STATE OF MARYLAND
DHMH
Medical Care Policy Administration
1-800-685-5861

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 164

October 1, 1999

Nursing Home Administrators

FROM: Joseph M. Millstone, Director
Medical Care Policy Administration

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

Proposed Amendments to Nursing Facility Services Regulations -
Fiscal Year 2000 Reimbursement Parameters

ACTION:
Emergency Regulations
Proposed Regulations (Permanent Status)

EFFECTIVE DATE:
October 1, 1999
April 1, 2000

WRITTEN COMMENTS TO:
Michele Phinney, 201 W. Preston Street
Baltimore, Maryland 21201
Fax (410) 333-7687 or
Call (410) 767-6499

PROGRAM CONTACT PERSON:
Stephen E. Hiltner, Supervisor.
Nursing Home Program
(410) 767-1447

COMMENT PERIOD EXPIRES: 11/22/99

The Maryland Medical Assistance Program proposes to amend Regulations .04, .05, .07-.11, .13, .16, .25 and to adopt new Regulation .09-1 under COMAR 10.09.10 Nursing Facility Services.

These amendments will implement significant modifications to the nursing home reimbursement system effecting payment parameters, the structure of the system, and the target occupancy percentage as recommended by a nursing home reimbursement system study group mandated by House Bill 1084 (1998). The intent is also to reimburse at a lower rate for bed hold days associated with acute hospitalization and therapeutic leave as mandated by Senate Bill 740 (1999).

Specifically, these proposed amendments will:

Remove physical and occupational therapy costs as allowable costs in the Other Patient Care cost center and establish payment procedures for these services as well as speech therapy services rendered to Medicaid recipients.

Establish the ceiling for the remaining Other Patient Care costs at 120 percent of the median regional cost, and the efficiency payment in this cost center at 25 percent of the difference between providers' costs and the ceiling with a cap on this payment at 5 percent of the ceiling.

Establish the ceiling in the Administrative and Routine cost center at 114 percent of the median regional cost, and the efficiency payment in this cost center at 50 percent of the difference between providers' costs and the ceiling.

Increase the per bed appraisal ceiling to $44, 400, the per bed equipment allowance to $4,500 and the net capital value rental rate to 8.9 percent.

Implement the results of the 1994 nursing services work measurement study resulting in significantly increased reimbursement in the Nursing cost center.

Establish the time frame for future nursing service recalibration studies and delineate procedures for revising the nursing service times each year based on data from the Program's annual nursing wage and hour survey.

Eliminate the payment for patient transition management and establish a differential payment for patients who require additional nursing time due to behavior management issues.

Establish the maximum allowable profit in the nursing cost center at 5 percent of standard per diem rates.

Change the 95 percent occupancy standard to the average statewide occupancy plus 0.5 percent.

Remove reimbursement in the nursing cost center from the rate paid to nursing home providers for bed hold days associated with acute hospitalization and therapeutic leave.

Revise the payment rate and eliminate cost reporting and wage survey obligations for providers with less than 1000 days of care in a fiscal year.

Revise the cost settlement procedure for ventilator care to better reflect providers' costs that provide this care on 50 percent or more of its Maryland Medicaid days of care.

These emergency amendments, as submitted to be published in the Maryland Register, are attached. Any questions regarding this transmittal should be directed to the Nursing Home Section of the Division of Long Term Care at (410) 767-1444 or, for nonlocal calls within Maryland, 1-800-685-5861 ext 1444.

JMM:seh
Attachments

cc: Nursing Home Liaison Committee

.04 Covered Services.

The Program covers routine care and the following supplies, equipment, and services when appropriate to meet the needs of the recipient:

A.-E. (text unchanged)

F. Specialized rehabilitative therapy services which meet the conditions listed below:

(1) - (2) (text unchanged)

(3) Speech Therapy. Speech therapy services for Medical Assistance Program purposes are those services furnished to a recipient which meet all of the following conditions:

(a) The services are directly and specifically related to a plan of care designed by the physician after any needed consultation with the qualified speech and language pathologist;

(b) The services are of such a level of complexity and sophistication or the condition of the recipient needs the judgment, knowledge, and skills of a qualified speech and language pathologist;

(c) The services are performed by or under the supervision of a qualified speech and language pathologist;

(d) The services are provided with the expectation, based on the assessment made by the physician of the recipient's restorative potential after any needed consultation with the qualified speech and language

pathologist, that the recipient will improve significantly in a reasonable, and generally predictable, period of time;

(e) The services are considered under accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and

(f) The services are reasonable and necessary to the treatment of the recipient's condition.

G.- AA. (text unchanged)

.05 Limitations.

The following are not covered:

A.- E. (text unchanged)

[F. Speech therapy services;]

[G.]F. - [H.]G. (text unchanged)

.07 Payment Procedures—Maryland Facilities.

A. (text unchanged)

B. The per diem average of all projected Medicaid payments for all cost centers shall be determined in accordance with the provisions of §A of this regulation. When this average exceeds the average determined if payment were to be made for Medical Assistance Program covered services on the basis of Medicare's principles of cost reimbursement, selected parameters of the rate determination process shall be adjusted downward in order to project a per diem patient average for Medicaid payments which does not exceed the Medicare Statewide class average. The following apply:

(1) - (2) (text unchanged)

(3) Adjustments to the parameters of the rate determination process for the Medical Assistance Program shall be effected in the following cumulative and repetitive sequence until the per diem average of all projected Medicaid payments does not exceed the Medicare Statewide class average of §B(1) of this regulation:

(a) (text unchanged)

~~[~~(b) The efficiency allowance percentage for the other patient care cost center referred to in Regulation .09B of this chapter shall be reduced by 5 percentage points unless the efficiency allowance of 25 percent has already been reached. If the per diem average of all projected Medicaid payments exceeds the Medicare Statewide class average, proceed with §B(3)(c) of this regulation.~~]~~

~~[~~(c)~~]~~ (b) The efficiency allowance percentage for the Administrative and Routine cost center referred to in Regulation .08B(2) of this chapter shall be reduced by 5 percentage points unless the efficiency allowance of 25 percent has already been reached. If the per diem average f all projected Medicaid payments exceeds the Medicare Statewide class average, proceed with ~~[~~§B(3)(d)~~]~~ §B(3)(c) of this regulation.

~~[~~(d)~~]~~ (c) The amount of allowed nursing service reimbursements referred to in Regulation .11C(2)(b) of this chapter shall be reduced by subtracting 0.005 from the specified multiplication factor. If the per diem average of all projected Medicaid payments exceeds the Medicare Statewide class average, proceed with ~~[~~§B(3)(e)~~]~~ §B(3)(d) of this regulation.

[(e)] (d) The maximum per diem rate for the Administrative and Routine cost center determined in Regulation .08E(5) of this chapter shall be lowered by 1 percentage point unless a maximum per diem rate equal to 105 percent of the lowest indexed current interim cost which is equal to the indexed current interim costs associated with at least 50 percent of the paid Medical Assistance days in the reimbursement class from the most recent desk-reviewed uniform cost reports has already been reached. If the per diem average of all projected Medicaid payments exceeds the Medicare Statewide class average, proceed with [§B(3)(f)] §B(3)(e) of this regulation.

[(f)](e) (text unchanged)

C. (text unchanged)

.08 Rate Calculation — Administrative and Routine Costs.

A. (text unchanged)

B. The final per diem rate for administrative and routine costs in each reimbursement class is the sum of:

(1) (text unchanged)

(2) An efficiency allowance equal to the lesser of 50 percent [*40* percent for the period July 1, *1998*, through June 30, *1999*] of the amount by which the allowable per diem costs in §B(1) of this regulation are below the maximum per diem rate for this cost center, or 10 percent of the maximum per diem rate for the cost center.

C. — D. (text unchanged)

E. Maximum per diem rates for administrative and routine costs in each reimbursement class shall be established according to the following:

(1) — (4) (text unchanged)

(5) The maximum per diem rate for each reimbursement class shall be [115 percent (*114* percent for the period July 1, *1998*, through June 30, *1999*)] 114 percent of the lowest aggregate indexed current interim per diem cost, from §E(1) of this regulation, which is equal to the aggregate indexed current interim per diem costs associated with at least 50 percent of the paid Medical Assistance days in the reimbursement class.

F. — G. (text unchanged)

.09 Rate Calculation—Other Patient Care Costs.

A. The Other Patient Care cost center includes:

(1) (text unchanged)

[(2) Physical therapy;
(3) Occupational therapy;]

[(4)] (2) - [(9)] (7) (text unchanged)

B. The final per diem rate for Other Patient Care costs in each reimbursement class is the sum of:

(1) (text unchanged)

(2) An efficiency allowance equal to the lesser of [50 percent (*40* percent for the period July 1, *1998* through June 30, *1999*)] 25 percent of the amount by which the allowable per diem costs in §B(1) of this regulation are below the maximum per diem rate for this cost center, or [10] 5 percent of the maximum per diem rate for the cost center.

C. — D. (text unchanged)

E. Maximum per diem rates for other patient care costs in nursing facilities shall be established using the provisions described in Regulation .08E of this chapter except that 120 percent [(*119* percent for the period July 1, *1998*, through June 30, *1999*,] of the lowest aggregate indexed current interim per diem cost which is equal to the aggregate indexed current interim costs associated with at least 50 percent of the paid Medical Assistance days in the reimbursement class shall be used instead of the percentage expressed in Regulation .08E(5) of this chapter and except that the table of monthly indices listed under Regulation .21 of this chapter shall be used instead of that presented in Regulation .20 of this chapter.

F. — G. (text unchanged)

.09 -1 Rate Calculation - Therapy Services.

A. Reimbursement for therapy services which meet the conditions as stated in Regulation .04F of this chapter is outlined in §§B. - C. of this regulation.

B. Physical, Occupational and Speech Therapy Services.

(1) Physical, occupational and speech therapy services will be reimbursed in 15 minute increments with a maximum per diem duration of 1 hour.

(2) Reimbursement rates for each type of therapy shall be calculated as a percent of an hourly rate comprised of two components from the Medicare Therapy Services Guidelines and a per diem supply cost. The hourly rate shall be the sum of:

(a) The adjusted hourly salary equivalent amount effective for the period corresponding to the State fiscal year from the Medicare guidelines.

(b) One-sixth of the total travel allowance for the period corresponding to the State fiscal year from the Medicare guidelines; and

(c) A supply allowance established at $.30 for the period October 1, 1999 through June 30, 2000 and indexed in subsequent years based on the Consumer Price Index for All Urban Consumers (CPI-U), nonprescription medical equipment and supplies component, from U.S. Department of Labor, Bureau of Labor Statistics, CPI Detailed Report, Table 4.

(3) Reimbursement rates shall be established at 25 percent of the hourly rate for a 15 minute therapy session, 50 percent of the hourly rate for a 30 minute therapy session, 75 percent of the hourly rate for a 45 minute therapy session and 100 percent of the hourly rate for a 60 minute therapy session.

(4) Providers shall be reimbursed based upon the Medicare Therapy Services Guidelines established for the geographic area in which the provider is located.

C. Reimbursement for therapy services is not subject to cost settlement.

.10 Rate Calculation—Capital Costs.

A.-K. (text unchanged)

L. The net capital value rental for those facilities which are subject to rate determination under §C of this regulation is determined through the following steps:

(1) - (3) (text unchanged)

(4) The allowable portion of the combined appraised value for land, building, and nonmovable equipment may not exceed a specified limit. This limit shall be established at [$22,000] $44,400 per licensed bed [for March 1981,] effective December 31, 1999 and shall be indexed forward as determined from §J of this regulation.

(5) (text unchanged)

(6) The allowance for movable equipment shall be:

(a) Established at [$2,200] $4,500 per licensed bed [for March 1981;] effective December 31, 1999 ;

(b)-(c) (text unchanged)

(7)-(9) (text unchanged)

(10) The value of net capital from §I(8) of this regulation shall be multiplied by [0.0911 (*0.0787* for the period July 1, *1998*, through June 30, *1999*)] 0.089 in order to generate the net capital value rental.

M.-R. (text unchanged)

.11 Rate Calculation—Nursing Service Costs.

A. — B. (text unchanged)

C. The final Medical Assistance reimbursement for nursing services is the lesser of:

(1) (text unchanged)

(2) The sum of the:

(a) (text unchanged)

(b) Amount of the reimbursements calculated under §B(1) of this regulation multiplied by [0.085 (*0.075* for the period July 1, *1998*, through June 30, *1999*)] 0.05, and

(c) — (d) (text unchanged)

D.-F. (text unchanged)

G. The resident-specific standard reimbursement rates shall be determined by the following steps:

(1) Maryland comprehensive care facilities serving Medicaid patients shall provide salary data and hours of work data at least 3 months before the start of the new rate year. These data shall be for selected personnel types for a 2-week period to be specified by the Department.

The providers who did not file a cost report for the provider's most recent fiscal period under the provisions of Regulation .13M of this chapter shall be exempt from the requirement to submit salary data and hours of work data.

(2) - (6) (text unchanged)

(7) Multiply the hourly wages plus benefits applicable to each reimbursement class by procedure and activity times using the weights associated with each personnel category to determine the nursing service unadjusted standard per diem reimbursement rates for each reimbursement class. Current procedure and activity times and personnel category weights are established by the table under Regulation .25B of this chapter, and shall be recalibrated [effective July 1, ~~1999~~, and at least every 5 years after that,] as follows:

(a) Effective July 1, 2003 and at subsequent 7 year intervals, procedure and activity times and personnel category weights shall be recalibrated based on a work measurement study of nursing procedures in nursing homes. The work measurement study sample may not include:

(I) Providers operating with a finding made by the Department of immediate jeopardy or substandard quality of care based upon deficiencies in nursing services.

(ii) Providers operating with a civil money penalty imposed by the Department or the Health Care Financing Administration in excess of $5,000.

(iii) Providers operating with a ban on admissions imposed in accordance with Health-General Article, §19-328, Annotated Code of Maryland.

(iv) Providers operating with a terminated Medicare or Medicaid provider agreement, or

(v) Any provider whose percentage of Medical Assistance days of care is more than one standard deviation below the statewide average, based on the most current data available; and

(b) In any year that procedure and activity times and personnel category weights are not recalibrated based upon a work measurement study, times and weights shall be revised based on annual wage survey data modified to exclude those providers which during the wage survey period met any of the criteria referenced in §G7(a) of this regulation.

(8)-(9) (text unchanged)

H.-Q. (text unchanged)

[R. In recognition of the intensive supervision required to acclimate certain patients to the nursing home, a provider shall be paid a patient transition management fee equal to 30 percent of the facility's heavy care rate as calculated under §G of this regulation, for up to the first 6 months, when all of the following conditions are met:

(1) The patient is admitted from a special psychiatric c. special rehabilitation facility;

(2) At the time of admission, the patient may not have been a resident of a nursing home within the previous 6 months;

(3) A physician at the discharging facility has certified that intensive supervision of the patient is required for transition to the nursing home level;

(4) The discharging facility has agreed to readmit the patient within the first 28 days if the nursing home seeks transfer of the patient; however, transitional status of the patient does not abrogate any rights of the patient as established under COMAR 10.07.09;

(5) The nursing home shall prepare and submit monthly to the Department a status report on the patient's condition which is acceptable to the Program, and which includes information on ADL classification, medications, activities, special programming, referrals to other providers, and acclimation to the facility.]

R. In recognition of the nursing time required to assist and treat patients with behavior management problems, a provider shall be paid at a differential rate to account for the added nursing time required by these patients, as follows:

(1) Behavior management rates shall apply to light and moderate level patients only;

(2) The nursing time and personnel category weights associated with days of care for behavior management patients are indicated under Regulation .25B of this chapter;

(3) The Program shall establish behavior management criteria and documentation requirements; and

(4) The utilization control agent shall review the documentation required in §R(3) of this regulation.

S. - U. (text unchanged)

.13 Cost Reporting.

A. - K. (text unchanged)

L. Except as indicated in §M of this regulation, [Administrative] administrative and routine, other patient care, and capital costs incurred by the provider exclusively for providing ventilator care are not allowed in those cost centers, but are allowable nursing service costs. These costs shall be identified and reported to the Department or its designee for the purpose of recalibrating the percentage adjustment under Regulation .11G(9)(h) of this chapter. This percentage shall be recalibrated at least every 3 years.

M. For any provider who provides ventilator care on 50 percent or more of its Maryland Medical Assistance days of care, all costs incurred by the provider exclusively for providing ventilator care are not allowable costs. At final settlement this provider will be reimbursed for each day of ventilator care at the standard per diem rate.

N. A provider which renders a minimal number of Maryland Medical Assistance days of care may not be subject to cost reporting or field verification requirements for a specified fiscal period when the following criteria are met:

(1) The provider bills the Maryland Medical Assistance Program for less than 1,000 Maryland Medical Assistance days of care during the provider's fiscal period; and

(2) The provider gives notice to the Program within 3 months after the end of the provider's fiscal period of the intent to not file a cost report for that period.

O. The notice required in §N(2) of this regulation shall include:

(1) An assurance that the provider billed the Medical Assistance Program for less that 1, 000 days of care in the fiscal period; and

(2) A statement that the provider agrees to accept as final reimbursement the average projected Medical Assistance payment calculated under Regulation .07B(2) of this chapter for each day of care rendered to a Maryland Medical Assistance recipient during the fiscal period.

.16 Selected Costs — Allowable.

The following costs are allowable in establishing interim and final per diem payment rates:

A. - B. (text unchanged)

C. Leave of Absence. The [department] Department will reimburse at the interim

per diem rates for the Administrative and Routine, Other Patient Care, and Capital cost centers, [and at the standard rate for the ADL classification the patient was assigned on the last day the patient was a resident of the facility,] less patient resources for the cost of reserving beds for recipients for therapeutic home visits or participation in State-approved therapeutic or rehabilitative programs, subject to the following conditions:

(1)-(4) (text unchanged)

D. Hospital Leave. The Department will reimburse at the interim per diem rates for the Administrative and Routine, Other Patient Care, and Capital cost centers, [and at the standard rate for the ADL classification the patient was assigned on the last day the patient was a resident of the facility,] less patient resources up to 15 days for the cost of reserving beds for patients hospitalized for an acute condition, subject to the following conditions:

(1)-(5) (text unchanged)

[E. The Department will reimburse at the standard rate for Communicable Disease Care calculated under the provisions of Regulation .11G of this chapter for patients on leave of absence in accordance with the conditions of §C of this regulation, or for patients on hospital leave in accordance with the conditions of §D of this regulation, if the patient was receiving Communicable Disease Care in accordance with Regulation .11S or T of this chapter on the last day the patient was a resident of the facility.]

[F.] E. Administrative Days. The Department will reimburse at the interim per diem rates for Administrative and Routine, Other Patient Care, and Capital cost centers, and at the standard rate for each procedure received and for the ADL classification of the patient less patient resources for administrative days, documented on forms designated by the Department, which satisfy the conditions listed below:

(1) When the recipient's required level of care has changed, and the following conditions are met:

(a) - (c) (text unchanged)

(d) Documentation.

(i) The provider has submitted documentation to the Department or its designee that it has complied with the requirements of [§F(1)(a)—(c)] §E(1)(a)-(c) of this regulation for the entire period of the administrative stay claimed for reimbursement;

(ii) (text unchanged)

(e) (text unchanged)

(2) When institutional care is no longer appropriate, and the following conditions are met:

(a) - (c) (text unchanged)

(d) Documentation.

(i) The provider has submitted documentation to the Department or its designee that it has complied with the requirements of [§F(2)(a)—(c)] §E(2)(a)-(c) of this regulation for the entire period of the administrative stay claimed for reimbursement;

(ii) (text unchanged)

(e) (text unchanged)

(3) (text unchanged)

[G.] F. Bed Occupancy.

(1) The per diem cost determined for a provider, or a distinct part thereof in a multilevel facility, shall be calculated at the actual occupancy of the nursing facility beds or at [95 percent of the licensed nursing facility bed capacity,] the Statewide average occupancy of nursing facility beds, based on the cost reports used to set the current interim rates, plus 0.5 percent, whichever is higher, for the calculation of ceilings, current interim costs, and final costs in the cost centers of Administrative and Routine, and Other Patient Care.

(2) The per diem cost determined for a provider, or a distinct part of it in a multilevel facility, shall be calculated at the actual occupancy of the nursing facility beds or at [95 percent of the licensed nursing facility bed capacity,] the Statewide average occupancy of nursing facility beds, based on the cost reports used to set the current interim rates, plus 0.5 percent, whichever is higher, for all Capital cost items exclusive of the net capital value rental.

(3) The per diem rate determined for a provider, or a distinct part of it in a multilevel facility, shall be calculated at the actual occupancy of the nursing facility beds plus 95 percent of licensed capacity of the non-nursing facility beds, or at [95 percent of the total licensed bed capacity,]

the Statewide average occupancy of nursing facility beds, based on the cost reports used to set the current interim rates, plus 0.5 percent plus 95 percent of licensed capacity of the non-nursing facility beds,

whichever is higher, for the net capital value rental.

(4) The Statewide average occupancy, referenced in §F(1)-(3) of this regulation, shall be calculated after the exclusion of all providers which operated under a waiver of the occupancy standard during any part of the cost report period.

[(4)](5) A waiver of the [95 percent] occupancy standards described in [§G(1) and (2)] §F(1) and (2) of this regulation may be made **by the Department under the following conditions:**

(a) (text unchanged)

(b) During periods throughout which [95 percent occupancy] the occupancy standard **could not be attained due to labor strike, fire, flood, or act of God, when this event is reported to the State licensing authority within 10 days of the event and request for waiver is submitted to the Program within 30 days of the event;**

(c) (text unchanged)

(d) For a period not to exceed 12 months after a new provider acquires an existing facility which has been operated by the previous provider below [95 percent occupancy] the occupancy standard due to a ban on admissions, and

when prior approval for the waiver has been granted by the Program; or

(e) (text unchanged)

[(5)] (6) When a waiver is granted under the provisions of [§G(4)(c)] §F(5)(c) of this regulation, the occupancy standards shall be applied to the reduced licensed capacity.

[(6)] (7) A waiver of the occupancy standards described in [§G(1) and (2)] §F(1) and 2 of this regulation may not be allowed due to a ban on admissions or under any circumstances other than those described in [§G(4)] §F(5) of this regulation.

[(7)] (8) The occupancy standard described in [§G(3)] §F(3) of this regulation may not be waived.

.25 Nursing Service Personnel and Procedures.

A. (text unchanged)

B. Procedure and Activity Times and Personnel Category Weights.

ADL Classifications and Procedure Types	*Daily Hours Required*	*Personnel Categories*	*Weights*
Light care	1.8418	DON	0.0401
		RN	0.0814
		LPN	0.1683
		NA	0.6075
		CMA	0.1027
Moderate care	2.3604	DON	0.0312
		RN	0.0834
		LPN	0.1670
		NA	0.6383
		CMA	0.0801
Heavy care	3.2599	DON	0.0227
		RN	0.0729
		LPN	0.1439
		NA	0.7026
		CMA	0.0579
Heavy special care	3.2599	DON	0.0227
		RN	0.0729
		LPN	0.1439
		NA	0.7026
		CMA	0.0579
Decubitus ulcer care	0.4235	RN	0.3552
		LPN	0.6448
Communicable disease care	3.3500	RN	0.1821
		LPN	0.2358
		NA	0.4388
		CMA	0.1433
Central intravenous line	1.0000	RN	1.0000
Peripheral intravenous care	0.3333	RN	1.0000

Tube feeding	0.6582	RN	0.3552
		LPN	0.6448
Ventilator care	4.1100	RN	0.5094
		LPN	0.4906
Turning and positioning	0.4273	NA	1.0000
Ostomy care	0.1147	RN	0.3552
		LPN	0.6448
Oxygen/aerosol therapy	0.1018	RN	0.3552
		LPN	0.6448
Suction/tracheotomy	0.2415	RN	0.3552
		LPN	0.6448
Injections—single	0.0913	RN	0.3552
		LPN	0.6448
Injections—multiple	0.1827	RN	0.3552
		LPN	0.6448
Light care	1.6600	DON	0.0613
		RN	0.1005
		LPN	0.2309
		NA	0.4983
		CMA	0.1090
Light care - behavior management	2.0319	DON	0.0501
		RN	0.0801
		LPN	0.2208
		NA	0.5697
		CMA	0.0793

Moderate care	2.8076	DON	0.0423
		RN	0.0883
		LPN	0.1622
		NA	0.6595
		CMA	0.0477
Moderate care - behavior management	2.9725	DON	0.0399
		RN	0.0700
		LPN	0.1467
		NA	0.6737
		CMA	0.0697
Heavy care	3.4660	DON	0.0327
		RN	0.0768
		LPN	0.1752
		NA	0.6745
		CMA	0.0408
Heavy special care	3.4660	DON	0.0327
		RN	0.0768
		LPN	0.1752
		NA	0.6745
		CMA	0.0408
Decubitus ulcer care	0.2579	RN	0.2500
		LPN	0.7500

Communicable disease care	3.3500	RN	0.1821
		LPN	0.2358
		NA	0.4388
		CM	0.1433
Central intravenous line	0.3917	RN	1.0000
Peripheral intravenous care	1.3021	RN	0.4976
		LPN	0.5024
Tube feeding	0.5145	RN	0.2275
		LPN	0.7725
Ventilator care	4.1100	RN	0.5094
		LPN	0.4906
Turning and positioning	0.4405	RN	0.0156
			0.0177
		NA	0.9629
			0.0038
Ostomy care	0.2949	LPN	0.1554
			0.7645
		CMA	0.801

Oxygen/aerosol therapy	0.1567	RN	0.2104
		LPN	0.7896
Suction/tracheotomy	0.3625	RN	0.1648
			0.8352
Injections-single	0.0884	RN	0.2552
			0.7448
Injections-multiple	0.1891	RN	0.2131
			0.7869

GEORGES C. BENJAMIN, M.D.
Secretary of Health and Mental Hygiene