445 Hutchinson Avenue, Suite 700
Columbus, OH 43235
P (614) 444-2882 | F (614)444-2974
LeadingAgeOhio.org

April 1, 2026

Scott R. Partika
Director, Ohio Department of Medicaid
50 West Town Street, 4th Floor
Columbus, OH 43215

Comments on draft rule 5160-3-18, Nursing facilities (NFs): ventilator program

Dear Director Partika:

Thank you for the opportunity to review draft rule 5160-3-18 ahead of its release to offer input on updates to the Nursing Facility Ventilator Program. LeadingAge Ohio appreciates the Department's focus on strengthening program integrity, preventing fraud, waste, and abuse, and ensuring that Medicaid beneficiaries with highly complex respiratory needs receive safe, appropriate, and medically necessary care.

Our members support reforms that preserve access for medically fragile individuals while addressing vulnerabilities that may allow bad actors to exploit the program's enhanced payments. We offer the following recommendations for the Department's consideration.

Provider Eligibility Requirements

LeadingAge Ohio supports the draft's requirement for full-time staffing of a respiratory therapist, 24/7 on-call availability of respiratory therapy, specialized nursing services as well as an active contract with a pulmonologist for the management of individuals receiving ventilator services. We believe all three components are critical to a safe ventilator program, and in particular, that nursing services should not supplant the involvement of a respiratory therapist. Additionally, the rule's ambiguity on the level of pulmonologist involvement provides flexibility to allow providers to participate in the ventilator program even amidst physician shortages.

LeadingAge Ohio supports the staffing standards being applied uniformly across ventilator programs rather than stratified by billing level (non invasive, invasive, ventilator weaning). This maintains the integrity of a uniform program design.

Finally, we appreciate that the Department included our suggestion to remove facilities that have not billed for ventilator services within a twelve-month period from the program**.** We

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believe this will make the program's administration more efficient and improve accuracy of our understanding of vent program providers.

(D) Reimbursement

We appreciate the Department's maintaining separate payment levels for ventilator care and ventilator weaning. Ventilator weaning is significantly more resource-intensive and requires additional staffing, monitoring, and clinical expertise beyond maintenance ventilation.

(E) Coverage Requirements

In our earlier comments, we suggested aligning medical necessity criteria with the **Centers for Medicare & Medicaid Services requirements for non-invasive ventilation** in the community. These criteria included documented usage and benefit at an intensity of 4 hours daily, for at least 70 percent of days, as well as that the patient have clinically significant hypercapnia, (e.g., $PaCO_2$ ≥52 mmHg) confirmed by arterial blood gas. We continue to believe that aligning Medicaid's rule should align the Medicare criteria, and ask the Department to 1. reduce the hourly requirement to four hours per day, and 2. add a requirement for documented blood gas levels at or below this threshold for individuals to be eligible to be paid for non-invasive ventilation. This will provide clear criteria by which both Medicaid and managed care plans can evaluate prior authorization requests.

(F) Documentation

Under section (d), the term "flow sheet" is unclear to providers. We suggest alternate language such as respiratory and nursing "treatment administration record" for ventilator-related services.

(G) Improved Health Outcomes

We appreciate that the Department did not include hard-and-fast measures for its annual reports, and we are committed to working with our members to develop a standard format for these reports, to further ease administrative burden. That said, we recognize the importance of quality reporting and transparency, so suggest that the While this is a very frail, complex population whose metrics may look characteristically different from counterparts, it is nonetheless important that measurable outcomes be tracked, that they might drive future program improvements.

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(H) Prior authorization

We support the Department's proposal to require prior authorization for 100 percent of complex non-invasive ventilation cases. We do believe that the criteria outlined under (E) of this rule will provide clarity for both the health plan and provider on criteria for payment, but anticipate there will be a learning curve as providers change their practices. Prior authorization is an important tool to use as this rule is implemented.

Finally, we reiterate our suggestion that the Department evaluate long-term acute care hospital utilization trends to assess whether the Nursing Facility Ventilator Program has reduced costs or utilization in other areas of the Medicaid program while maintaining appropriate care.

We have greatly enjoyed the collaboration with the Department, and look forward to the rule being finalized, so that we may get to the work of educating members and ultimately, improving care for residents.

Sincerely,

Susan Wallace

President/CEO