MARYLAND REGISTER

Proposed Action on Regulations

Transmittal Sheet PROPOSED OR REPROPOSED Actions on Regulations	Date Filed with AELR Committee	TO BE COMPLETED BY DSD
	02/12/2018	Date Filed with Division of State Documents
		Document Number
		Date of Publication in MD Register

1. Desired date of publication in Maryland Register: 3/30/2018

2. COMAR Codification

Title	Subtitle	Chapter	Regulation
10	01	09	01 and .06
10	09	10	01, .03, .04, .06-.35

3. Name of Promulgating Authority

Department of Health and Mental Hygiene

4. Name of Regulations Coordinator **Telephone Number**
Michele Phinney 410-767-5623

Mailing Address

201 W. Preston Street

City **State** **Zip Code**
Baltimore MD 21201

Email
michele.phinney@maryland.gov

5. Name of Person to Call About this Document **Telephone No.**
Alison Donley 410-767-6541

Email Address
alison.donley@maryland.gov

6. Check applicable items:
_ New Regulations

X- Amendments to Existing Regulations

Date when existing text was downloaded from COMAR online: 9/11, 9/12, 9/14, 9/15 and 9/26/17.

X- Repeal of Existing Regulations

X- Recodification

_ Incorporation by Reference of Documents Requiring DSD Approval

_ Reproposal of Substantively Different Text:

: Md. R

(vol.) (issue) (page nos) (date)

Under Maryland Register docket no.: --P.

7. Is there emergency text which is identical to this proposal:

_ Yes **X-** No

8. Incorporation by Reference

_ Check if applicable: Incorporation by Reference (IBR) approval form(s) attached and 18 copies of documents proposed for incorporation submitted to DSD. (Submit 18 paper copies of IBR document to DSD and one copy to AELR.)

9. Public Body - Open Meeting

_ OPTIONAL - If promulgating authority is a public body, check to include a sentence in the Notice of Proposed Action that proposed action was considered at an open meeting held pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland.

_ OPTIONAL - If promulgating authority is a public body, check to include a paragraph that final action will be considered at an open meeting.

10. Children's Environmental Health and Protection

_ Check if the system should send a copy of the proposal to the Children's Environmental Health and Protection Advisory Council.

11. Certificate of Authorized Officer

I certify that the attached document is in compliance with the Administrative Procedure Act. I also certify that the attached text has been approved for legality by David Lapp, Assistant Attorney General, (telephone #410-767-5292) on October 26, 2017. A written copy of the approval is on file at this agency.

Name of Authorized Officer

Robert R. Neall

Title	**Telephone No.**
Secretary of Health	410-767-6500

Date

January 12, 2018

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Subtitle 01 PROCEDURES
10.01.09 Procedures for Hearing Before the Hospital Appeal Board and Nursing Home Appeal Board
Subtitle 09 MEDICAL CARE PROGRAMS
10.09.10 Nursing Facility Services

Authority: See proposal.

Notice of Proposed Action

[]

The Secretary of Health proposes to :
(1) Amend Regulations .01 and .06 under COMAR 10.01.09 Procedures for Hearing Before the Hospital Appeal Board and Nursing Home Appeal Board; and
(2) Amend Regulations .01, .03, .04, and .06, repeal Regulations .07, .08, .09, .09-1, .10, .11, .12, .14, .15, .16, .17, and .20—.23, amend and recodify Regulations .07-1, .07-2, .08-1, .09-2, .10-1, .11-1—.11-8, .12-1, .13, .14-1, .14-2, .15-1, .16-1, .17-1, .18, and .25 to be Regulations .08, .07, .09—.11, .14—.19, .12, .13, .20—.22, .24—.28, and .31, and recodify existing Regulations .19, .24, .26—.29, and .30 to be Regulations .29, .30, .32—.35, and .23, respectively, under COMAR 10.09.10 Nursing Facility Services.

Statement of Purpose

The purpose of this action is to repeal outdated regulations, reorganize the Nursing Facilities Services chapter, and update cross-references.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Maryland Department of Health, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499; TTY:800-735-2258, or email to mdh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through April 30, 2018. A public hearing has not been scheduled.

Economic Impact Statement Part C

A. Fiscal Year in which regulations will become effective: FY 2018
B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?

C. If 'yes', state whether general, special (exact name), or federal funds will be used:

D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:

E. If these regulations have no economic impact under Part A, indicate reason briefly: The sole purpose of the proposed action is to update the chapter by repealing outdated provisions.
F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.
See E. above.
G. Small Business Worksheet:

Attached Document:

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 01 PROCEDURES

10.01.09 Procedures for Hearing Before the Hospital Appeal Board and Nursing Home Appeal Board

Authority: Health-General Article, §15-108, Annotated Code of Maryland

10.01.09.01 (9/26/2017)

.01 General.

[These regulations set**]** *This chapter sets* out the procedures for appeals *of final cost settlements* before the Hospital Appeal Board, *pursuant to COMAR 10.09.92.10, 10.09.93.12, and 10.09.95.12,* and the Nursing Home Appeal Board, **[**of final cost settlements**]** pursuant to COMAR **[**10.09.06.18 and 10.09.10.14**]** *10.09.10.34.*

10.01.09.06

.06 Recommendation to the Board.

A. If the hearing is not conducted before a Board consisting of three members as provided in COMAR **[**10.09.06.18 and 10.09.10.14**]** *10.09.10.34, 10.09.92.10, 10.09.93.12, and 10.09.95.12*, the presiding officer or officers at the hearing shall issue recommendations to the Board on all of the issues appealed in the notice of appeal.

B.—D. (text unchanged)

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.10 Nursing Facility Services

Authority: Health-General Article, §§2-104(b), 15-103, 15-105, 19-14B-01, and 19-310.1, Annotated Code of Maryland

10.09.10.01 (09/15/2017)

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

[(1) “2012 final per diem rate” means a nursing facility per diem amount representative of the reimbursement methodology in effect before January 1, 2015 and is based on each nursing facility’s cost report ending in calendar year 2012.**]**

[(2)**]** *(1)* (text unchanged)

[(3) "Activity of daily living (ADL)" means one of five functions (bathing, dressing, mobility, continence, eating) for which nursing home residents are to be evaluated in terms of requiring help in the performance of the function.

(4) "ADL classification" means one of four categories into which a resident will be assigned on the basis of the number of activities of daily living in which the resident is found dependent during a patient assessment and the types of procedures the facility is required to provide to the resident.**]**

[(5)**]** *(2)*—**[**(11)**]** *(8)* (text unchanged)

[(12) “Change of provider status” means:

(a) A provider’s Medical Assistance participating provider number and tax identification number remain intact;

(b) The provider’s participating number will continue to be utilized for purposes of billing the Program for covered services; and

(c) One of the following occurs:

(i) The assignment, transfer, disposition, or sale of all or substantially all of a provider’s assets to another entity;

(ii) In the case of a partnership, the removal, addition, or substitution of a partner;

(iii) In the case of a limited liability company, the removal, addition, or substitution of a limited liability company member;

(iv) In the case of an unincorporated sole proprietorship, the transfer of title and property to another party;

(v) The assignment, transfer, disposition, or sale of a majority of the ownership, equity, or voting control of a provider;

(vi) The provider enters into a management, operating, or lease agreement with a third party pursuant to which the third party obtains the right to direct and control all or substantially all of the activities of the provider;

(vii) The provider files a change of name or trade name application with the Maryland Department of Assessments and Taxation; or

(viii) The provider files a change of principal office application with the Maryland Department of Assessments and Taxation.

(13) “Consolidation” means two or more providers combining to form a new business entity.**]**

[(14)**]** *(9)*—**[**(16)**]** *(11)* (text unchanged)

[(17) "Current interim costs" means those costs in the Uniform Cost Report most recently submitted by a provider to the Department or its designee and which have been desk reviewed by the Department or its designee.**]**

[(18)**]** *(12)* (text unchanged)

[(19) "Dependency" means requiring a specified level of assistance in performing one or more of the activities of daily living.

(20) "Drugs" means legend drugs (those requiring a prescription under federal or State law) and over-the-counter drugs (those not requiring a prescription under federal or State law).

(21) "Efficiency allowance" means a payment made to a provider in recognition of incurring costs below a prespecified level.

(22) “Entity” means:

(a) A receiver, trustee, guardian, personal representative, fiduciary, or representative of any kind; or

(b) Any partnership, firm, association, corporation, or other corporate form recognized by the Maryland State Department of Assessments and Taxation.**]**

[(23)**]** *(13)*—**[**(24)**]** *(14)* (text unchanged)

[(25) "Final per diem rate" means a rate established following field verification or desk review, which is applied retroactively.**]**

[(26)**]** *(15)*—**[**(27)**]** *(16)* (text unchanged)

[(28) "Health Services Cost Review Commission (HSCRC)" means the independent organization within the Department of Health which is responsible for reviewing and approving rates for hospitals pursuant to Health-General Article, §§19-201—19-222, Annotated Code of Maryland.**]**

[(29)**]** *(17)* (text unchanged)

[(30) "Indexed current interim costs" means the projection of current interim costs by means of prespecified indices from the midpoint of the cost reporting year to the midpoint of the rate or reimbursement year.

(31) "In-place" means lease and mortgage financing that is part of a formal, written contract between the facility owner-operator and the arm's-length creditor in the case of a mortgage and a formal, written lease between the facility tenant and the facility owner (landlord) in the case of a lease.

(32) "Interim per diem rate" means a rate established by the Department to pay for care rendered during the facility's fiscal year subject to retroactive adjustment to a final per diem rate.**]**

[(33)**]** *(18)* (text unchanged)

[(34) "Investor-operated facility" means a facility that is managed under the auspices of persons who actually own the facility or of related parties of the owner.**]**

[(35)**]** *(19)*—**[**(36)**]** *(20)* (text unchanged)

[(37) "Maximum per diem rate" means the maximum rate which the Department will pay a facility for care rendered to a recipient.**]**

[(38)**]** *(21)*—**[**(39)**]** *(22)* (text unchanged)

[(40) "Medical Care Programs" means the unit of the Department responsible for the administration of the Medical Assistance Program.**]**

[(41)**]** *(23)*—**[**(42)**]** *(24)* (text unchanged)

[(43) "Multilevel facility" means a facility licensed or certified to provide more than one level of care.

(44) "Net capital value rental" means the rental amount imputed to a facility by applying a prespecified rental rate to the value of the net capital.**]**

[(45)**]** *(25)* "New facility" means:

(a) A facility that has not been a provider during the previous 12-month period or, for rates effective January 1, 2015 and after, does not have a cost report in the price database as set forth in Regulation **[**.08-1B(1)**]** *.09B(1)* of this chapter; and

(b) (text unchanged)

[(46)**]** *(26)* (text unchanged)

[(47) "Non-investor-operated facility" means a facility that is managed by someone, other than an owner of the facility or related parties of the owner of the facility, who controls the use of the facility for a specified period of time through a rental arrangement or lease agreement.**]**

[(48)**]** *(27)*—**[**(49)**]** *(28)* (text unchanged)

[(50) "Original lease" means the lease in effect as of January 1, 1986 or, for a new non-investor-operated facility provider, the first lease executed to operate the facility.**]**

[(51)**]** *(29)* (text unchanged)

[(52) "Patient assessment" means the determination of the status of each facility resident by the utilization control agent with regard to the resident's dependency in each activity of daily living and the resident's authorized usage of reimbursable procedures over a specified period of time.**]**

[(53)**]** *(30)*—**[**(56)**]** *(33)* (text unchanged)

[(57)**]** *(34)* "Prospective rate" means a facility-specific quarterly per diem rate **[**effective January 1, 2015, and after,**]** based on the RUG classification system, and calculated as the sum of:

(a) Administrative and Routine rate as calculated in accordance with Regulation **[**.08-1**]** *.09* of this chapter;

(b) Other Patient Care Rate as calculated in accordance with Regulation **[**.09-2**]** *.10* of this chapter;

(c) Capital Rate as calculated in accordance with Regulation **[**.10-1**]** *.11* of this chapter; and

(d) Nursing Rate as calculated in accordance with Regulation **[**.11-7**]** *.12* of this chapter.

[(58)**]** *(35)*—**[**(60)**]** *(37)* (text unchanged)

[(61)**]** *(38)* "Quality measure" means a specific performance criterion, as described in Regulation **[**.11-3**]** *.15* of this chapter, used to assess a facility's performance level.

[(62)**]** *(39)*—**[**(64)**]** *(41)* (text unchanged)

[(65)**]** *(42)* "Reimbursement class" means the group of providers for which a separate **[**maximum per diem rate or standard**]** per diem rate will be prepared in the Administrative and Routine, Other Patient Care, and Nursing Service cost centers based on geographic region as set forth in Regulation **[**.24**]** *.30* of this chapter.

[(66)**]** *(43)*—**[**(73)**]** *(50)* (text unchanged)

[(74) "Standard per diem rates" means the predetermined daily rates of interim reimbursement for Nursing Services to be paid on behalf of Medical Assistance patients in a facility for each ADL classification and procedure when verified through a patient assessment.**]**

[(75)**]** *(51)*—**[**(81)**]** *(57)* (text unchanged)

[(82) "Unadjusted standard per diem rate" means the standard per diem rate for each ADL classification and procedure before the application of an adjustment factor, the addition of provisions for Nursing Service supplies, or the inclusion of other procedure-related supplies.**]**

[(83)**]** *(58)* (text unchanged)

[(84) "Utilization control agent" means the organization responsible for reviewing the use of nursing facility services to determine medical necessity and lengths of stay according to professional standards and for conducting patient assessments.

(85) "Value of net capital" means the value of the land, building, and equipment at the midpoint of the rate year as determined through an appraisal, minus the outstanding mortgage debt at the midpoint of the rate year.**]**

10.09.10.03 (09/11/2017)

.03 Conditions for Participation.

To participate in the Program, the provider shall:

A.—G. (text unchanged)

H. Accept payment by the Department as payment in full for covered services rendered and make no additional charge to any person for covered services except as provided for in Regulation **[**.18**]** .*28* of this chapter;

I.—V. (text unchanged)

W. Not less than 30 days before the date of any change of ownership, except when the Program agrees to a shorter period, provide the Department the notification and indemnity bond, letter of credit, or certificate of assurance required by Regulation **[**.15B(2) or .15-1C(2)(b)**]** .*25D(1)—(3)* of this chapter.

10.09.10.04 (09/11/2017)

.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.—D. (text unchanged)

E. Administrative days approved by the Department or its designee according to the conditions set forth in Regulation **[**.16E or .16-1D**]** .*26D* of this chapter.

F.—BB. (text unchanged)

10.09.10.06 (09/11/2017)

.06 Preauthorization Requirements.

A. The Department of Human Services shall certify the recipient for financial eligibility, and the Department or its designee shall certify the recipient as requiring nursing facility services, except as provided in Regulation **[**.16E or .16-1D**]** .*26D* of this chapter.

B. (text unchanged)

10.09.10.07-1 (09/11/2017)

[.07-1] .*08* Interim Working Capital Fund.

A.—C. (text unchanged)

[D. Notwithstanding the provisions of Regulation .07C(8) of this chapter, allotments shall be available, on request, after May 1, 2004.**]**

[E.**]** *D.* The maximum allotment for any provider shall be 0.015 times the total Medicaid payments to that provider in *the prior* State fiscal year **[**2003**]**.

[F.**]** *E.*—**[**I.**]** *H.* (text unchanged)

10.09.10.07-2 (09/11/2017)

[.07-2] .*07* Prospective Rates[Effective January 1, 2015].

[A. For dates of service from January 1, 2015 through December 31, 2016, a 2012 final per diem rate shall be determined based on the following from each nursing facility's cost report ending in 2012 and shall be adjusted by the nursing facility budget changes implemented from the settled 2012 rate through and including December 31, 2016:

(1) The Administrative and Routine final per diem rate identified under Regulation .08B of this chapter;

(2) The Other Patient Care final per diem rate identified under Regulation .09B of this chapter;

(3) The kosher kitchen add-ons identified under Regulations.08H and .09H of this chapter;

(4) The total amount of therapy payments identified under Regulation .09-1 of this chapter divided by the total Medicaid days excluding hospital bed hold days for the cost reporting period;

(5) The Capital component calculated as:

(a) Capital payments identified under Regulation .10 of this chapter, less the Nursing Facility Quality Assessment expense; and

(b) Divided by the total Medicaid days excluding hospital bed hold days; and

(6) The Nursing payments identified under Regulation .11C of this chapter divided by the total Medicaid days less Hospital Bed Hold Days and Therapeutic Leave Days.

B. Per diem rates paid for services beginning January 1, 2015, shall be calculated as follows:

(1) Rates paid for services January 1, 2015, through December 31, 2015, shall be calculated as the sum of:

(a) 75 percent of the 2012 final per diem rate in accordance with §A of this regulation;

(b) 25 percent of the prospective rate; and

(c) The Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter;

(2) Rates paid for services January 1, 2016, through June 30, 2016, shall be calculated as the sum of:

(a) 50 percent of the 2012 final per diem rate in accordance with §A of this regulation;

(b) 50 percent of the prospective rate; and

(c) The Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter;

(3) Rates paid for services July 1, 2016, through December 31, 2016, shall be calculated as the sum of:

(a) 25 percent of the 2012 final per diem rate in accordance with §A of this regulation;

(b) 75 percent of the prospective rate; and

(c) The Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter; and

(4) Rates paid for services after December 31, 2016, shall be calculated as 100 percent of the prospective rate plus the Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter.

C. Hold Harmless.

(1) For each provider, the Department shall determine the difference between the rate calculated in §A of this regulation excluding any budget changes implemented after June 30, 2014 and the rate calculated under §B(1)(a) and (b) of this regulation.

(2) If a provider's rate determined under §B(1)(a) and (b) of this regulation is less than the rate under §A of this regulation excluding any budget changes implemented after June 30, 2014, the provider shall be paid the rate determined under §B(1) of this regulation plus 100 percent of the amount calculated in §C(1) of this regulation.

(3) During implementation of §B(2) of this regulation, providers identified in §C(2) of this regulation shall be paid the rate determined under §B(2) of this regulation plus 50 percent of the amount calculated in §C(1) of this regulation.

D. Hold Harmless Offset.

(1) The Department shall determine the total aggregate amount under §C(1) of this regulation for all facilities for which the rate determined under §B(1)(a) and (b) of this regulation is less than the rate under §A of this regulation excluding any budget changes implemented after June 30, 2014.

(2) The Department shall determine the total aggregate amount under §C(1) of this regulation for all facilities for which the rate determined under §B(1)(a) and (b) of this regulation is greater than the rate under §A of this regulation excluding any budget changes implemented after June 30, 2014.

(3) The Department shall determine the percentage of the amount in §D(2) of this regulation that is equal to the amount calculated under §D(1) of this regulation.

(4) The Department shall identify all facilities that have a rate determined under §B(1)(a) and (b) of this regulation that is greater than the rate identified under §A of this regulation excluding any budget changes implemented after June 30, 2014.

(5) For each facility identified in §D(4) of this regulation, the Department shall multiply the amount by which §B(1)(a) and (b) of this regulation is greater than the rate identified under §A of this regulation, excluding any budget changes implemented after June 30, 2014, by the percentage determined in §D(3) of this regulation.

(6) During implementation of §B(1) of this regulation, providers identified in §D(4) of this regulation shall be paid the amount determined under §B(1) of this regulation, minus 100 percent of the amount determined under §D(5) of this regulation.

(7) During implementation of §B(2) of this regulation, providers identified in §D(4) of this regulation shall be paid the amount determined under §B(2) of this regulation, minus 50 percent of the amount determined under §D(5) of this regulation.**]**

A. A provider shall be paid the prospective rate for nursing facility services as defined in Regulation .01B of this chapter plus the Nursing Facility Quality Assessment add-on identified in Regulation .11E of this chapter.

[E.**]** *B.* When necessary, each facility's per diem rate **[**paid for services January 1, 2015 and after**]** shall be reduced by the same percentage to maintain compliance with the Medicare upper payment limit requirement.

[F.**]** *C.* Power wheelchairs and bariatric beds are not included in **[**either the 2012 final per diem rate or**]** the prospective rate, but may be preauthorized for payment in accordance with COMAR 10.09.12.

[G.**]** *D.* Support Surfaces.

(1) Support surfaces are not included in **[**either the 2012 final per diem rate or**]** the prospective rate.

(2)—(4) (text unchanged)

[H.**]** *E.* Negative pressure wound therapy is not included in **[**either the 2012 final per diem rate or**]** the prospective rate, but is reimbursed in accordance with rates established under COMAR 10.09.12. Reimbursement shall include the cost of pumps, dressings, and containers associated with this procedure.

[I.**]** *F.* Nursing facilities that are owned and operated by the State are not paid in accordance with the provisions of **[**§§A—C**]** *§A* of this regulation, but are reimbursed reasonable costs based upon Medicare principles of reasonable

costs as described at 42 CFR Part 413. Aggregate payments for these facilities may not exceed Medicare upper payment limits as specified at 42 CFR §447.272. If the Medicare upper payment limit is above aggregate costs for this ownership class, the State may elect to make supplemental payments to increase payments up to the Medicare upper payment limit.

[J. Final facility rates for the period July 1, 2015 through December 31, 2015 shall be each nursing facility's quarterly rate reduced by the budget adjustment factor of 1.96 percent plus the Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter.

K. Final facility rates for the period January 1, 2016 through June 30, 2016 shall be each nursing facility's quarterly rate reduced by the budget adjustment factor of 3.28 percent plus the Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter.

L. Final facility rates for the period July 1, 2016 through December 31, 2016 shall be each nursing facility's quarterly rate, exclusive of the amount identified in Regulation .11-8A(2) of this chapter, reduced by the budget adjustment factor of 6.076 percent, plus the Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter and the ventilator care add-on amount identified in Regulation .11-8A(2) of this chapter when applicable.

M. Final facility rates for the period January 1, 2017 through June 30, 2017 shall be each nursing facility's quarterly rate, exclusive of the amount identified in Regulation .11-8A(2) of this chapter, reduced by the budget adjustment factor of 8.212 percent, plus the Nursing Facility Quality Assessment add-on identified in Regulation .10-1E of this chapter and the ventilator care add-on amount identified in Regulation .11-8A(2) of this chapter when applicable.**]**

[N.**]** *G.* Final facility rates for the period July 1, 2017 through June 30, 2018 shall be each nursing facility's quarterly rate, exclusive of the amount identified in Regulation **[**.11-8A(2)**]** *.13A(2)* of this chapter, reduced by the budget adjustment factor of 9.652 percent, plus the Nursing Facility Quality Assessment add-on identified in Regulation **[**.10-1E**]** *.11E* of this chapter and the ventilator care add-on amount identified in Regulation **[**.11-8A(2)**]** *.13A(2)* of this chapter when applicable.

10.09.10.08-1 (09/12/2017)

[.08-1] .*09* Rate Calculation — Administrative and Routine Costs[for Rates Effective January 1, 2015].

A.—E. (text unchanged)

F. The reimbursement classes for the Administrative and Routine cost center are specified under Regulation **[**.24A**]** *.30A* of this chapter.

G. (text unchanged)

10.09.10.09-2 (09/12/2017)

[.09-2] .*10* Rate Calculation — Other Patient Care Costs[for Rates Effective January 1, 2015].

A. (text unchanged)

B. The Department shall initially establish Other Patient Care prices for the rate period January 1, 2015, through June 30, 2015, and thereafter rebase the Other Patient Care prices between every 2 and 4 rate years. Prices may be rebased more frequently if the Department determines that there is an error in the data or in the calculation that results in a substantial difference in payment, or if a significant change in provider behavior or costs has resulted in payment that is inequitable across providers. The Department shall rebase based on the following steps:

(1) The indexed costs shall be calculated as set forth in Regulation **[**.08-1B(1)—(3)**]** *.09B(1)—(3)* of this chapter;

(2) (text unchanged)

(3) For each reimbursement class, each cost report's Medicaid resident days shall be used in the array of Other Patient Care cost per diems identified in §B(2) of this regulation to calculate the Other Patient Care Medicaid day weighted median using the method established in Regulation **[**.08-1B(5)**]** *.09B(5)* of this chapter;

(4) (text unchanged)

(5) For years between periods when the prices are rebased, the final price for Other Patient Care costs shall be calculated as set forth in Regulation **[**.08-1D**]** *.09D* of this chapter.

C. (text unchanged)

D. The reimbursement classes for the Other Patient Care cost center are specified under Regulation **[**.24B**]** *.30B* of this chapter.

E. Kosher Kitchen Add-on.

(1) (text unchanged)

(2) For years between periods when the kosher kitchen add-ons are rebased, the kosher kitchen add-on shall be calculated as the prior year kosher kitchen add-on multiplied by the rate year monthly index divided by the prior year monthly index as identified in Regulation **[**.08-1B(3)(a)**]** *.09B(3)(a)* of this chapter.

10.09.10.10-1 (09/12/2017)

[.10-1] .*11* Rate Calculation — Capital Costs[for Rates Effective January 1, 2015].

A. (text unchanged)

B. Final Capital Cost.

(1) The determination of a provider's allowable final Capital per diem rate for the cost items under §A of this regulation is calculated as follows:

(a)—(j) (text unchanged)

(k) Divide the facility's annual fair rental value by the greater of actual resident days, or days at full occupancy times an occupancy standard calculated under Regulation **[**.08-1B(4)**]** *.09B(4)* of this chapter, to establish a fair rental value per diem rate;

(l) Divide real estate taxes obtained from the most recent desk reviewed cost report available 2 months before the start of the rate year by the greater of actual resident days, or days at full occupancy times an occupancy standard calculated under Regulation **[**.08-1B(4)**]** *.09B(4)* of this chapter, to establish a real estate tax per diem rate; and

(m) (text unchanged)

(2) (text unchanged)

C. (text unchanged)

D. The provider may protest the appraisal by submitting written notification to the Department within 90 days of receipt of the appraisal. If the protest cannot be resolved administratively, the provider may appeal under Regulation **[**.28**]** *.34* of this chapter.

E. (text unchanged)

10.09.10.11-1 (09/12/2017)

[.11-1] *.14* Pay-for-Performance — Eligibility.

In order to be eligible to receive funds through the pay-for-performance program under the provisions of Regulations **[**.11-2—.11-6**]** *.15—.19* of this chapter:

A.—B. (text unchanged)

10.09.10.11-2 (09/12/2017)

[.11-2] *.15* Pay-for-Performance — Quality Measures.

A. (text unchanged)

B. Staffing Levels.

(1) (text unchanged)

(2) Each Maryland facility covered by these regulations which fails to comply with §B(1) of this regulation shall incur a 1 percentage point reduction in its applicable rental rate presented in Regulation **[**.10-1B(1)(i) or (j)**]** *.11B(1)(i) or (j)* of this chapter.

(3) (text unchanged)

(4) A facility's average acuity shall be determined based on the facilities Minimum Data Set Resource Utilization Groups (RUG) during the 6-month period ending December 31 of the most recent State fiscal year. To establish expected staffing hours, each RUG group will be multiplied by the corresponding hours under Regulation **[**.25C**]** *.31B* of this chapter and divided by the total days of care during the same period.

(5) The result from **[**§B(3)**]** *§B(4)* of this regulation shall be multiplied by 1.26555 in order to establish the facility's staffing goal.

(6) The facility's staffing level from **[**§B(2)**]** *§B(3)* of this regulation shall be divided by the facility's staffing goal from **[**§B(4)**]** *§B(5)* of this regulation in order to determine a score based on its percentage of the goal. A facility staffing exceeding its goal shall be scored at 100 percent.

(7) Providers shall receive 0—20 points based upon the scoring methodology described under Regulation **[**.11-3**]** *.16* of this chapter.

C. Staff Stability.

(1)—(2) (text unchanged)

(3) Providers shall receive 0—20 points based upon the scoring methodology described under Regulation **[**.11-3**]** *.16* of this chapter.

D. Family Satisfaction.

(1) (text unchanged)

(2) Providers shall receive 0—40 points based upon the scoring methodology described under Regulation **[**.11-3**]** *.16* of this chapter, as follows:

(a)—(b) (text unchanged)

E. Minimum Data Set Clinical Quality Indicators.

(1) (text unchanged)

(2) Providers shall receive 0—2.67 points for each quality indicator based on the scoring methodology described under Regulation **[**.11-3**]** *.16* of this chapter.

[(3) Payments distributed during State fiscal year 2012 shall be based upon scores for the 3-month period ending September 30, 2010, rather than the period indicated under §E(1) of this regulation.**]**

F.—G. (text unchanged)

10.09.10.11-3 (09/12/2017)

[.11-3] .*16* Pay-for-Performance — Scoring Methodology.

A. Facilities that are eligible for pay-for-performance under Regulation **[**.11-1**]** .*14* of this chapter shall receive a score for each quality measure described in Regulation **[**.11-2**]** .*15* of this chapter.

B. For the quality measures described in Regulation **[**.11-2B—E**]** .*15B—E* of this chapter, a facility is ranked and awarded points as follows:

(1)—(4) (text unchanged)

C. (text unchanged)

10.09.10.11-4 (09/14/2017)

[.11-4] .*17* Pay-for-Performance — Payment for Improvement.

A. In order to be eligible for improvement payment, a facility:

(1) Shall meet the eligibility criteria specified in Regulation **[**.11-1**]** .*14* of this chapter;

(2) (text unchanged)

(3) May not be receiving a payment based upon its score as described in Regulation **[**.11-6C**]** .*19C* of this chapter.

B. (text unchanged)

10.09.10.11-5 (09/14/2017)

[.11-5] .*18* Pay-for-Performance — Scoring Data Review.

A. The Department shall report scores for pay-for-performance quality measures in Regulation **[**.11-2**]** .*15* of this chapter, on or about July 1 of each year, based on data compiled during the prior fiscal year.

B.—C. (text unchanged)

10.09.10.11-6 (09/14/2017)

[.11-6] .*19* Pay-for-Performance — Payment Distribution.

A.—B. (text unchanged)

C. Eighty-five percent of the amount identified in §A or B of this regulation shall be distributed to the highest scoring facilities, representing 35 percent of the eligible days of care, in accordance with the methodology described in Regulation **[**.11-3**]** .*16* of this chapter.

D. (text unchanged)

E. Fifteen percent of the amount identified in §A or B of this regulation shall be distributed to the facilities that qualify for payment for improvement in accordance with Regulation **[**.11-4**]** .*17* of this chapter.

F.—G. (text unchanged)

10.09.10.11-7 (09/14/2017)

[.11-7] .*12* Rate Calculation — Nursing Service Costs[for Rates Effective January 1, 2015].

A. (text unchanged)

B. The Department shall initially establish Nursing Service prices for the rate period January 1, 2015, through June 30, 2015, and thereafter rebase the Nursing Service prices between every 2 and 4 rate years. Prices may be rebased more frequently if the Department determines that there is an error in the data or in the calculation that results in a substantial difference in payment, or if a significant change in provider behavior or costs has resulted in payment that is inequitable across providers. The Department shall rebase based on the following steps:

(1) The indexed costs shall be calculated as set forth in Regulation **[**.08-1B(1)—(3)**]** .*09B(1)—(3)* of this chapter;

(2)—(3) (text unchanged)

(4) For each reimbursement class, each cost report's Medicaid resident days shall be used in the array of cost per diems identified in §B(3) of this regulation to calculate the Medicaid day weighted median using the method established in Regulation **[**.08-1B(5)**]** .*09B(5)* of this chapter;

(5) (text unchanged)

(6) For years between periods when the prices are rebased, the final price for Nursing Service costs shall be adjusted as set forth in Regulation **[**.08-1D**]** .*09D* of this chapter.

C. The final Nursing Service rate for each nursing facility for each quarter is calculated as follows:

(1)—(4) (text unchanged)

(5) For years between periods when the prices are rebased, the indexed Nursing Service cost per diem identified under §B(2) of this regulation shall be adjusted as set forth in Regulation **[**.08-1D**]** .*09D* of this chapter.

D. The reimbursement classes for the Nursing Service cost center are specified under Regulation **[**.24C**]** .*30C* of this chapter.

E.—G. (text unchanged)

10.09.10.11-8 (09/15/2017)

[.11-8] .*13* Ventilator Care Nursing Facilities[Effective January 1, 2015].

Nursing facilities with licensed nursing facility beds, which have been determined by the Department to meet the standards for ventilator care under COMAR 10.07.02, shall be reimbursed as follows:

A. Services for residents receiving ventilator care shall be reimbursed as follows:

(1) The Nursing Service rate identified in Regulation **[**.11-7**]** *.12* of this chapter shall be calculated with a facility average Medicaid case mix index that includes only residents receiving ventilator care; and

(2) (text unchanged)

[B. Rates under §A of this regulation shall be paid in full and are not subject to the phase-in provisions identified in Regulation .07-2B of this chapter;**]**

[C.**]** *B.* The facility average Medicaid case mix index for rates under §A of this regulation are not subject to the Medicaid case mix index equalizer adjustment in Regulation **[**.11-7F(6)**]** *.12F(6)* of this chapter;

[D.**]** *C.*—**[**E.**]** *D.* (text unchanged)

[F.**]** *E.* For years between periods when the Nursing Services prices are rebased, the final price for Ventilator costs shall be adjusted as set forth in Regulation **[**.08-1D**]** *.09D* of this chapter; and

[G. Services for**]** *F. For* residents not receiving ventilator care **[**shall be reimbursed as follows:

(1) The**]** *the* Initial Facility Nursing Service rate identified in Regulation **[**.11-7**]** *.12* of this chapter shall be calculated with a facility average Medicaid case mix index that excludes residents receiving ventilator care**[**;

(2) The 2012 final settlement per diem identified in Regulation .07-2B of this chapter shall be calculated exclusive of ventilator care costs; and

(3) The 2012 final settled per diem for nursing services exclusive of ventilator costs shall be calculated as follows:

(a) Determine the ratio of settled 2012 nursing costs, including incentives and add-ons, to interim payments;

(b) Multiply the ratio by 2012 interim payments for ventilator payments including heavy special daily rate payments and add-on payments included in additional procedures payments;

(c) Subtract the result from the total settled 2012 nursing cost including incentives and add-ons to compute the 2012 final settled per diem for nursing services exclusive of ventilator costs; and

(d) Divide by Medicaid patient days exclusive of Medicaid ventilator days per the 2012 final settlement report for nursing**]**.

10.09.10.12-1 (09/15/2017)

[.12-1] *.20* Payment Procedures — Out-of-State Facilities[for Rates Effective January 1, 2015].

A. Out-of-State nursing facilities that are not special rehabilitation nursing facilities and do not meet the exception to cost reporting requirements set forth in Regulation **[**.13N**]** *.21M* of this chapter shall be reimbursed at a rate that is the lesser of:

(1) The average Statewide quarterly rate identified by Regulation **[**.07-2**]** *.07* of this chapter for in-State nursing facilities minus the quality assessment; and

(2) (text unchanged)

B. Out-of-State nursing facilities that are not special rehabilitation nursing facilities and do meet the exception to cost reporting requirements set forth in Regulation **[**.13N**]** *.21M* of this chapter shall be reimbursed the average Statewide quarterly rate identified by Regulation **[**.07-2**]** *.07* of this chapter for in-State nursing facilities minus the quality assessment.

C. Out-of-State special rehabilitation nursing facilities shall be reimbursed by the Program when the following conditions are met:

(1)—(2) (text unchanged)

(3) Services for which reimbursement is requested have been preauthorized by the Program **[**and subject to all utilization review requirements of Regulation .11I of this chapter or the MDS validation requirement of Regulation .11-7G of this chapter**]**.

D. (text unchanged)

10.09.10.13 (09/15/2017)

[.13] *.21* Cost Reporting.

A.—D. (text unchanged)

E. Financial and Statistical Data Required.

(1) (text unchanged)

[(2) The provider shall submit nursing cost report data, in the form prescribed, for costs incurred from the end of their most recent fiscal period through June 30, 2003, by September 30, 2003.

(3) If reports ending December 31, 2014 or before are not received within 3 months and an extension has not been granted, the Department shall withhold from the provider 10 percent of the interim payment for services provided during the calendar month after the month in which the report is due and any subsequent calendar month through the month during which the report has been submitted. This amount shall be repaid to the provider upon final cost settlement for the fiscal year from which the payments were withheld.**]**

[(4)**]** *(2)* If reports **[**ending after December 31, 2014**]** are not received within 3 months and an extension has not been granted, the Department shall reduce the per diem rate by 3 percent for services provided during the calendar month after the month in which the report is due and any subsequent calendar month through the month during which the report has been submitted.

[(5)**]** *(3)*—**[**(6)**]** *(4)* (text unchanged)

F. When a report is not submitted by the last day of the sixth month after the end of the provider's fiscal year, the Department shall impose one or more sanctions as provided for in Regulation **[**.27**]** *.33* of this chapter.

[G. When a report ending December 31, 2014 or before is not submitted by the last day of the sixth month after the end of the provider's fiscal year, or a report ending December 31, 2014 or before is submitted but the provider cannot furnish proper documentation to verify costs, the Department shall make final cost settlement for that fiscal year at the last final per diem rates for which the Department has verified costs for that facility, provided that the rates established will not exceed the maximum per diem rates in effect when the facility's costs were last settled.**]**

[H.**]** *G.* For purposes of **[**§§E—G**]** *§§E and F* of this regulation, reports are considered received when the submitted reports are completed according to instructions issued by the Department or its designee.

[I.**]** *H.*—**[**J.**]** *I.* (text unchanged)

[K.**]** *J.* If the Department exercises its option under the provisions of **[**§J**]** *§I* of this regulation, the period covered by the two reports in the specific provider's fiscal year shall be divided as follows:

[L.**]** *K.* Except as indicated in **[**§M**]** *§L* of this regulation, administrative and routine, other patient care, and capital costs incurred by the provider exclusively for providing ventilator care are not allowed in these cost centers, but are allowable nursing service costs. **[**For payments for dates of service on or before December 31, 2014, 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.**]** *L.* 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, for payments for dates of service on or before December 31, 2014, this provider will be reimbursed for each day of ventilator care at the standard per diem rate.**]**

[N.**]** *M.* (text unchanged)

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

(1) (text unchanged)

(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, or for rates effective after December 31, 2014, **]**the average rate paid to all other nursing facilities in the facility's geographic region identified in Regulation **[**.24A**]** *.30A* of this chapter, minus the quality assessment add-on for facilities that are exempt from Nursing Facility Quality Assessment identified in COMAR 10.01.20.

[P.**]** *O.* (text unchanged)

10.09.10.14-1 (09/15/2017)

[.14-1] .*22* Desk Reviews and Field Verification[for Rates Effective January 1, 2015].

A.—B. (text unchanged)

10.09.10.14-2 (09/15/2017)

[.14-2] .*24* MDS Validation and Ventilator Care Validation[for Rates Effective January 1, 2015].

A.—B. (text unchanged)

10.09.10.15-1 (09/15/2017)

[.15-1] .*25* New Nursing Facilities, Replacement Facilities, and Change of Ownership[for Rates Effective January 1, 2015].

A. (text unchanged)

B. New Nursing Facilities.

(1) Until such time as an appraisal for the new facility is available as set forth in Regulation **[**.10-1B(1)(b)**]** *.11B(1)(b)* of this chapter, the fair rental value per diem rate shall be based on the lower of the facility's construction costs plus the assessed land value divided by the number of licensed beds, or the maximum appraised value per bed in Regulation **[**.10-1B(1)(g)**]** *.11B(1)(g)* of this chapter.

(2) (text unchanged)

(3) The nursing facility shall be assigned to the appropriate geographic region, as specified under Regulation **[**.24**]** *.30* of this chapter, for purposes of assigning the Nursing Service rate, the Other Patient Care price, and the Administrative and Routine price.

(4) (text unchanged)

(5) The fair rental value per diem rate shall use days as the greater of total estimated resident days or days at full occupancy times an occupancy standard calculated under Regulation **[**.08-1B(4)**]** *.09B(4)* of this chapter and the

maximum bed value identified in Regulation **[**.10-1B(1)(g)**]** *.11B(1)(g)* of this chapter. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation **[**.16-1F**]** *.26F* of this chapter, the fair rental value per diem rate shall be calculated using estimated resident days. At the completion of the waiver period, either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(6) Upon providing the real estate bills to the State which incorporate the new construction at least 15 days before the start of operations or at least 15 days before the beginning of any calendar quarter, the real estate tax per diem rate shall be calculated in accordance with Regulation **[**.10-1B(1)(l)**]** *.11B(1)(l)* of this chapter. This amount shall be used for the period from the time of submission until the next facility cost report is filed. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation **[**.16-1F**]** *.26F* of this chapter, the real estate tax per diem rate shall be calculated using estimated resident days. At the completion of the waiver period, either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(7) (text unchanged)

C. Replacement Facilities.

(1) Until such time as an appraisal for the replacement facility is available as set forth in Regulation **[**.10-1B(1)(b)**]** *.11B(1)(b)* of this chapter, the fair rental value per diem rate shall be based on the lower of the facility's construction costs plus the assessed land value divided by the number of licensed beds, or the maximum appraised value per bed in Regulation **[**.10-1B(1)(g)**]** *.11B(1)(g)* of this chapter.

(2) The fair rental value per diem rate shall use days as the greater of total estimated resident days or days at full occupancy times an occupancy standard calculated as the Statewide average under Regulation **[**.08-1B(4)**]** *.09B(4)* of this chapter. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation **[**.16-1F**]** *.26F* of this chapter the fair rental value per diem rate shall be calculated using estimated resident days. At the completion of the waiver period either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(3) Upon providing the real estate bills to the State, which incorporate the new construction, at least 15 days before the start of operations or at least 15 days before the beginning of any calendar quarter, the real estate tax per diem rate shall be calculated in accordance with Regulation **[**.10-1B(1)(l)**]** *.11B(1)(l)* of this chapter. This amount shall be used for the period from the time of submission until the next facility cost report is filed. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation **[**.16-1F**]** *.26F* of this chapter, the real estate tax per diem rate shall be calculated using estimated resident days. At the completion of the waiver period either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(4)—(6) (text unchanged)

D. Change of Ownership.

(1) Except when the Program agrees to a shorter notification period, when there is an anticipated change of ownership of a provider, not less than 30 days before the date of the change of ownership:

(a) (text unchanged)

(b) The purchaser shall:

(i) (text unchanged)

(ii) Submit a provider application and execute a provider agreement with the Department **[**before being assigned new interim per diem rates**]**; and

(iii) (text unchanged)

(2) Indemnity Bond or Standby Letter of Credit.

(a) The indemnity bond or standby letter of credit required by §D(1)(a)(ii) or (b)(iii) of this regulation shall be in the amount of:

(i)—(iii) (text unchanged)

(iv) All debt owed by the provider to the Interim Working Capital Fund under Regulation **[**.07-1**]** *.08* of this chapter.

(b)—(c) (text unchanged)

(3)—(4) (text unchanged)

(5) The new owner shall be paid at the same rates as the old nursing facility provider except for the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation **[**.16-1F**]** *.26F* of this chapter in which the Capital rate shall be calculated using estimated resident days. At the completion of the waiver period either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

10.09.10.16-1 (09/15/2017)

[.16-1] *.26* Selected Costs — Allowable[for Payments for Services Provided Effective January 1, 2015].

A.—B. (text unchanged)

C. Leave of Absence. The Department shall pay the sum of the rates identified in Regulations **[**.08-1, .09-2 and .10-1**]** *.09—.11* of this chapter, 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. Administrative Days. The Department shall pay the sum of the rates identified in Regulations **[**.08-1, .09-2, and .10-1**]** *.09—.11* of this chapter, and 50 percent of the rate identified in Regulation **[**.11-7**]** *.12* of this chapter, less patient resources for administrative days, documented on forms designated by the Department, which satisfy the following conditions:

(1)—(3) (text unchanged)

E. Bed Occupancy. The Statewide average occupancy, defined in Regulation **[**.08-1B(4)**]** *.09B(4)* of this chapter, 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.

F. A waiver of the occupancy standards defined in Regulation **[**.08-1B(4)**]** *.09B(4)* of this chapter may be made by the Department under the following conditions:

(1)—(6) (text unchanged)

G. (text unchanged)

H. A waiver of the occupancy standards defined in Regulation **[**.08-1B(4)**]** *.09B(4)* of this chapter may not be allowed due to a ban on admissions or under any circumstances other than those described in §F of this regulation.

I. (text unchanged)

10.09.10.17-1 (09/15/2017)

[.17-1] *.27* Selected Costs — Not Allowable[for Payments for Services Provided Effective January 1, 2015].

The following costs are not allowable in establishing prospective rates:

A.—K. (text unchanged)

L. Interest paid by a provider under **[**Regulations .14J(2) or .30E(5)**]** *Regulation .23E(5)* of this chapter;

M.—T. (text unchanged)

U. Legal, accounting, and other professional expenses related to an appeal challenging a payment determination pursuant to Regulations [.28 and .30E**]** *.23E and .34* of this chapter unless a final adjudication is issued sustaining the nursing facility's appeal;

V.—X. (text unchanged)

10.09.10.18 (09/15/2017)

[.18] *.28* Recipient's Resource.

A.—B. (text unchanged)

C. The total of a recipient's available resource for medical or remedial care and the Department's payment may not exceed the provider's **[**interim**]** per diem rate.

D. (text unchanged)

[.19] *.29* (text unchanged)

[.24] *.30* (text unchanged)

10.09.10.25 (09/15/2017)

[.25] *.31* Nursing Service Personnel and Procedures.

A. (text unchanged)

[B. Procedure and Activity Times and Personnel Category Weights. Effective for the period July 1, 2006 — June 30, 2007.

ADL Classifications and Procedure Type	Daily Hours Required	Personnel Categories	Weights
Light care	2.6597	DON	0.0206
		RN	0.1053
		LPN	0.3014
		NA	0.4270
		CMA	0.1457
Moderate care	3.4383	DON	0.0164
		RN	0.1023

		LPN	0.2264
		NA	0.5328
		CMA	0.1221
Heavy care	3.6300	DON	0.0149
		RN	0.1007
		LPN	0.1932
		NA	0.5801
		CMA	0.1111
Heavy special care	4.3613	DON	0.0122
		RN	0.1158
		LPN	0.2644
		NA	0.5148
		CMA	0.0927
Decubitus ulcer care	0.3517	RN	0.3627
		LPN	0.6373
Central intravenous line	0.7750	RN	0.6316
		LPN	0.3684
Peripheral intravenous care	0.4283	RN	0.4507
		LPN	0.5493
Tube feeding	0.8160	RN	0.3673
		LPN	0.6327
Ventilator care	4.1100	RN	1.0000
Turning and positioning	0.4405	RN	0.0156
		LPN	0.0177
		NA	0.9629
		CMA	0.0038
Oxygen/aerosol therapy	0.0928	RN	0.4559
		LPN	0.5441
Suction/tracheotomy	1.0034	RN	0.5378
		LPN	0.4622**]**

[C.**]** *B.* (text unchanged)

[.26] ***.32*****—[.29]** ***.35*** (text unchanged)

[.30] ***.23*** (text unchanged)

ROBERT R. NEALL

Secretary of Health