

# NURSING FACILITY ENHANCED DIRECT CARE STAFF RATE

Open Enrollment Webinar  
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A project of  
the Texas Health and Human Services Commission (HHSC)

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## BACKGROUND

### **76<sup>th</sup> Legislature: Senate Bill 1, Article II, DHS Rider 38**

"Contingency Appropriation: Nursing Facility Staffing and Quality of Care. Out of the amounts appropriated above, the Texas Department of Human Services is appropriated \$15,800,000 in general revenue funds and \$25,185,733 in federal funds for fiscal year 2000 for reimbursement increases for nursing homes and hospice care. Contingent upon certification by the Health and Human Services Commissioner of the adoption of agency rules that incentivize increased direct care staffing and direct care wages and benefits in nursing homes, the amounts of \$15,800,000 in general revenue funds and \$25,090,269 in federal funds appropriated above may be expended for fiscal year 2001 for reimbursement increases for nursing homes and hospice. The Commissioner shall make the certification to the Governor and the Legislative Budget Board by July 1, 2000, and the certification must be accompanied by supporting documentation detailing how the agency will ensure that providers will comply with the new staffing reimbursement rules, as well as other supporting materials specified by the Governor or the Legislative Budget Board. These funds are appropriated for the purpose of improving the quality of care for nursing home and hospice clients."

### **77<sup>th</sup> Legislature: Senate Bill 1, Article II, DHS Rider 44**

Of the funds appropriated for NF and hospice rate increases, \$20 million in general revenue (approximately \$52 million state and federal) per year of the biennium "may only be expended to improve the quality of care in nursing homes."

"In determining improvement of quality of care," the DHS Commissioner "shall utilize standards provided by Senate Bill 1839." If SB 1839 does not provide quality of care standards, "the Commissioner may only expend funds subject to this provision after promulgation of rules and standards to improve the quality of nursing facility care in accordance with those standards and upon distribution of such rules and standards to each member of the legislature."

### **77<sup>th</sup> Legislature: Senate Bill 1839, Article 10, Rates Paid for Nursing Home Services**

The Health and Human Services Commission shall ensure that NF rate determination rules improve quality of care by: providing incentives for increasing direct care staff and direct care wages and benefits; and if appropriated funds are available after allocation for incentive-based rates (referenced above), providing incentives that incorporate the use of a quality of care index, customer satisfaction index, and a resolved complaint index developed by the commission.

**78<sup>th</sup> Legislature: House Bill 2292, Section 2.102**

The Health and Human Services Commission shall ensure that rules governing the incentives program:

- (1) provide that participation in the program by a nursing home is voluntary;
- (2) do not impose on a nursing home not participating in the program a minimum spending requirement for direct care staff wages and benefits;
- (3) do not set a base rate for a nursing home participating in the program that is more than the base rate for a nursing home not participating in the program.

**78<sup>th</sup> Legislature: House Bill 1; HHSC Rider 46**

**Medicaid Provider Reimbursement – Application of Fiscal Year 2004-05 Reductions.** It is the intent of the Legislature that the Health and Human Services Commission shall apply Medicaid reimbursement rate reductions, required by fiscal year 2004-05 appropriation levels, as follows:

Reductions related to any long term care budget strategy shall be calculated without rebasing of current reimbursement factors and shall be shared equally across all Medicaid providers funded by the strategy.

## **METHODOLOGY: KEY FEATURES AND MODIFICATIONS**

- May 1, 2000 – Implementation of the enhanced rate system is expedited to promote increased direct care staffing and introduce accountability for direct care spending.
  - Enhanced payments are made available on a voluntary basis to nursing homes agreeing to maintain required staffing levels for nurses and nurse aides.
  - Homes not spending at least 85 percent of the portion of Medicaid rates linked to direct care staff costs—i.e., nurse and nurse aide compensation—are subject to recoupment of unspent funds.
  - Homes not meeting direct care staff spending requirement may mitigate all or part of recoupment if dietary or property spending exceeds those components of the rate.
- January 1, 2001 – Implementation of first set of features to increase provider flexibility and improve system functioning.
  - Entities that control more than one NF contract may request to have their contracts' compliance with spending requirements determined in the aggregate.
  - Enrollment in the enhancement program may “rollover” from one enrollment period to the next without the provider having to submit additional paperwork.
  - Homes that miss their self-selected staffing targets by two or more minutes are subject to an interest charge on recouped funds.
- September 1, 2001 – Implementation of second set of features to increase provider flexibility and improve system functioning.
  - Homes receiving enhanced staffing payments but not fully meeting staffing requirements may mitigate recoupment to the extent that enhanced payments are spent on direct care staff compensation.
  - Homes not meeting spending requirements may mitigate all or part of recoupment depending on performance scores reflecting regulatory outcomes and quality indicators.
  - Six-Month Staffing Report eliminated and homes given the option of combining Cost Report and Annual Staffing and Compensation Report.
  - Homes staffing above their required staffing levels become eligible for reinvestment of recouped funds.

- January 7, 2003 – Implementation of third set of features to increase provider flexibility and improve system functioning.
  - Assistant administrators cannot be included in the direct care staff cost center (Administrators were already excluded).
  - Removed the increase in the spending requirement to 90% scheduled to be effective September 1, 2002.
  - Revised enrollment limitations for facilities that miss their staffing requirement.
  - Clarified that requests by providers to aggregate all their facilities for determination of the spending requirement must be received at the same time the annual staffing and compensation report is received by HHSC and that a new request must be submitted each year.
  
- September 1, 2003 – Implementation of fourth set of revisions in response to H.B. 2292 and limited funding.
  - The minimum spending requirement, base rate and reporting requirements for nonparticipants were eliminated.
  - Direct care rates will never be recouped below the direct care base rate.
  - Performance-based mitigation of spending recoupment was eliminated.
  - Training requirements for preparers were clarified (for odd-year reports must have attended most recent training available; for even-year reports must have attended most recent odd-year training available).
  - Interest charges for missing staffing requirements were deleted.
  - Provisions allowing new owners, after a change of ownership, to request to become participants or increase their enhancement level were deleted.
  - Reinvestments limited to ongoing contracts and contracts with an approved Successor Liability Agreement between the contract in effect during the reinvestment reporting period and the contract in effect when reinvestment is determined.
  
- June 6, 2004 – Implementation of fifth set of revisions to increase provider flexibility and improve system functioning.
  - Eliminated requirement that a nursing facility have met its minimum staffing requirement prior to “purchasing” credit for additional direct care staff minutes.
  - Clarified that facilities participating in the enhancement program are required to staff at least one level higher than the facility’s minimum staffing requirement.
  - Only facilities participating in the enhancement program can be included in any aggregate calculations for determining compliance with spending requirements.

- Further clarified that requests from controlling entities to aggregate their contracts for purposes of determining compliance with spending requirements must be submitted at the time each Staffing and Compensation Report is submitted.
- Swing beds are reimbursed at the direct care staff base rate with no enhancement levels.
- Paid feeding assistants may not be counted toward staffing requirements.
- Mandated that each facility's enrollment be limited to the lower of its current level of enrollment plus three levels or the level it achieved in a prior period.
- January 9, 2005 – Implementation of sixth set of revisions to increase provider flexibility and improve system functioning.
  - Added provision to allow HHSC to recoup owed funds from other Medicaid contracts controlled by a provider if the provider fails to repay the amount due or submit an acceptable payment plan within 60 days of notification of a recoupment.
  - Added provisions to allow providers that were reclassified from a Level 0 to nonparticipant in fiscal year 2004 due to legislation contained in H.B. 2292, 78<sup>th</sup> Legislature, Regular Session, 2003 (H.B. 2292), to be considered for reinvestment in fiscal years 2004 and 2005.
- September 1, 2008 - Conversion of case mix system from the Texas Index for Level of Effort (TILE) system to the Resource Utilization Groups (RUG) system. Three level enrollment increase limit is waived for fiscal year 2009.
- September 1, 2009 – Implementation of seventh set of revisions to increase provider flexibility and improve system functioning.
  - Modify Staffing and Compensation Report submittal requirements to use cost reports in place of Staffing and Compensation Reports.
  - Eliminate reinvestment of recouped funds.
  - Add commonly owned corporations to the types of controlled entities permitted to aggregate their costs for determination of compliance with spending.

- November 1, 2009 – HHSC adopted changes to program rules at 1 TAC §355.308 to eliminate stand-alone Annual Staffing and Compensation Reports and Reinvestment as of fiscal year 2010.
  - Fiscal year 2009. For services delivered on or before August 31, 2009, providers must still file Annual Staffing and Compensation Reports unless you have received approval from HHSC Rate Analysis to submit a combined cost report.
  - Fiscal year 2010. For services delivered from September 1, 2009 to August 31, 2010, participating providers may be required to submit Transition Staffing and Compensation Reports in addition to required cost reports. The Transitional Staffing and Compensation Report reporting period will include those days in calendar years 2009 and 2010 not included in either the 2009 Annual Staffing or Compensation report or on the provider's 2010 cost report.
  - Fiscal year 2011. For services delivered on September 1, 2010 and thereafter, participating providers will be required to complete additional items added to the cost report to accommodate the information necessary to verify compliance with staffing and spending requirements and will no longer be required to submit separate Annual Staffing and Compensation Reports except in certain limited situations.

## **OVERVIEW OF NURSING FACILITY DIRECT CARE STAFF ENHANCEMENT PROGRAM & ACCOUNTABILITY**

- Optional participation. Participation in the direct care staff enhancement is voluntary.
- Participation agreement. Facilities may choose to participate in the direct care staff enhancement by submitting to the Texas Health and Human Services Commission (HHSC) a signed Enrollment Contract Amendment choosing to enroll, meet specified staffing levels and provide staffing and spending reports to HHSC.
- Direct care staffing and revenue enhancements for participants. Facilities choosing to participate in the direct care staff enhancement agree to maintain a certain staffing level in return for increased direct care staff revenues.
  - Minimum staffing requirements. Minimum staffing requirements for participants are based on the statewide average direct care staff hours associated with the direct care staff rate component for NFs, adjusted for each facility's case mix. All times are expressed in terms of Licensed Vocational Nurse (LVN) equivalent minutes.
  - Enhanced staffing payment options. Facilities participating in the direct care staff enhancement may choose to staff at one of several optional levels above the minimum requirement for participation and receive additional payments associated with their chosen level. Requested levels will be granted beginning with the lowest level requested and granting successive levels until requested enhancements are granted within available funds.
- Staffing accountability for participating facilities. Determination of each facility's staffing level will be made on an annual basis with adjustments to direct care staff payments and staffing requirements made upon determination that a facility is failing to meet its requirement.
  - Participating facilities failing to meet their staffing requirement for any particular reporting period will have all direct care staff revenues associated with unmet staffing goals recouped.
  - Participating facilities failing to meet their staffing requirement for any particular reporting period will be limited to participating at the level actually achieved during the subsequent enrollment unless they submit an acceptable Request for Revision Report that shows they are currently staffing above that level.
  - Participating facilities may mitigate staffing recoupments to the extent that the enhanced funds are expended on direct care nursing staff.

- Direct Care Staff Compensation Accountability. Participants are subject to recoupment, based upon an Annual Staffing and Compensation Report, of unexpended funds below 85 percent of Direct Care Staff Compensation component revenues. **At no time will a participating facility's direct care rate after spending recoupment be less than the direct care base rate.**
  - Dietary and fixed capital offsets to recoupment. Recoupment based on direct care staff spending below 85 percent of Direct Care Staff Compensation component revenues may be offset, within specified limits, by allowable dietary and fixed capital asset costs in excess of those components of the Medicaid rates.
- Grouping. Compliance with spending requirements may be evaluated in the aggregate for all participating nursing facility contracts controlled by common ownership.

## TIMELINE

September 1, 2012:	Fiscal year 2013 enrollments effective; beginning of fiscal year 2013 staffing and spending accountability period
September 30, 2012:	2012 Accountability Reports – Multipurpose due (as needed)
June 2013:	Notification of recoupments for fiscal year 2011
July 2013:	Collection of recoupments for fiscal year 2011
March 31, 2013:	Fiscal year 2012 Cost Reports and Accountability Reports – Multipurpose (as needed) due
Spring / Summer 2013:	Audit of fiscal year 2012 Cost Reports and Accountability Reports - Multipurpose
July 1 - 31, 2013:	Open Enrollment for fiscal year 2014
September 1, 2013:	Fiscal year 2014 enrollments effective; beginning of fiscal year 2014 staffing and spending accountability period
January 2014:	Notification of recoupments for fiscal year 2012
February 2014:	Collection of recoupments for fiscal year 2012
March 31, 2014:	Fiscal year 2013 Cost Reports and Accountability Reports -Multipurpose (as needed) due
Spring / Summer 2014:	Audit of fiscal year 2013 Cost Reports and Accountability Reports - Multipurpose

## **WHO CAN BE COUNTED AS DIRECT CARE STAFF?**

**Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs), Licensed Vocational Nurses (LVNs), including DONs and ADONs, Medication Aides and Certified Nurse Aides (CNAs), including Restorative Aides, performing nursing-related duties for Medicaid-contracted beds.**

### What is Direct Care?

Resident care provided by nursing personnel (i.e., RNs, LVNs, Medication Aides and CNAs) in order to carry out the physician's planned regimen of total resident care.

### What Is A Nurse Aide?

A Certified Nurse Aide or a nurse aide in training who has completed at least the first 16 hours of a Nurse Aide Training, Competency and Evaluation Program (NATCEP). Any time worked before the completion of 16 hours of NATCEP training (i.e., time worked as a hospitality aide) cannot be reported as a nurse aide, but must be reported as "Other Resident Care Staff – Nonprofessional".

### What Types of Contract Labor Count?

Direct care hours provided by nonstaff RNs, LVNs, Medication Aides and Nurse Aides. Nonstaff refers to personnel who provide services to the facility intermittently, whose fee or compensation is not subject to payroll tax contributions by the facility and who perform tasks routinely performed by direct care employees. Contract labor hours do not include consultant hours.

### Function + Professional Certification or Licensure Status

To be allowable as direct care staff, an individual must both meet the appropriate professional certification or licensure requirements and perform nursing-related duties for Medicaid-contracted beds.

### Required Documentation

To be allowable for purposes of the Enhanced Direct Care Staff Rate, direct care staff time and associated costs must be supported by proper documentation including, but not limited to, proof of licensure and certification status, timesheets (for staff performing more than one function or working for more than one entity), job descriptions, payroll records and documentation of payroll taxes and employee benefits.

## ENROLLMENT LIMITATIONS

During open enrollment, a facility will not be enrolled in the enhanced direct care staff rate at a level higher than the level it achieved on its most recently audited report functioning as its fiscal year 2011 Staffing and Compensation Report. Fiscal year 2014 open enrollment is based on the 2011 Report.

Based upon the current enrollment level and the level achieved in the provider's fiscal year 2011, the facility falls into one of the following three Enrollment Limitation Groups.

- **Enrollment Limitation Group 1.** The facility is currently enrolled at a level higher than the level it achieved in fiscal year 2011. For the period beginning September 1, 2013 and ending August 31, 2014, your facility's enhancement level will be reduced to the level it achieved in its fiscal year 2011.
- **Enrollment Limitation Group 2.** The facility is currently enrolled at the same level that it achieved in its fiscal year 2011. Although you were recouped from a higher level on your 2011 report, your achieved level is the same as your current level of participation. As a result, for the period beginning September 1, 2013 and ending August 31, 2014, your facility's level will be held at the level it achieved in its fiscal year 2011.
- **Enrollment Limitation Group 3.** The facility is currently enrolled at a level lower than the level it achieved in its fiscal year 2011 and will be allowed to participate in the open enrollment for fiscal year 2014 but will not be allowed to request a higher enrollment level than the level it achieved in its fiscal year 2011.

When HHSC notifies the facility about a limitation, the facility has the opportunity to submit a **Request for Revision Report (RFR)** within 30 days of the letter, if the facility can show that it is currently staffing above the level indicated by their fiscal year 2011 report functioning as its Staffing and Compensation Report. The RFR is a special accountability report for the first 8 months of the current fiscal year (September through April).

If your facility's fiscal year 2013 Cost Report (or other report functioning as its Staffing and Compensation Report for the time period included in the 2013 RFR) shows that your facility staffed below the level it presented in its 2014 RFR, HHSC will immediately recoup all enhancement payments associated with the RFR, and your facility will be limited to the level supported by your fiscal year 2013 report for the remainder of the rate year.

## OPEN ENROLLMENT AND ENHANCEMENT

Open enrollment for the enhanced direct care staff rates begins on the first day of July and ends on the last day of that same month unless the Texas Health and Human Services Commission (HHSC) notifies the providers prior to the first day of July that open enrollment has been postponed or cancelled.

An initial Enrollment Contract Amendment (ECA) is required from each facility choosing to participate in the enhanced direct care staff rate. Participating and nonparticipating facilities may request to modify their enrollment status.

- New facilities to the enhancement program will be given the opportunity to select the level of enhancement at which they wish to participate.
- Facilities already participating in the enhancement program may request a level higher than its current level plus three additional levels.
- At anytime during the year, facilities can request a reduction in level or withdraw from enhancement program completely.
- The highest enhancement level is level 27. Each level increases by \$0.3861 above the nonparticipant rate.
- Levels are awarded within available funds; therefore, it is possible that a facility will not be awarded the level it requests due to limited funding for the program.
- Requested enhancements will be distributed beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds. Pre-existing enhancements will have priority over new enhancements.
- Facilities that do not receive a limitation letter and who do not wish to change their level will automatically be re-enrolled in the enhancement at their current level of participation. Also known as “Roll-over” enrollment.

## ENROLLMENT CONTRACT AMENDMENT

Facilities may choose to participant, change their current level of enrollment, or withdraw from the Rate Enhancement program, by submitting a properly completed Enrollment Contract Amendment (ECA). A properly completed ECA must:

- Be signed by a person authorized on the DADS Signature Authority Designation Form (Form 2031) as a signatory for the contract. If you do not know who your authorized signatories are, call (512) 438-2547 or visit the DADS website at: [www.dads.state.tx.us/providers/NF/signatories.cfm](http://www.dads.state.tx.us/providers/NF/signatories.cfm).
- Be received by HHSC Rate Analysis by 5:00 p.m. on July 31, 2013. Consider sending the ECA by certified or overnight mail so you have confirmation of delivery. *No late forms, faxes, e-mails, or copies will be accepted.*
- Have a check mark in either the "Yes, this facility chooses to enroll" or the "No, this facility chooses not to enroll" box.
- Have their chosen participation level in the "Level" box if you checked "Yes, this facility chooses to enroll".
- Specify fiscal year end of entity.
- Reflect the correct 4-digit facility number and 9-digit provider/contract number.
- Be legible.

Forms that do not meet all the requirements listed above will not be accepted.

**If an acceptable ECA is not received by HHSC Rate Analysis by 5:00 p.m. on July 31, 2013, your contract will continue at the Level of Participation in effect during the open enrollment period, within available funds, (unless the facility was subject to an Enrollment Limitation). This continued enrollment provision is called "roll-over" enrollment.**

**TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
Nursing Facility Enhanced Direct Care Staff Rate Enrollment Contract Amendment**

**IMPORTANT:** The completed Enrollment Contract Amendment **must be received by 5:00 p.m., July 31, 2013**, at the following address:

Rate Analysis  
Health and Human Services Commission

Regular Mail  
M.C. H-400  
P.O. Box 149030  
Austin, TX 78714-9030

Special Delivery  
Brown Healty Building, M.C. H-400  
4900 North Lamar  
Austin, TX 78751-2399

**FACSIMILES AND E-MAILS WILL NOT BE ACCEPTED**

The 76th Texas Legislature directed DHS (the legacy agency for the new Department of Aging and Disability Services [DADS]), by means of its app rider 38, to provide incentives for nursing facilities (NFs) to increase direct care staffing and direct care wages and benefits. In response to rider 38, the Health and Human Services Commission (HHSC) adopted rules at Title 1 Texas Administrative Code (TAC) §355.308 to establish procedures for NFs to obtain funds for increased staffing for registered nurses (RNs), licensed vocational nurses (LVNs), medication aides, and certified nurse aides. As per the rules, providers who choose to participate in receiving enhanced funds must demonstrate compliance with enhanced staffing requirements. Providers who do not participate are also subject to a spending requirement for direct care staff compensation. Participating providers who do not spend at least 85% of the funds received for direct care staff compensation on direct care staff compensation will have enhancement funds intended for that purpose recouped by DADS.

**Providers who choose not to participate will not be subject to a staffing or spending requirement.**

1 TAC §355.308(d) states that an initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care program. Participating and nonparticipating facilities may request to modify their enrollment status during any open enrollment period. Requests to modify enrollment status must be received by HHSC's Rate Analysis by 5:00 p.m. on the last day of the open enrollment period. **Facilities from which HHSC's Rate Analysis has not received an acceptable request to modify their enrollment by 5:00 p.m. on July 31, 2013 will continue at the level of participation in effect during the open enrollment period, within available funds.**

By execution of this Enrollment Contract Amendment, I acknowledge that the rules stated at 1 TAC §355.308, as amended, govern my NF contract. In accordance with 1 TAC §355.308, I am executing the following enrollment decision for this contract.

Yes, this facility chooses to enroll in the Enhanced Direct Care Staff Rate.  
The Level of Enhancement for which this facility requests to enroll is Level # :  
(Level 0 is not an option; please indicate a level between 1 and 27)

**NOTE: Levels are awarded within available funds, and it is possible that you will not be awarded the level you request due to limited funding for the enhancement program.**

No, this facility chooses **not** to enroll in the Enhanced Direct Care Staff Rate.

Legal Entity Name as it appears on contract

Name of Nursing Facility

9-Digit Provider Number

4-Digit Facility Number

Signature of Authorized Signatory per DADS Signatory Authority Designation Form (Form 2031)

Facility Address (Street)

Printed Name of Authorized Signatory

Facility Address (City, State, Zip Code)

E-mail address

( )

( )

Enter last month of the fiscal year for this entity.

Telephone Number

Facsimile Number

## NOTIFICATION OF ENROLLMENT

HHSC Rate Analysis will post on its website, by September 16, 2013, a list of contracted providers and their enrollment status (i.e., participant or nonparticipant) and enhancement level awarded. **This posting will be the only notification of enrollment status provided by HHSC Rate Analysis.**

**HHSC Rate Analysis Website:**

**[www.hhsc.state.tx.us/rad/long-term-svcs/nursing-facility/index.shtml](http://www.hhsc.state.tx.us/rad/long-term-svcs/nursing-facility/index.shtml)**

Scroll down the page and locate “Rate Enhancement – Direct Care Staff Compensation”  
Click on “View 2014 Rate Enhancement – Direct Care Staff Compensation Information”.  
Click on “Participation Status – Levels Awarded”.

## LVN EQUIVALENTS

### LVN EQUIVALENTS

In order to permit providers the flexibility to substitute RN, LVN and Nurse Aides (i.e., medication, certified and restorative aides) staff resources and, at the same time, comply with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN equivalent minutes. Conversion factors to convert RN and aide minutes into LVN equivalent minutes are based upon relative compensation levels and are presented in the table below.

#### LVN-Equivalent Conversion Scale

1 RN minute = 1.4615 LVN equivalent minutes  
1 LVN minute = 1.0000 LVN equivalent minute  
1 Aide minute = 0.4872 LVN equivalent minutes

1 LVN equivalent minute = 0.68 RN minutes  
1 LVN equivalent minute = 1.00 LVN minutes  
1 LVN equivalent minute = 2.05 Aide minutes

## **STAFFING AND SPENDING REQUIREMENTS**

During each year, a provider must submit an annual Cost Report. The Cost Report is reported covering the provider's fiscal year end. This report also includes additional line items to verify compliance with staffing and spending requirements for each facility participating in the Enhanced Direct Care Staff Rate.

### **Staffing Requirements**

- All direct care staff revenues associated with unmet staffing goals will be recouped from participating facilities that fail to meet their staffing requirements.
- Participating facilities that fail to meet their required staffing levels will have their enrollment for the following year limited to the level they did achieve.

### **Spending Requirements**

- Participants are subject to a spending floor on direct care staff revenues.
- Participants must spend 85% of their direct care staff compensation revenues on direct care staff compensation or DADS will recoup the difference between 85% of direct care staff compensation revenues and direct care staff compensation costs.
- Participants with high dietary and/or fixed capital costs may claim mitigation to their direct care staff spending recoupment.
- No participating facility's direct care rate after spending recoupment will ever be less than the direct care base rate.

## **ALLOWABLE AND UNALLOWABLE COMPENSATION**

Allowable and Unallowable Compensation in accordance with 1 Texas Administrative Code (TAC) §355.103(b).

### **Allowable**

- Salaries and Wages - includes overtime, bonuses, and taxable fringe benefits such paid vacation, paid sick leave, and other allowances.
- Direct care staff contract labor.
- Payroll Taxes - FICA, Medicare, Unemployment.
- Workers' Compensation - Premiums and paid claims.
- Employer-Paid Health Insurance – Premiums and paid claims.
- Employer-Paid Life Insurance – Premiums.
- Certain Other Employer-Paid Benefits - includes employer-paid disability insurance, retirement contributions, deferred compensation plan contributions, childcare, and accrued leave.

### **Unallowable**

- Unrecovered cost of meals and room and board furnished to direct care employees.
- Uniforms.
- Hepatitis B Vaccinations and TB testing/x-rays.
- Personal staff vehicle mileage reimbursement.
- Job-related training reimbursements.
- Job certification renewal fees.

## PURCHASING OF MINUTES

### Prerequisite

Direct care staff expenses per diem must exceed spending requirement.

### Calculation

1. **Calculate per diem spending requirement:**

Direct care staff revenue per diem including enhancement revenue times 85%

2. **Calculate additional LVN-equivalent minutes purchased through excess direct care staff spending:**

$$\frac{(\text{Direct care staff expense per diem} - \text{Per diem spending requirement})}{\text{Cost of one LVN-equivalent minute}}$$

Cost of one LVN-equivalent minute

### Hypothetical Example

1. Minimum staffing requirement = 100 LVN-equivalent minutes
2. Enhancement level = 7 LVN-equivalent minutes
3. Total staffing requirement =  $100 + 7 = 107$  LVN-equivalent minutes
4. Actual staffing = 105 LVN-equivalent minutes
5. Direct care staff revenue per diem including enhancement = \$58.05
6. Spending requirement =  $\$58.05 * 0.85 = \$49.34$
7. Direct care staff expense per diem = \$50.12
8. Direct care spending surplus =  $\$50.12 - \$49.34 = \$0.78$
9. Cost of one LVN-equivalent minute for fiscal year 2012 = \$0.39
10. Number of LVN-equivalent minutes mitigated by direct care spending surplus =  $\$0.78 / \$0.39 = 2$
11. Total staffing achieved including mitigated minutes =  $105 + 2 = 107$ .

## **STAFF PERFORMING MORE THAN ONE FUNCTION**

Nursing personnel who work performing both nursing direct care functions and other functions (e.g., nursing facility administrative functions or any functions for other business components such as a retirement center, residential care center, assisted living component, etc.) must maintain continuous, daily timesheets.

The daily timesheet must document for each day . . .

- The employee's start time.
- The employee's stop time.
- Total hours worked by the employee.
- Actual time worked (in increments of 30 minutes or in sufficient detail to document functions) performing nursing facility direct care functions.
- Actual time worked performing other functions.
- Time must be directly charged. Allocation of time is not acceptable.
- The only exception to the "no allocation rule" is when nursing personnel work for both Medicaid-contracted and noncontracted nursing facility beds. In such a situation, the hours worked must be allocated between contracted and noncontracted beds based upon units of service (i.e., resident days) if they cannot reasonably be directly charged.

The employee and the employee's supervisor must sign the timesheet.

## COMMON QUESTIONS

1. The following functions are considered direct care functions if performed by a Director of Nurses (DON), Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medication Aide, Restorative Aide or Certified Nurse Assistant (CNA): completion of the MDS assessment forms; development of care plans; attendance at direct care training; charting, the nursing administration aspects of a DON's job, and class-room based direct care training provided by the DON.
2. The following functions are not considered direct care functions: medical records; central supply; someone other than a DON presenting classroom-based direct care training; quality assurance nurse consultant from central office; and time spent filling water pitchers and changing linen by individuals other than RNs, LVNs, Medication Aides, Restorative Aides and CNAs.
3. Does paid time off for direct care staff (e.g., paid vacation, paid sick leave) count as direct care time for this report? Yes, but if it is associated with an individual performing more than one function, it needs to be allocated. If a staff person "cashes in" his/her paid time off instead of taking leave, the time associated with this leave is not to be reported on this report. The compensation received as a result of "cashing in" is treated as a bonus and should be reported in the period in which it is subject to payroll taxes.
4. Pay for being "on-call" is reported as salaries by employee type but only on-call hours actually worked performing direct care functions can be reported as time. For example, if a RN was on call for an entire weekend and received \$200 as on-call compensation, the total \$200 would be reported as salaries. If the RN was required for three hours to provide assistance to staff while on-call during the weekend, only three hours would be reported as paid hours and not the full 48 hours of the weekend.
5. Graduate Vocational Nurses (GVNs) should be reported as LVNs.
6. Unpaid overtime hours that meet all the other requirements to be reported as direct care staff time may be reported if they are properly documented. Unpaid overtime hours should be reported at the highest level of licensure or certification the individual working the overtime possesses. For example, if an RN DON works four hours unpaid overtime after the end of her shift, filling in for an absent Medication Aide, the four hours should be reported as RN time. Since the overtime is unpaid, no associated compensation should be reported. Compensation costs may not be imputed for unpaid overtime hours. Volunteer time should not be included on this report.
7. Paid overtime that meets all the other requirements to be reported as direct care staff time may be reported if it is properly documented. Paid overtime hours and compensation should be reported at the highest level of licensure or certification the individual working the overtime possesses. For example, if an RN DON works four hours paid overtime after the end of the shift, filling in for an absent Medication Aide, the four hours and associated compensation should be reported as RN hours and compensation.
8. Nurses that are also schedulers, infection control or facility-based quality assurance nurses and CNAs that drive vans must spend at least 50% of their time on direct care functions in order to report 100% of their paid hours and salaries as direct care. To

document the 50+%, the employee should perform a one-month functional time study (i.e., maintain daily timesheets for an entire month). Such a functional study should be completed at least annually. Otherwise, the employee must maintain daily, continuous timesheets to directly charge as direct care only those hours/salaries applicable to direct care functions. Time spent driving a van is not considered direct care time.

9. Respiratory therapists providing direct care in facilities receiving the ventilator and/or pediatric tracheotomy supplemental payments may be counted as LVNs.
10. Hours and wages for nurse aides in a Nurse Aide Training and Competency Evaluation Program (NATCEP) can only be reported as direct care if the nurse aide has completed at least the first 16 hours of NATCEP training. Any hours and wages associated with time worked before 16 hours of NATCEP training are completed (e.g. time spent as a hospitality aide or receiving the first 16 hours of NATCEP training) is to be reported as Other Resident Care Staff – Nonprofessional.
11. Respiratory therapists providing direct care in facilities receiving the ventilator and/or pediatric tracheotomy supplemental payments may be counted as LVNs.
11. Physical, occupational and speech therapists, activities staff and social work staff are not direct care staff.
12. Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, medication aide, or certified nurse aide, the staff member is not to be included in the direct care staff cost center but rather in the cost center where staff members with that licensure or certification status are typically reported.
13. Nursing facility administrators and assistant administrators are not included in the direct care cost center.
14. Time spent working on a non-contracted wing is not direct care time.

**Worksheet A: Estimate average direct care staff base rate**

RUG Group	COLUMN A		COLUMN B		COLUMN C								
	Medicaid Days of Service in Medicaid-Contracted Beds excluding Hospice & Star+Plus		"Proposed" Direct Care Staff Base Rate per Resident Day		Total Direct Care Staff per Resident Day								
RAD	0	x	\$105.72	=	\$0.00								
RAC	0	x	\$89.46	=	\$0.00								
RAB	5	x	\$81.97	=	409.85								
RAA	64	x	\$68.03	=	\$4,353.92								
SE3	0	x	\$132.81	=	\$0.00								
SE2	62	x	\$107.68	=	\$6,676.16								
SE1	0	x	\$89.07	=	\$0.00								
SSC	0	x	\$86.20	=	\$0.00								
SSB	11	x	\$79.65	=	\$876.15								
SSA	103	x	\$79.40	=	\$8,178.20								
CC2	0	x	\$64.24	=	\$0.00								
CC1	0	x	\$59.08	=	\$0.00								
CB2	0	x	\$56.15	=	\$0.00								
CB1	314	x	\$52.09	=	\$16,365.26								
CA2	81	x	\$47.75	=	\$3,867.75								
CA1	21	x	\$42.87	=	\$900.27								
IB2	507	x	\$47.88	=	\$24,275.16								
IB1	411	x	\$42.36	=	\$17,409.96								
IA2	0	x	\$35.76	=	\$0.00								
IA1	111	x	\$32.17	=	\$3,570.87								
BB2	0	x	\$46.40	=	\$0.00								
BB1	196	x	\$38.79	=	\$7,602.84								
BA2	125	x	\$34.46	=	\$4,307.50								
BA1	0	x	\$27.97	=	\$0.00								
PE2	0	x	\$52.56	=	\$0.00								
PE1	275	x	\$47.85	=	\$13,158.75								
PD2	0	x	\$48.99	=	\$0.00								
PD1	382	x	\$44.12	=	\$16,853.84								
PC2	0	x	\$42.05	=	\$0.00								
PC1	190	x	\$38.94	=	\$7,398.60								
PB2	1	x	\$37.03	=	\$37.03								
PB1	111	x	\$33.60	=	\$3,729.60								
PA2	1,439	x	\$29.42	=	\$42,335.38								
PA1	989	x	\$25.85	=	\$25,565.65								
BC1	0	x	\$25.85	=	\$0.00								
PCE	1	x	\$25.85	=	\$25.85								
<b>Total Medicaid Days of Service</b>	Box A1				Total	Box A2							
						\$207,889.59							
Ventilator Continuous	0	x	\$93.16	=	Box A3	\$0.00							
Ventilator Partial	0	x	\$37.26	=	Box A4	\$0.00							
Pediatric Tracheostomy	0	x	\$55.90	=	Box A5	\$0.00							
<p align="center"><b>NOTE:</b> This estimate is based on the distribution of your facility's days of service by RUGs as captured by this worksheet. If the distribution is incorrect or changes, your average direct care staff base rate will be incorrect or change.</p>						Box A6	\$207,889.59						
												Sum A2- A5	
												Box A7	5,399
												From Box A1	
						Box A8	\$38.51						
						Box A6 divided by Box A7							

**Worksheet B: Estimate LVN equivalent staffing level for Medicaid-contracted beds**

Enter only hours and days of service for Medicaid-contracted beds

**STEP B1**

	Registered Nurses (including RN DONs)	Licensed Vocational Nurses (including LVN DONs)	Medication Aides	Restorative and Certified Nurse Aides
<b>A</b> Employee Hours	Box B1 2,321 hrs.	Box B2 8,944 hrs.	Box B3 2,064 hrs.	Box B4 19,762 hrs.
Contract Labor Hours	Box B5 hrs.	Box B6 hrs.	Box B7 hrs.	Box B8 hrs.

**B** Enter Total Days of Service (include Medicaid, Medicare and Other days in Medicaid-contracted beds) Box B9  
12,045

**STEP B2**

<b>A</b> Total Employee RN hours	2,321 <sup>From B1</sup>	X	1.4615	=	3,392.14	X	60	=	Box B10 203,528.49
<b>B</b> Total Contract RN hours	0 <sup>From B5</sup>	X	1.4615	=	0.0000	X	60	=	Box B11 0.00
<b>C</b> Total Employee LVN hours	8,944 <sup>From B2</sup>	X		=		X	60	=	Box B12 536,640.00
<b>D</b> Total Contract LVN hours	0 <sup>From B6</sup>	X		=		X	60	=	Box B13 0.00
<b>E</b> Total Employee Aide hours	21,826 <sup>B3 + B4</sup>	X	0.4872	=	10,633.63	X	60	=	Box B14 638,017.63
<b>F</b> Total Contract Aide hours	0 <sup>B7 + B8</sup>	X	0.4872	=	0.0000	X	60	=	Box B15 0.00
<b>G</b> Total LVN equivalent minutes provided during selected reporting period									Box B16 1,378,186.12 <small>Sum B10 - B15</small>
<b>H</b> Total days of service in Medicaid-contracted beds during selected reporting period									Box B17 12,045 <small>From Box B9</small>
<b>I</b> Estimated staffing level in LVN equivalent minutes per resident day during selected reporting period									Box B18 114.42 <small>Box B16 divided by Box B17</small>

**Worksheet C:  
Estimate Minimum Required LVN Equivalent Minutes Per Resident Day for Participation**

RUG Group	COLUMN A		x	COLUMN B		=	COLUMN C	
	Medicaid Days of Service in Medicaid-Contracted Beds including Hospice & Star+Plus			"Proposed" Minimum Required Medicaid LVN Equivalent Minutes per Resident Day			Total Minimum LVN Equivalent Minutes per Resident Day	
RAD	0		x	241.68	=	0.00		
RAC	0		x	204.50	=	0.00		
RAB	5		x	187.38	=	936.90		
RAA	64		x	155.51	=	9,952.64		
SE3	0		x	303.60	=	0.00		
SE2	62		x	246.13	=	15,260.06		
SE1	0		x	203.61	=	0.00		
SSC	0		x	197.05	=	0.00		
SSB	11		x	182.08	=	2,002.88		
SSA	103		x	181.50	=	18,694.50		
CC2	0		x	146.86	=	0.00		
CC1	0		x	135.05	=	0.00		
CB2	0		x	128.37	=	0.00		
CB1	314		x	119.06	=	37,384.84		
CA2	81		x	109.15	=	8,841.15		
CA1	21		x	98.01	=	2,058.21		
IB2	507		x	109.44	=	55,486.06		
IB1	411		x	96.82	=	39,793.02		
IA2	0		x	81.74	=	0.00		
IA1	111		x	73.55	=	8,164.05		
BB2	0		x	106.08	=	0.00		
BB1	196		x	88.67	=	17,379.32		
BA2	125		x	78.75	=	9,843.75		
BA1	0		x	63.94	=	0.00		
PE2	0		x	120.14	=	0.00		
PE1	275		x	109.35	=	30,071.25		
PD2	0		x	112.00	=	0.00		
PD1	382		x	100.84	=	38,520.88		
PC2	0		x	96.15	=	0.00		
PC1	190		x	89.03	=	16,915.70		
PB2	1		x	84.61	=	84.61		
PB1	111		x	76.82	=	8,527.02		
PA2	1,439		x	67.25	=	96,772.75		
PA1	989		x	59.08	=	58,430.12		
BC1	0		x	59.08	=	0.00		
PCE	1		x	59.08	=	59.08		

Box C1 5,399

Total Box C2 475,178.81

Ventilator Continuous	0	x	214.89	=	Box C3 0.00
Ventilator Partial	0	x	85.96	=	Box C4 0.00
Pediatric Tracheostmy	0	x	128.94	=	Box C5 0.00

Box C6 475,178.81  
Sum C2 - C5

$$\frac{475,178.81}{5,399} = 88.01$$
 From Box C1

**Worksheet C: (Continued)**  
**Estimate Minimum Required LVN Equivalent Minutes Per Resident Day for Participation**

Medicare Days of Service in Medicaid- Contracted Beds		Medicare LVN Equivalent Minutes Per Resident Day			
Box C8     1,373	X	177.11	=	Box C9     243,172.03	

Other Days of Service in Medicaid- Contracted Beds		Enter the lower of 100.84 or the value in Box C7.			
Box C10     5,273	X	88.01	=	Box C11     464,076.73	

Total Minimum LVN Equivalent Minutes per Resident Day in Medicaid- Contracted Beds		Total Resident Days in Medicaid-Contracted Beds			Estimated Minimum Required LVN Equivalent Minutes Per Resident Day for Participation
Box C12     1,182,428  <small>Sum C6, C9, C11</small>	÷	Box C13     12,045  <small>Sum C1, C8, C10</small>	=	Box C14     98.17	NOTE: This estimate is based upon the distribution of your facility's days of service by RUGs and payor type as captured by this worksheet. If the distribution changes, your required minimum will change.

**Worksheet D: Estimate average per diem direct care staff expenses.**

Employee Salaries and Wages - Registered Nurses (including RN DONs)	Box D1	63,455	.00
Employee Salaries and Wages - Licensed Vocational Nurses (including LVN DONs)	Box D2	174,824	.00
Employee Salaries and Wages - Medication Aides	Box D3	24,481	.00
Employee Salaries and Wages - Certified Nurse Aides	Box D4	184,746	.00
Contract Staff Compensation - Registered Nurses (including RN DONs)	Box D5	0	.00
Contract Staff Compensation - Licensed Vocational Nurses (including LVN DONs)	Box D6	0	.00
Contract Staff Compensation - Medication Aides	Box D7	0	.00
Contract Staff Compensation - Certified Nurse Aides	Box D8	0	.00
Payroll Taxes - FICA and Medicare	Box D9	34,234	.00
Payroll Taxes - State and Federal Unemployment	Box D10	2,168	.00
Workers' Compensation - Insurance Premiums	Box D11	4,706	.00
Workers' Compensation - Paid Claims	Box D12	654	.00
Employee Benefits - Health Insurance	Box D13	0	.00
Employee Benefits - Life Insurance	Box D14	0	.00
Employee Benefits - Other Benefits	Box D15	0	.00
Total Direct Care Cost (Sum Boxes D1 through D15)	Box D16	489,268	.00
		Sum D1 - D15	
Total Days of Service in Medicaid-contracted beds(from Box B9)	Box D17	12,045	
		From B9	
Direct Care Cost Per Unit of Service for selected reporting period	Box D18	40.62	
		Box D16 divided by D17	

NURSING FACILITY  
DIRECT CARE STAFF ENHANCEMENT WORKSHEETS  
FISCAL YEAR 2014

**Worksheet E: Estimate adjusted staffing level**

<b>A</b>	Enter estimated staffing level in LVN equivalent minutes per resident day (from Box B18)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E1</td><td style="text-align: right;">114.42</td></tr> <tr><td colspan="2" style="text-align: right;">From Box B18</td></tr> </table>	Box E1	114.42	From Box B18	
Box E1	114.42					
From Box B18						

<b>B</b>	Enter estimated minimum required LVN equivalent minutes per resident day for participation (from Box C14)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E2</td><td style="text-align: right;">98.17</td></tr> <tr><td colspan="2" style="text-align: right;">From Box C14</td></tr> </table>	Box E2	98.17	From Box C14	
Box E2	98.17					
From Box C14						

<b>C</b>	Subtract Box E2 from Box E1. <b>Round down to the nearest whole number.</b> Enter the result in Box E3. The value in Box E3 is the estimated number of LVN equivalent minutes above the minimum staffing requirement that the facility achieved during the reporting period.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E3</td><td style="text-align: right;">16</td></tr> </table>	Box E3	16
Box E3	16			

<b>D</b>	If the value in Box E3 is negative, enter "0" in Box E4. If the value in Box E3 is zero or positive, enter the value from Box E3 in Box E4.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E4</td><td style="text-align: right;">16</td></tr> </table>	Box E4	16
Box E4	16			

<b>E</b>	Enter estimated average direct care staff base rate (from Box A8).	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E5</td><td style="text-align: right;">\$38.51</td></tr> <tr><td colspan="2" style="text-align: right;">From Box A8</td></tr> </table>	Box E5	\$38.51	From Box A8	
Box E5	\$38.51					
From Box A8						

<b>F</b>	Multiply the value in Box E4 by E6 and enter the product in Box E7.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E6</td><td style="text-align: right;"><b>\$0.39</b></td></tr> </table>	Box E6	<b>\$0.39</b>
Box E6	<b>\$0.39</b>			

<b>F</b>	Multiply the value in Box E4 by E6 and enter the product in Box E7.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E7</td><td style="text-align: right;">\$6.24</td></tr> <tr><td colspan="2" style="text-align: right;">Box E4 times Box E6</td></tr> </table>	Box E7	\$6.24	Box E4 times Box E6	
Box E7	\$6.24					
Box E4 times Box E6						

<b>G</b>	Determine direct care revenue for staffing level currently achieved by summing Boxes E5 and E7 and entering the result in Box E8.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E8</td><td style="text-align: right;">\$44.75</td></tr> <tr><td colspan="2" style="text-align: right;">Sum Boxes E5 and E7</td></tr> </table>	Box E8	\$44.75	Sum Boxes E5 and E7	
Box E8	\$44.75					
Sum Boxes E5 and E7						

<b>H</b>	Determine direct care spending requirement associated with direct care revenue for staffing level currently achieved by multiplying Box E8 by Box E9. Enter the result in Box E10.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E9</td><td style="text-align: right;"><b>0.85</b></td></tr> </table>	Box E9	<b>0.85</b>
Box E9	<b>0.85</b>			

<b>H</b>	Determine direct care spending requirement associated with direct care revenue for staffing level currently achieved by multiplying Box E8 by Box E9. Enter the result in Box E10.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E10</td><td style="text-align: right;">\$38.03</td></tr> <tr><td colspan="2" style="text-align: right;">Box E8 times Box E9</td></tr> </table>	Box E10	\$38.03	Box E8 times Box E9	
Box E10	\$38.03					
Box E8 times Box E9						

<b>I</b>	Enter direct care cost per unit of service (from Box D18)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E11</td><td style="text-align: right;">\$40.62</td></tr> <tr><td colspan="2" style="text-align: right;">From Box D18</td></tr> </table>	Box E11	\$40.62	From Box D18	
Box E11	\$40.62					
From Box D18						

<b>J</b>	Determine current estimated direct care staff surplus expenses by subtracting Box E10 from Box E11. Enter the result in Box E12.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Box E12</td><td style="text-align: right;">\$2.59</td></tr> <tr><td colspan="2" style="text-align: right;">Box E11 minus Box E10</td></tr> </table>	Box E12	\$2.59	Box E11 minus Box E10	
Box E12	\$2.59					
Box E11 minus Box E10						

<b>K</b>	<p>If the value in Box E12 is less than or equal to zero, your facility is not estimated to qualify to purchase credit for additional LVN equivalent minutes; enter a "1" in Box E13 and skip to Box E15. If the value in Box E12 is greater than zero, enter a "2" in Box E13 and continue with Box E14.</p>	<table border="1"> <tr> <td>Box E13</td> <td>2</td> </tr> </table>	Box E13	2		
Box E13	2					
<b>L</b>	<p>Compute surplus minutes purchased by dividing Box E12 by Box E6. Enter the result in Box E14.</p>	<table border="1"> <tr> <td>Box E14</td> <td>6.63</td> </tr> <tr> <td colspan="2"><small>Box E12 divided by Box E6</small></td> </tr> </table>	Box E14	6.63	<small>Box E12 divided by Box E6</small>	
Box E14	6.63					
<small>Box E12 divided by Box E6</small>						
<b>M</b>	<p>Compute adjusted LVN equivalent minutes. If Box E13 equals "1", enter the value from Box E1 in Box E15. If Box E13 equals "2", sum Boxes E1 and E14 and enter the result in Box E15.</p>	<table border="1"> <tr> <td>Box E15</td> <td>121.05</td> </tr> </table>	Box E15	121.05		
Box E15	121.05					
<b>N</b>	<p>Compute adjusted estimated LVN equivalent minutes above the minimum staffing requirement that the facility achieved during the reporting period. Subtract Box E2 from Box E15 and enter the result in Box E16.</p>	<table border="1"> <tr> <td>Box E16</td> <td>22.88</td> </tr> <tr> <td colspan="2"><small>Box E15 minus Box E2</small></td> </tr> </table>	Box E16	22.88	<small>Box E15 minus Box E2</small>	
Box E16	22.88					
<small>Box E15 minus Box E2</small>						

## MISCELLANEOUS

### Billing Issues

- What do I have to do to get paid my enhancement?

Nothing. You should automatically get your new level when you bill for units of service provided on or after September 1, 2013. You do not have to modify your billing procedures. If you bill more frequently than the recommended bi-weekly frequency, it is possible that you will be paid at your 2012 level on claims for fiscal year 2014 billed prior to September 15, 2013, with retroactive adjustments made after September 15, 2013.

- How will the billing system handle recoupments?

Recoupments will be considered adjustments to prior billings and will process as adjustments.

### Administrative Details

- Throughout the rate year, new facilities must submit an Enrollment Contract Amendment within 30 days of notification by HHSC if open enrollment has not been cancelled.
- Facilities that change ownership - their enrollment status conveys to new owner. The new owner may not request to enroll at a higher level until the next open enrollment.
- If you are a participant and your contract is terminated or sold, your last vendor payment will be held by DADS until a final Accountability Report – Multipurpose (ARM) is submitted and recoupments determined.
- Facilities may request to withdraw from the enhancement or reduce their staffing requirements at any time. Facilities withdrawing must submit a final report covering the period of time they were participants. If the final report is not received by the due date specified by HHSC Rate Analysis, you will be subject to Vendor Hold.

## Who to Contact for Help.....

### Contact:

Bob Dailey, Rate Analyst  
Phone: (512) 730-7447  
Fax: (512) 730-7475  
E-mail: [bob.dailey@hhsc.state.tx.us](mailto:bob.dailey@hhsc.state.tx.us)

Health and Human Services Commission  
HHSC Rate Analysis  
Mail Code H-400  
PO Box 149030  
Austin, TX 78714-9030

HHSC Rate Analysis Website:  
[www.hhsc.state.tx.us/rad/index.shtml](http://www.hhsc.state.tx.us/rad/index.shtml)

DADS Nursing Facility Resources Website:  
<http://www.dads.state.tx.us/providers/NF/index.cfm>

Authorized Signature Questions:  
DADS Provider Services (512) 438-2547 or,  
[www.dads.state.tx.us/providers/nf/signatories.cfm](http://www.dads.state.tx.us/providers/nf/signatories.cfm)

Verify receipt of completed Enrollment Contract Amendment forms:  
HHSC Rate Analysis (512) 707-6094

Billing Questions:  
Provider Claims Services Help Desk (512) 438-2200