up equipment, along with the service and maintenance policies and plans.

3. Description of the licensed staff and all other practitioners assigned to provide VDC services including the shift for each licensed nurse/practitioner, staffing ratios and coverage plans (including emergency backup) in accordance with the Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care.

4. Documentation of a formal relationship between the NF and a local hospital for the emergency care of all ventilator dependent residents and a plan for hospitalization for all VDC residents. The plan must satisfy the following:

    a) The plan must be documented via a signed written agreement with a local hospital within twenty (20) miles or thirty (30) minutes of the NF that has an Emergency Department with the capability to treat emergencies for all of the NFs beneficiaries with ventilator dependency.

b) The agreement must also include provisions for twenty-four (24) hour access to VDC services.

c) The agreement must document the hospital's ability and willingness to service the needs of beneficiaries with ventilator dependency on an as-needed basis, in emergency situations when the entire VDC population of the unit/ventilator dependent residents must be temporarily transferred to the hospital, and the agreement should outline transfer logistics and financial responsibilities for these VDC services.

5. Name of the physician who will provide oversight of the ventilator dependent residents and the physician's current Medicaid provider number.

PART II:

VDC service providers are required to comply with the Rules promulgated in the Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care, and Long-Term Care federal and state regulations for Nursing Facilities and Institutions for the Aged or Infirm. By signing below, the NF administrator affirms that the facility possesses the capability to provide the following VDC services including, but not limited to:

1. In addition to the services required to be provided to non-ventilator dependent NF residents, the NF will provide all required mechanical ventilation services to Medicaid beneficiaries who meet the VDC criteria outlined in Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care.

2. The NF will establish long-term respiratory stability for individuals and utilize mechanical ventilation capacity efficiently and effectively. The goal is to wean individuals from mechanical ventilator dependency when medically appropriate. The NF will be proactive in identifying a beneficiary's potential to be weaned and applying weaning techniques according to evidence-based, nationally accepted practice guidelines.

3. The NF will notify DOM on official NF letterhead within ten (10) days of any change in the staffing or staffing ratio of primary Registered Nurses or the Respiratory Therapists designated for VDC (regardless of whether such staffing change resulted from resignation or for any other reason). Updates to staffing information required in Part I of this Addendum must be received within ten (10) days of the change in staffing and sent to:

- Division of Medicaid, Office of Long-Term Care, Division of Institutional/Case Mix, Secure Fax at 601-359-9521.

4. Comply with prior authorization requirements as specified in Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care. The provider cannot bill DOM for VDC services that have not been prior authorized.

5. Accept the VDC established reimbursement per diem rate as Medicaid reimbursement for residents in need of VDC services.

6. Ensure that a physician will provide oversight of the ventilator-dependent residents. Arrange for on-call availability of the Medical Director or designated physician for the NF or VDC services in the event that the resident's primary care physician is not available twenty-four (24) hours each day.

7. Provide licensed nursing and respiratory therapy services for residents in need of VDC services in accordance with Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care.

8. Ensure the availability of on-site respiratory therapy services twenty-four (24) hours per day in accordance with Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care.

9. Ensure that all services provided to non-ventilator dependent NF residents included in the NF's regular per diem rate will also be provided to the VDC residents. Only additional services related to VDC will be included in the VDC established reimbursement per diem rate.

10. DOM reserves the right to terminate the NF's Provider Agreement, including this Addendum, for failure to comply with the VDC policy as outlined in the Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care and/or citations by the MSDH-HFLC.

    a) Upon receipt of a termination notice, the NF has ten (10) days to submit a transfer plan for each VDC resident addressing the resident's individual needs including, but not limited to:

        1) Providing the residents or their representatives with a contact name and information regarding appropriate facilities for placement,

2) Contacting identified facilities on behalf of the residents,

3) Making arrangements for the safe and orderly transfer of residents, and

4) Providing counseling to residents or their representatives regarding available community resources and appropriate state or social service organizations.

b) All transfers that result from termination of the Provider Agreement, including this Addendum, must be completed within thirty (30) days from the date of the termination notice.

c) Providers notified of termination may appeal this decision pursuant to Miss. Admin. Code, Title 23, Part 300.

d) DOM reserves the right to enforce an immediate transfer of ventilator dependent residents if the NF's compliance failure is so egregious in nature that resident(s) safety is threatened.

e) Once terminated, the provider cannot reapply to provide VDC services for one (1) year from the date of termination.

PART III:

By signing this Addendum, the administrator identified below states and affirms that he or she is duly authorized to bind the NF designated above. By signing this Addendum seeking participation in the VDC services program, the administrator agrees to comply with the requirements set forth in the Miss. Admin. Code, Title 23, Part 207, Chapter 2: Nursing Facility, Rule 2.15: Ventilator Dependent Care, and Long-Term Care federal and state regulations for Nursing Facilities and Institutions for the Aged or Infirm, respectively. The administrator also agrees and understands that payment will not be received for VDC services until an approval is granted by DOM and all reimbursement criteria are met.

Administrator Name (print): ____

______________________________________ ____________________

Administrator's Signature Date

For Medicaid Use Only:

Date reviewed _______________ Reviewed by __________________________
Additional information needed:

Date requested:

Recommend:

Approved/Operational Effective Date: Initialed by ________________

Denied/Date: ____ Initialed by___________

State of Mississippi
Division of Medicaid