

Minnesota Department of Human Services

ACT, IRTS & RCS Rate Setting Manual

Adult Mental Health Division
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Provider and Client Eligibility Requirements

This manual is a summary of requirements and procedures. It is not a definitive compilation of all statutes, rules, regulations, standards, or best practices that may be applicable in a given situation.

Provider Authorization Requirements

Only providers authorized by the Commissioner of the Minnesota Department of Human Services (DHS) are eligible for Medicaid (MA)¹ reimbursement. The online MHCP Provider Manual is your primary information source for [MHCP](#) coverage policies, rates and billing procedures and is updated on an ongoing basis. The requirements for authorization are different for each of the three service types.

The statutory reference for each service is provided below.

Provider Authorization Requirements for Assertive Community Treatment (ACT)

ACT provider authorization is established in Minnesota Statutes 256B.0622 subdivision 3(a).

Provider Authorization Requirements for Intensive Residential Treatment Services (IRTS)

IRTS provider authorization is established in Minnesota Statutes [256B.0622 subdivision 4 and 5a](#) and in Minnesota Rules, parts [9520.0500](#) to [9520.0670](#), and the [IRTS variance](#).

Provider Authorization Requirements for Residential Crisis Services (RCS)

RCS provider authorization is established in Minnesota Statutes [256B.0624](#); in Minnesota Statutes [256B.0622](#), particularly subdivision 4 and 5a; and in Minnesota Rules, parts [9520.0500](#) to [9520.0670](#), and the [IRTS variance](#).

Provision of Services Directly by Counties

Counties that operate their own ACT, RCS, or IRTS services, using their own employees, apply directly to the Commissioner for enrollment and rate setting, and a County contract is not required (Minnesota Statutes [256B.0622](#), subdivision 9).

Provision of Services for a Subpopulation of Eligible Individuals

Minnesota Statutes [256B.0622](#), subdivision 10, allows a provider to propose serving a subpopulation of eligible individuals, bypassing the county approval procedures and receiving authorization for provider enrollment directly from the Commissioner when:

- the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities, and
- the subpopulation is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

Client Eligibility Requirements

Eligibility for Medicaid coverage for clients of the three services varies with the service.

Client Eligibility Requirements for ACT

Eligibility requirements for clients of ACT are established in Minnesota Statutes [256B.0622 subdivision 2a and 2b](#).

Client Eligibility Requirements for IRTS

Eligibility requirements for clients of IRTS are established in Minnesota Statutes [256B.0622 subdivision 3](#).

¹ Throughout this document, the terms Medicaid and Medical Assistance (MA) are used synonymously.

Client Eligibility Requirements for RCS

Eligibility requirements for clients of RCS are established in Minnesota Statutes [256B.0624 subdivision 2\(e\) and subdivision 3](#).

Requirements for Establishing a New ACT, IRTS or RCS Program

This section identifies the requirements that must be met by a provider seeking authorization to establish a new ACT, IRTS, or RCS program in Minnesota.

Rate Setting Procedures Applicable to All Three Service Types

Whenever an ACT, RCS, or IRTS program is established for the first time, acquired by a new owner/entity, or undergoes a program conversion the following procedures apply:

- The DHS Commissioner authorizes the new service prior to establishing a Medicaid rate for the program, using procedures described in the remaining sections of this manual, including the Appendices.

Intensive Residential Treatment and Crisis Residential Treatment

The procedures for establishing a new IRTS or RCS Program are provided at:

[Establishing New IRTS and RCS](#).

Note that enrollment as a Minnesota Health Care Provider (includes MA fee for service) an IRTS program must comply with the following:

- Be licensed with the [Rule 36 Variance \(PDF\)](#)
- Not exceed 16 beds (or otherwise result in a Medicaid IMD [Institution for Mental Diseases] exclusion.)
- Have a contract with the host county agency, which approves the IRTS service
- Have a rate approved by DHS

Additionally, new IRTS programs must also submit (Minnesota Statutes [256B.0622 sub 4\(b\)](#)):

- a. The program design will address the size of the proposed program, the location of the office, the staffing patterns and qualifications, the specialized skills needed by the staff (for example, bi-cultural staff persons), and any other requirements specific to the proposed service and location. (The program design will respond to the local needs assessment.)
- b. A program description of both required and optional service components.
- c. A staffing plan to support proposed direct service budget

In consideration of this process, it is important that proposed providers work with their local Adult Mental Health Initiative and Host County to establish the service design in response to local needs assessment (Sample Needs Assessment in Appendix A). A needs assessment identifies existing service capacity and unmet service needs, and it defines the target population(s) within the geographic area. Programs must also ensure that location of the proposed service does not result in an IMD exclusion. IMD exclusion is based on the co-location of other behavioral health services provided in a residential or inpatient program.

For technical assistance with IRTS or RCS program contact Ruth Moser at 651-431-4373 or Ruth.moser@state.mn.us.

Assertive Community Treatment

For the Procedures on establishing a new ACT Program or for technical assistance with the initial steps in the process, a county, Adult Mental Health Initiative (AMHI), Tribe, or service provider must contact the Mental Health Division ACT policy staff Kacie Norlien at Kacie.norlien@state.mn.us or Lynette Studer at lynette.studer@state.mn.us

Changes in Ownership or Program Conversions

Assertive Community Treatment

Changes in Ownership and Program Conversions

ACT Changes in Ownership

A new ACT program that is acquired by a new owner/entity must be authorized by the DHS Commissioner to provide Minnesota Health Care Programs (MHCP)-reimbursed ACT services.

A provider must supply the Mental Health Division with evidence that the following requirements have been met:

- Execution of a host County contract, as specified in Minnesota Statutes [256B.0622](#).
- Submission of program design to the Mental Health division that is in compliance with the Minnesota Statutes [256B.0622](#), including evidence that the ACT program's parent organization is capable of providing ACT services.
- The program design must the size of the proposed program, the location of the office, the staffing patterns and qualifications, the specialized skills needed by the staff (for example, bi-cultural staff persons), and any other requirements specific to the proposed service and location.
- The program design will also outline any changes in the ACT program that will result from a change in ownership. The new provider must outline a transition plan that emphasizes minimal disruption for the individuals currently served by the previous ACT team.
- After the program design has been determined and approved by DHS, the County, AMHI, or Tribe must provide a letter of support for the new provider to DHS along with the above approved needs assessment and information needed to begin the provider authorization and rate-setting processes.
- Enrollment as a Minnesota Health Care Programs (MHCP) provider.

Final determination of the new proposed provider's ability to operate as an ACT team will be made by DHS MH Policy division.

ACT Program Conversions

A current ACT provider seeking to change the design of the program, to serve a different specific population, or to change its capacity would be considered a program conversion and must seek Mental Health Division (MHD) approval to implement the conversion.

For ACT programs converting, the following questions must be submitted to DHS ACT Policy staff, in writing:

1. The exact changes the program intends to make and how that brings the program into closer compliance with the revised Minnesota statute 256B.0622 (e.g., will add one mental health professional to the team or will be expanding hours of operation until 9 p.m. which will have a fiscal impact of {x}.)
2. Detailed projected costs of **each** change the team intends to make that will result in a fiscal change.
3. The proposed timelines for when outlined additional changes will be made (which must correlate with the costs projected).
4. Additional information that is requested by the Mental Health Policy staff to determine the plan for program conversion.

Final determination for whether or not a program is considered to fit the definition of a program conversion lies with DHS. A provider will be notified of the decision in writing so that the proper rate setting procedures can be followed.

Continuing Programs

All continuing ACT program must maintain its authorization by the DHS Commissioner to provide MHCP-reimbursed ACT services. The provider's ongoing responsibilities include:

- Compliance with all [MHCP requirements pertaining to ACT](#), as specified in the Provider Manual.
- Compliance with the rate-setting procedures described in this manual.
- Compliance with the Minnesota Statute 256B.0622.

Intensive Residential Treatment and Residential Crisis Stabilization Services

Changes in Ownership and Program Conversion

Program conversions and changes in ownership must be authorized by the DHS Commissioner to provide MHCP reimbursed IRTS program services. A residential program with changes to its service capacity is considered a converted program and will be expected to follow the same process as a new program. Examples of a change to service capacity are the increase or decrease in the number of licensed beds and/or structural changes made to serve persons with high service needs. AMHD approval is needed prior to a program capacity change. This will also require a change in the terms approved by the DHS Licensing Division. Application procedures are discussed in the section entitled "Specific Procedures for Acquiring, Renewing, or Changing Provider Authorization."

Continuing Programs

Continuing IRTS and CRS programs must maintain its authorization by the DHS Commissioner to provide MHCP-reimbursed IRTS services. The provider's ongoing responsibilities include:

- Compliance with the annual license renewal requirements of the DHS Licensing Division.
- Compliance with all [MHCP requirements pertaining to IRTS](#), as specified in the Provider Manual. Note: Additional information regarding MHCP Screening requirements is available at [this webpage](#).
- Compliance with the rate-setting procedures described in this manual.
- An RCS facility larger than five beds must be licensed as a Rule 36 facility with an IRTS Variance.
- All programs must re-enroll as an MHCP provider at the end of their county contract term or annually.
- All enrolled programs must meet the requirements for staffing, services, and supervision as identified in statute and rule.
- This rate setting process does not apply to a RCS facility that is licensed as an Adult Foster Care Facility.

***License Change**

A provider of residential services seeking a change in the terms of its license must seek authorization for the change from the DHS Licensing Division.

Overview of the Rate-Setting Process

Initial Rate-Setting Process for a New Program or Program Conversion

The rate-setting process for a new or converted program is very similar, but not identical, to the rate-setting process for an existing program. To begin the rate-setting process for a new or converted program, a provider uses a slightly modified version of the budget spreadsheets used for existing programs – entering **proposed** expense and utilization data instead of **actual** expense and utilization data. The spreadsheet for new program development is available on the [DHS Web page](#).

Rate-Setting Process for Existing Programs

ACT, IRTS, and RCS providers authorized by the DHS Commissioner for Medicaid reimbursement participate in a prospective, cost-based rate-setting process. The rate-setting process for a particular calendar year will begin on or around September 1 of that year and will follow the schedule presented in the following table. DHS retains the right to changes these dates as necessary.

Date	Action
On or around September 1	DHS notifies providers of the rate-setting process.
On or around October 31	Providers submit to DHS their actual costs for the previous state fiscal year (July 1 to June 30).

Date	Action
November 1 to November 30	DHS establishes new individual program rates for the next calendar year (January 1 to December 31).
On our around December 1	DHS publishes the new individual program rates.

Budget Forms Used in the Rate-Setting Process

Spreadsheets shall be used by providers of existing ACT, IRTS, and RCS programs when submitting their actual costs to DHS for the previous state fiscal year. These spreadsheets are available on the [DHS Web page](#).

See Appendix B for additional information on completing the spreadsheets.

Rate-Setting Method

The prospective Medicaid rate-setting method mandated by Minnesota Statutes [256B.0622](#), subdivision 8, is outlined in this section. DHS uses actual expenditure and utilization data from a previous 12-month period to establish future per diem, bundled reimbursement rates for ACT, IRTS, and RCS programs.

Rate Components

Direct Service Costs

The Direct Service component of the rate is calculated by dividing Total Direct Service Costs by Total Units of Service. There are three parts that comprise the Direct Service Rate: (1) employee costs associated with the program's direct service staff, including salaries, benefits, and payroll taxes; (2) staff training and service-related transportation; and (3) contracted direct service staff costs.

Once the Direct Service costs are determined, a flat percentage rate is applied to cover Other Program and Overhead Expense essential to the administration of the program (see below).

Other Program and Overhead Expense

DHS has previously reviewed program budgets and determined the costs for Other Program and Overhead Expense. These costs were converted into two flat percentage rates, one appropriate for ACT (41%) and the other appropriate for IRTS and RCS (37%).

Other Program and Overhead Expense include, but is not limited to the following:

- administrative staff, salaries, and benefits
- non-service related transportation
- central office allocations
- professional liability insurance
- organizational dues and subscriptions
- training provided to non-direct service staff

- supplies and materials
- equipment
- electronic records

Not included in the Other Program and Overhead Expense percentage calculation are any room and board expenses.

Allocated Space Costs

IRTS and RCS providers receive an Allocated Space rate component for their treatment and program space, based on square footage calculations. For details, see Appendix A.

Non-Allowable Costs

Non-medical, non-rehabilitative expenses – such as paying for program participants’ room and board, rent deposits, or vocational training for particular jobs – cannot be reimbursed by Medicaid.

There are many other costs that may also be non-allowable. Providers of ACT, IRTS and RCS services are responsible for the requirements in Minnesota Statutes [256B.0622](#), subdivision 8(c)(2), which specifies that “actual cost is defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under [Code of Federal Regulations, title 48, chapter 1, part 31](#), relating to for-profit entities, and [Office of Management and Budget Circular Number A-122](#), relating to nonprofit entities.”

Audit Process

DHS may require documentation to verify the appropriateness of any expense presented in conjunction with the rate-setting process described in this manual. As with all Medicaid-reimbursed services, ACT, IRTS and RCS providers are subject to audit by Federal and State authorities at any time, without notice.

Rates Paid By Other Payers

The Medicaid rate established by DHS for any provider must not exceed the rate charged by that provider for the same service to other payers (Minnesota Statutes [256B.0622](#), subdivision 8(g)).

Settle-Up Process When Entities Discontinue a Service

Providers that discontinue a service are subject to a “settle-up” process in which their actual costs for the previous 12 months are used to determine if they were overpaid or underpaid. Guidelines for a possible adjustment are spelled out in Minnesota Statutes [256B.0622](#), subdivision 8(i). Refer to Appendix C for additional information.

Appendix A

Elements of the Needs Assessment

The needs assessment identifies existing service capacity and unmet service needs, and it defines the target population(s) within the geographic area. The needs assessment answers the following questions:

2. What service do you plan to create, expand or modify?
3. Define the geographic service area, including the targeted and surrounding area(s).
4. Identify who you plan to serve, and include any group(s) that will be the focus of the service.
 - a. Consider poverty rate(s), race and ethnicity trends, underserved or disparately served population groups and high need groups with significant barriers to service, such as persons who are homeless or incarcerated.
 - b. Describe how the needs of underserved people will be addressed.
5. Describe the service continuum and how the proposed service fits.
6. Identify potential barriers to accessing the service.
7. Specify the number and the characteristics of individuals who are unserved or underserved. Be sure to include the following:
 - a. The number of people on waiting list(s),
 - b. The number of people diverted to other services,
 - c. The distance needed to travel to receive the proposed service.
8. Estimate the number of individuals that will use this service on a yearly basis. Describe how this number was determined.
9. Describe where referrals are likely to come from.

Appendix B

Guidance for Completing the Expenditure Reporting Spreadsheets for Existing Programs

Overview

There are three separate Excel spreadsheets to be used when reporting actual expenditures – one for Assertive Community Treatment (ACT) services, one for Intensive Residential Treatment Services (IRTS), and one for Residential Crisis Services (RCS). Choose the correct spreadsheet and enter your data in the non-shaded areas only (shaded areas may contain formulas and may be locked). Spreadsheets are available at [DHS Webpage](#).

Important – please note:

- ***If your program provides both IRTS and RCS at one location, you may combine FTEs and expenditures on one spreadsheet; however, you will need to provide a breakdown of units of service by IRTS and RCS separately.***
- ***DHS may require documentation to verify the appropriateness of any expense reimbursed by State or Federal funds through Medicaid or other Minnesota Health Care Programs (MHCP).***
- ***The following instructions apply to new programs also; however, enter proposed expenses instead of actual.***

Naming Your Files

Before going further with the preparation of your expenditure report, please re-name the Excel file using one of the following naming formats, depending on the service type:

- For an ACT program: [Your ACT Program's Name] ACT FYXX Actuals.xls or [Your ACT Program's Name] ACT FYXX Projected.xls
- For an IRTS program: [Your IRTS Facility's Name] IRTS FYXX Actuals.xls
- For a RCS program: [Your RCS Facility's Name] RCS FYXX Actuals.xls

Doing this will help DHS to distinguish your program(s) from the numerous other programs that will be submitting financial information at the same time.

Tab 1 – Direct Services Expenditures

You will notice that there are six different Tabs at the bottom of the Excel spreadsheet. Start with Tab 1.

Begin by entering your Program Name, Provider Number, and Host County/AMHI at the top of the page. (This information will automatically flow to the other Tabs on the spreadsheet.)

Next, enter the actual full-time equivalents (FTEs)² paid and the annual expenditures, by the categories provided and for the time periods specified. (Two years are required for comparison purposes.) These

² Throughout this document, FTE employment means 40 paid hours per week.

entries should be for Direct Service staff on your payroll *only*; any Contract staff should be included in the Contracts section. Refer to the [Assertive Community Treatment](#), [IRTS](#) and [Adult Crisis Services](#) sections of the MHCP Provider Manual for important information regarding the types of individual providers authorized under the specific categories.

Include Benefits (retirement, insurance, etc.), Payroll Taxes (FICA, etc.), and Workers Compensation for the Direct Service staff identified. **Note: Separation expense is considered an Administrative Expense and should be excluded from Direct Services expenditures.**

Specify the Contract staff (e.g., Psychiatrist, Registered Nurse, Interpreter, etc.) paid during the time periods identified. This should *include* any benefits, payroll taxes and/or administrative expenses for contracted staff that were paid directly by your organization, if applicable, but *exclude* direct service-related training expenses and direct service-related travel expenses.

Training for Direct Service Staff includes (but is not limited to) expenses such as the following, if those expenses are clearly related to improving or maintaining the quality of direct services provided by the program:

- training fees and conference fees for the program's direct service staff;
- expenses incurred by your organization when conducting in-service training activities to improve or maintain the quality of direct services provided to program participants.

Service-Related Travel includes (but is not limited to) expenses such as the following, if those expenses are clearly related to the provision of direct services by the program:

- mileage or other travel expenses incurred when serving program participants (for example, providing a home visit at the person's apartment, accompanying the person to a medical or legal appointment, meeting with the person's family at their home, taking a bus ride with the person to teach public transportation skills);
- mileage to relevant staff training events, including in-service training provided at another location of your organization; and
- travel and accommodations to attend relevant professional conferences.

In the Units of Service Provided area of the spreadsheet, provide a breakout of the total count of billable daily charges, for the time frames identified and by the categories listed. If appropriate for the service type, also include the total number of licensed beds for the program. **Note: If you are combining RCS and IRTS expenditures on one spreadsheet, you will need to provide a breakdown of units of service by IRTS and RCS separately on Tab 2.**

Use the box at the bottom of the spreadsheet to provide additional information or explanation.

Tab 2 – Units of Service Breakout

Tab 2 applies to programs providing IRTS and RCS at the same location and combining FTEs and Expenditures within one spreadsheet. Provide a separate breakout of the units of services provided for IRTS and RCS. This Tab calculates the total units of service provided and compares to the numbers entered on Tab 1. If the Difference is not zero, you will need to update your units of services on Tab 1 or Tab 2.

Tab 3 – Allocated Space Costs

Tab 3 applies to IRTS and RCS programs only – *not* ACT programs. Provide the annual expenditures for the identified Physical Plant Costs and Utilities, by time period. In order to allocate a portion of these costs to the treatment and program category, you will need to provide a breakdown of the square footage of your building by the following categories. **Use Tab 4 Space Designation (see instructions below) to provide a breakdown of the square footage of each room:**

Residential Space includes, but is not limited to, the following:

- resident bedrooms (including closet/storage space)
- resident restrooms (including, toilet, shower/tub, linen closets, etc.)
- resident lounge(s)
- kitchen (including food storage or pantry space)
- dining room
- laundry/linen room(s)
- other (must provide explanation/justification)

Treatment/Program Space includes, but is not limited to, the following:

- individual treatment or therapy rooms
- group treatment or therapy rooms
- other (must provide explanation/justification)

Administrative Space includes, but is not limited to, the following:

- administrative staff offices (program director, program assistant, receptionist or other office staff, etc.)
- lobby/entry way/vestibule
- janitorial space/storage
- records storage
- office supply storage
- information technology or data management rooms
- mechanical/electrical rooms
- staff restrooms
- staff break rooms
- trash area
- hallways and corridors
- other (must provide explanation/justification)

Other Space includes:

- space used by affiliated (agency) programs other than IRTS and RCS at the same location

General considerations for all types of space:

- Space may not be “split” between categories (e.g., resident lounge must be designated 100% to residential space, and may not be split between treatment space and residential space).
- **Provide a floor plan with the space designated as Residential, Treatment/Program, and Administrative (preferably color coded).**
- Include interior space only. *Do not* include the thickness of the walls; measure the inside wall space only.
- *Do not* include outside decks, porches, or designated “exercise” areas.

The Allocated Space Rate is calculated automatically in the lower right-hand cell of Tab 3 as follows: First, the Physical Plant and Utilities expenses in the upper left-hand table are allocated among four different categories (Residential, Treatment/Program, Administrative, and Other), based on the square footage breakdown in the lower left-hand table. Then the allocated Administrative portion of the expenses is further assigned to the Residential, the Treatment/Program, and Other categories, based again on the square footage breakdown. Finally, the resulting allocated Treatment/Program expense is divided by the total number of units of service identified in Tab 1. This rate component, called the Allocated Space Rate, is included in the Total MA Rate.

Tab 4 – Space Designation

Use Tab 4 to provide a breakout of the building space by room and designate the space as Residential, Trx/Program, Admin or Other.

Note that this Tab is unlocked. You may add rows as needed but make sure that the Grand Total calculations are correct as these cells are used to populate the Square Footage Breakdown on Tab 3.

Tab 5 – Summary of Rate Calculation

The table within Tab 5 summarizes the rate components to calculate the Total MA Rate for your program:

- “Direct Services Expenditures Rate” is the Total Direct Service Expenditures divided by the Total Units of Service (from Tab 1).
- “Other Program and Overhead Expense” is a flat percentage of the Direct Services Expenditures Rate (currently 41% for ACT programs, 37% for IRTS and RCS programs).
- “Total Direct Services and Other Program Costs” is the sum of the Direct Services Expenditures rate plus the Other Program and Overhead Expense rate.
- “Allocated Space Rate” is the number calculated on Tab 3; it applies only to IRTS and RCS programs.
- “Total MA Rate” is the sum of the Total Direct Services Expenditures Rate, plus the Other Program & Overhead Expense Rate, plus the Allocated Space Rate.

Tab 6 – Other Program & Overhead Expense

The information provided in Tab 6 will be used to review the Other Program and Overhead Expense percentages. NOTE: The current percentages (41% for ACT and 37% for IRTS and RCS programs) will not change for CY2017 rate setting.

Appendix C

Guidance for Completing the Expenditure & Revenue Spreadsheets for Discontinued Services

Providers that discontinue a service are subject to a “settle-up” process per Minnesota Statutes 256B.0622, subdivision 8(i). The settle-up process compares actual costs and reimbursements for a given time period to determine if a provider may have been overpaid or underpaid. Discontinuation of a service includes closing a program, transferring ownership, or changing services which requires a new program license and/or MA provider number.

Overview

There are two separate Excel spreadsheets to be used when reporting actual expenditures – one for Assertive Community Treatment (ACT) services and one for Intensive Residential Treatment Services (IRTS) and Residential Crisis Services (RCS) programs. Choose the correct spreadsheet and enter your data in the non-shaded areas only (shaded areas may contain formulas and may be locked). Spreadsheets are available on the [DHS Website](#).

Important – please note:

- ***DHS may require documentation to verify the appropriateness of any expense reimbursed by State or Federal funds through Medicaid or other Minnesota Health Care Programs (MHCP).***

Naming Your Files

Before going further with the preparation of your expenditure report, please re-name the Excel file using one of the following naming formats, depending on the service type:

- For an ACT program: [Your ACT Program’s Name] ACT Settle-Up [date].xls
- For an IRTS & RCS program: [Your IRTS/RCS Facility’s Name] IRTS-RCS Settle-Up [date].xls

Doing this will help DHS to distinguish your program(s) from other programs that may be submitting financial information at the same time.

Tab 1 – Direct Services Expenditures

Begin by entering your Program Name, Provider Number, Host County/AMHI and Settle-Up period at the top of the page. This information will automatically flow to the other Tabs on the spreadsheet. The Settle-Up period should include the last 12 months of actual operations. Do not include the last few months of ramp down. DHS would like a true picture of actual service expense and revenue for your operations.

Direct Services/Program Staff

Enter the actual full-time equivalents (FTEs) paid and the annual expenditures, by the categories provided and for the time periods specified. (Two years are required for comparison purposes.) These entries should be for Direct Service staff on your payroll *only*; any Contract staff should be included in the Contracts section. Refer to the [Assertive Community Treatment](#), [IRTS](#) and [Adult Crisis Services](#) sections

of the MHCP Provider Manual for important information regarding the types of individual providers authorized under the specific categories.

Include Benefits (retirement, insurance, etc.), Payroll Taxes (FICA, etc.), and Workers Compensation for the Direct Service staff identified. **Note: Separation expense is considered an Administrative Expense and should be excluded from Direct Services expenditures.**

Contracted Direct Services Staff

Specify the Contract staff (e.g., Psychiatrist, Registered Nurse, Interpreter, etc.) paid during the time periods identified. This should *include* any benefits, payroll taxes and/or administrative expenses for contracted staff that were paid directly by your organization, if applicable, but *exclude* direct service-related training expenses and direct service-related travel expenses.

Other Direct Services Expenditures

Treatment Space Allocation will automatically populate from the information provided on Tab 4 (applies to IRTS and RCS programs only).

Training for Direct Service Staff includes (but is not limited to) expenses such as the following, if those expenses are clearly related to improving or maintaining the quality of direct services provided by the program:

- training fees and conference fees for the program's direct service staff;
- expenses incurred by your organization when conducting in-service training activities to improve or maintain the quality of direct services provided to program participants.

Service-Related Travel includes (but is not limited to) expenses such as the following, if those expenses are clearly related to the provision of direct services by the program:

- mileage or other travel expenses incurred when serving program participants (for example, providing a home visit at the person's apartment, accompanying the person to a medical or legal appointment, meeting with the person's family at their home, taking a bus ride with the person to teach public transportation skills);
- mileage to relevant staff training events, including in-service training provided at another location of your organization; and
- travel and accommodations to attend relevant professional conferences.

Other Program Related Expenditures

The box to the right of Direct Services/Program Staff is to be used to record Other Program Related Expenditures. NOTE: Admin and Support Staff are to be recorded on Tab 2 and Central Office and Overhead Allocations are to be recorded on Tab 3. The totals from these two tabs will automatically populate within the shaded area of this box.

Enter the actual expense for the settle-up time period for the line items listed and include any additional items in the black lines under "Other Misc. Exp." You must identify the additional expenses. DHS reserves the right to exclude expenses that are not adequately identified or that may be considered unallowable under MA.

Room & Board Expenditures

Residential Space Allocation will automatically populate from the information provided on Tab 4 (applies to IRTS and RCS programs only). Enter the other expenses related to room and board in the lower right hand box. Enter the actual expense for the settle-up time period for the line items listed and include any

additional items in the black lines under “Other.” You must identify the additional expenses. DHS reserves the right to exclude expenses that are not adequately identified.

Tab 2 – Admin & Support Staff

Enter the actual FTEs paid and the salary expense for the settle-up period, by the categories provided. These entries should be for administrative and support staff on your payroll *only*. Include additional administrative and support staff not listed under “Other.” You must identify the additional staff. DHS reserves the right to exclude expenses that are not adequately identified or that may be considered un-allowable under MA.

Include Benefits (retirement, insurance, workers compensation, etc.) and Payroll Taxes (FICA, etc.) for the administrative and support staff identified. **Note: Separation expense (for both direct and admin/support staff) may be included as a separate line item under “Other.”**

Tab 3 – Central Office and Overhead Allocations

Use this tab to record Central Office and/or Overhead expenses not already included in Tab 1 or Tab 2. Enter the actual FTEs paid and the salary expense for the settle-up period, by the categories provided. These entries should be for central office staff on your payroll *only*. Any contracted staff should be listed under “Other”. Include additional central office and overhead expense not listed also under “Other.” You must identify the additional expenses. DHS reserves the right to exclude expenses that are not adequately identified or that may be considered un-allowable under MA.

Include Benefits (retirement, insurance, workers compensation, etc.) and Payroll Taxes (FICA, etc.) for the central office staff identified.

Tab 4 – Allocated Space Costs

Provide the actual expenditures for the identified Physical Plant Costs and Utilities, for the settle-up time period (applies to IRTS and RCS programs only). In order to allocate a portion of these costs to the treatment and program category, you will need to provide a breakdown of the square footage of your building by the following categories. **Use Tab 5 Space Designation (see instructions below) to provide a breakdown of the square footage of each room:**

Residential Space includes, but is not limited to, the following:

- resident bedrooms (including closet/storage space)
- resident restrooms (including, toilet, shower/tub, linen closets, etc.)
- resident lounge(s)
- kitchen (including food storage or pantry space)
- dining room
- laundry/linen room(s)
- other (must provide explanation/justification)

Treatment/Program Space includes, but is not limited to, the following:

- individual treatment or therapy rooms
- group treatment or therapy rooms
- other (must provide explanation/justification)

Administrative Space includes, but is not limited to, the following:

- administrative staff offices (program director, program assistant, receptionist or other office staff, etc.)

- lobby/entry way/vestibule
- janitorial space/storage
- records storage
- office supply storage
- information technology or data management rooms
- mechanical/electrical rooms
- staff restrooms
- staff break rooms
- trash area
- hallways and corridors
- other (must provide explanation/justification)

Other Space includes:

- space used by affiliated (agency) programs other than IRTS and RCS at the same location

General considerations for all types of space:

- Space may not be “split” between categories (e.g., resident lounge must be designated 100% to residential space, and may not be split between treatment space and residential space).
- **Provide a floor plan with the space designated as Residential, Treatment/Program, and Administrative (preferably color coded).**
- Include interior space only. *Do not* include the thickness of the walls; measure the inside wall space only.
- *Do not* include outside decks, porches, or designated “exercise” areas.

The Allocated Space Rate is calculated automatically in the lower right-hand cell of Tab 4 as follows: First, the Physical Plant and Utilities expenses in the upper left-hand table are allocated among four different categories (Residential, Treatment/Program, Administrative, and Other), based on the square footage breakdown in the lower left-hand table. Then the allocated Administrative portion of the expenses is further assigned to the Residential, the Treatment/Program, and Other categories, based again on the square footage breakdown. Finally, the resulting allocated Treatment/Program expense is automatically loaded on Tab 1 under Other Direct Service Expenditures. The allocated Residential expense is automatically loaded on Tab 1 as well under Room and Board Expenditures.

Tab 5 – Space Designation

Use Tab 5 to provide a breakout of the building space by room and designate the space as Residential, Trx/Program, Admin or Other (applies to IRTS and RCS programs only).

Note that this Tab is unlocked. You may add rows as needed but make sure that the Grand Total calculations are correct as these cells are used to populate the Square Footage Breakdown on Tab 4.

Tab 6 – Units of Services & Revenue

Actual Units of Services (Program)

In the Units of Service area of the spreadsheet, provide a breakout of the total count of billable daily charges, for the settle-up period identified and by the categories listed. Also include the total number of licensed beds for the program, if applicable.

Program Services Revenue and Collections

In the Program Revenue and Collections area of the spreadsheet, provide a breakout of the total dollars collected for the units of services identified. There may be a lag time between when services are billed and payments are collected; therefore, you may need to also include billed revenue for those services that you have not received payments.

Room & Board Revenue and Collections

In the Room & Board Revenue and Collections area of the spreadsheet, provide a breakout of the total dollars collected for the units of services identified (applies to IRTS and RCS programs only). There may be a lag time between when services are billed and payments are collected; therefore, you may need to also include billed revenue for those services that you have not received payments.

Tab 7 – Settle-Up Summary

The tables presented in this Tab show how the various factors are combined to determine the potential settle-up amount. (NOTE: the data in this table is automatically populated from data entered on the previous Tabs.)

- “Program Revenue Over/(Under) Expenditures” – total program/direct service expenditures less total program revenue. This amount represents the estimated program/direct services income/(loss) of a provider. A positive amount indicates the provider may have been overpaid whereas a negative amount indicates the provider may have been underpaid.
- “Room & Board Revenue Over/(Under) Expenditures” – total room and board expenditures less total room and board revenue. NOTE: This amount is excluded from the MA settle-up process as MA does NOT pay for room & board expenses. Applies to IRTS and RCS programs only.
- “Total Revenue Over/(Under) Expenditures” – total expenditures (direct services and room & board) less total revenue. This amount represents the providers’ net income/(loss) for this program. Applies to IRTS and RCS programs only.
- “Percent of Program Revenue to Program Expenditures” – total direct services/program revenues divided by total direct services/program expenditures. This is used to determine if revenues collected is less than 95% of expenditures or greater than 105% of expenditures. If the percentage falls within this range, there will be no settle-up.
- “Program Revenue Under 95% (- negative amount) or Over 105% (+ positive amount)” -- this amount represents the maximum potential settle-up amount.
- “Percent of MA Units of Service” – the number of MA units of service divided by the total number of units of service provided during the settle-up period (excludes Room and Board). This percentage is applied to the line above and used to determine the amount the provider may owe or may be owed under the settle-up review process for Medical Assistance.
- “Amount Provider May Owe State (Rev > 105%)” – provider may have been over paid and may be required to pay the state/DHS this amount.
- “Amount State May Owe Provider (Rev < 95%)” – provider may have been under paid and may be entitled to a payment in this amount from the state/DHS.