DEPARTMENT OF HUMAN SERVICES

ACT, IRTS, RCS and IRMHS Rate Setting Manual

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Introduction

This manual describes the rate setting procedures for ACT, IRTS, RCS and IRMHS in accordance with Minnesota Statutes 256B.0622, subdivision 8 and Minnesota Statutes 256B.0947.

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 8.

Provider Authorization Requirements for Residential Crisis Stabilization (RCS)

RCS provider authorization is established in Minnesota Statutes 256B.0624, subdivision 4.

Provider Authorization Requirements for Intensive Rehabilitative Mental Health Services (IRMHS/Youth ACT)

IRMHS/Youth ACT provider authorization is established in Minnesota Statutes 256B.0947, subdivision 4.

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

Provision of Services Directly by Counties

Counties that operate their own ACT 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 ACT providers 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-contracted 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.

Authorization Requirements for ACT, IRTS, RCS or IRMHS Programs

This section identifies the requirements that must be met by a provider seeking authorization to establish a new ACT, IRTS, RCS or IRMHS program in Minnesota. The DHS Commissioner authorizes the new service prior to establishing a Medicaid fee for service rate for the program, using procedures described in the remaining sections of this manual, including the Appendices.

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 Behavioral Health Division ACT policy staff at dhs.adultmhact_irts@state.mn.us

Intensive Residential Treatment Services and Residential Crisis Stabilization

DHS authorizes new IRTS and RCS services based on the following requirements:

The program's Service Description including requirements in IRTS variance R36V.13, Subd 2 (MS 245I.23 upon federal approval of the Mental Health Uniform Service Standards Act) including program specialties intended to meet the service needs of a target population, if applicable.

The proposed program capacity including number of beds for IRTS members and, if applicable, the number of beds for RCS recipients.

Evidence of ongoing relationships with other service providers which will be used to facilitate referrals to and from the proposed program.

A statement from the local mental health authority indicating whether the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If the local mental health authority does not respond within 60 days the applicant may seek approval of need from Behavioral Health Division.

DHS Rule 36 program license and a Variance to provide IRTS and/or RCS. Upon federal approval of the Mental Health Uniform Service Standards Act, a DHS 245I program license will be required.

New Program Development resources are available HERE

For additional technical assistance contact the Behavioral Health Division Adult Intensive Services Lead, Erin Ruiz at erin.ruiz@state.mn.us

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, subdivisions 2(a) and 2(b).

Client Eligibility Requirements for IRTS

Eligibility requirements for clients of IRTS are established in Minnesota Statutes 256B.0622 and are included in the MHCP Provider Manual.

Client Eligibility Requirements for RCS

Eligibility requirements for clients of RCS are established in Minnesota Statutes 256B.0624, subdivision 2(e) and subdivision 3 and are included in the MHCP Provider Manual.

Client Eligibility Requirements for IRMHS

Eligibility requirements for clients of IRMHS/Youth ACT are established in Minnesota Statutes 256B.0947, subdivision 3, and can be referenced here: Mental Health Services - Youth Assertive Community Treatment (Youth ACT)/Intensive Rehabilitative Mental Health Services (IRMHS) (state.mn.us)

For additional technical assistance contact Lorraine.Sellner@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 Behavioral Health Division with evidence that the following requirements have been met:

- Enrollment as a Minnesota Health Care Programs (MHCP) provider.
- Completion of the certification application is found: here and the recertification application here .
- Execution of a host County contract, as specified in Minnesota Statutes 256B.0622.
- Submission of program design to the Behavioral 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 include 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.

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

ACT Program Conversions

A current ACT provider seeking to change the design of the program in order to change its capacity would be considered a program conversion and must seek Behavioral Health Division (BHD) approval to implement the conversion.

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

1. Request for change in capacity indicating new capacity

2. Letters of support (i.e. agency board of directors, community entities, host county)
3. Plans for compliance to Minnesota Statutes 256B.0622, as applicable for new capacity.
4. Financial budget projection with additional staff, hours of operation, etc. to comply with Minnesota Statutes 256B.0622
5. Completion of the spreadsheet for new program development
6. Additional information that is requested by the Behavioral 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 programs must maintain their 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 approved by the Behavioral Health Division. A residential program with changes to its service capacity may be considered a converted program if capacity changes or significant changes are made to the service design. Examples of a change to service capacity are the increase or decrease in the number of licensed beds and/or programmatic changes made to serve persons with higher service needs or adding either RCS or IRTS services to an existing program. Changes may also require a change in the terms approved by the DHS Licensing Division. Changes in ownership must also follow the DHS Licensing Division change of ownership process.

Overview of the Rate-Setting Process

DHS establishes rates in accordance with Minnesota Statute 256B.0622, subdivisions 8, 9 and 10.

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

To begin the rate-setting process for a new or converted program, a provider uses a slightly modified version of the cost report 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 Mental Health Service Rates page.

Initial Rate Setting Procedures for IRTS and RCS Programs:

Rates for new IRTS and RCS programs are established by DHS following a review of:

- New Program Expenditure Worksheet;
- Statement of Need in compliance with MS section 256B.0622, subdivision 4(d);
- Program services description (R36V.13, subdivision 2 or MS 245I.23 upon federal approval of the Mental Health Uniform Service Standards Act) including optional services and services intended to meet the needs of a target population;
- A staffing plan which shows how direct services staff identified in the proposed expense worksheet will be utilized.
- DHS uses existing program actual reported expenditures, occupancy and rates to determine that the proposed expenses and utilization are reasonable in comparison to similar programs with established rates.

Rate-Setting Process for Existing Programs

ACT, IRTS, RCS and IRMHS Process

ACT, IRTS, RCS and IRMHS 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 change these dates as necessary.

IRMHS Dates	**ACT, IRTS, RCS Dates**	**Action**
On or around September 1	On or around September	DHS notifies providers of the rate-setting process.

IRMHS Dates	ACT, IRTS, RCS Dates	Action
On or around October 15	October 15	Providers submit to DHS their actual costs for the previous state fiscal year (July 1 to June 30).
On or around November 1	October 15 through mid-December	DHS establishes new individual program rates for the next calendar year (January 1 to December 31).
On or around January 1	Mid to late December	DHS publishes the new individual program rates.

Cost Report Forms Used in the Rate-Setting Process

Spreadsheets shall be used by providers of existing ACT, IRTS, RCS and IRMHS programs when submitting their actual costs to DHS for the previous state fiscal year. These spreadsheets are available on the Mental Health service rates page.

See Appendix B for additional information on completing the spreadsheets.

Rate-Setting Methodology

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. The IRMHS/Youth ACT rate-setting method is mandated by Minnesota Statutes, section 256B.0947, subdivision 7.

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, clinical supervision, 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, RCS and IRMHS 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 2 CFR 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, (federal guidance that supersedes OMB A-122). Scroll down to "Chapter II – Office of Management and Budget Guidance" and click on "200". Providers of IRMHS services are responsible for the requirements in Minnesota Statutes 256B.0947, which specifies reporting of "actual costs incurred by entities

providing the services;" The same federal guidelines referenced in this paragraph are applicable when reporting allowable actual costs for IRMHS services.

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, RCS and IRMHS 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) and Minnesota Statutes, 256B.0947, subdivision 7 (d).

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 B for additional information.

Appendix A

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 Residential Crisis Stabilization (RCS), and one for Intensive Rehabilitative Mental Health Services (IRMHS). 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 Mental Health service rates page.

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).***

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 an RCS program: [Your RCS Facility's Name] RCS FYXX Actuals.xls
- For an IRMHS program: [Your IRMHS/Youth ACT Program's Name] Youth ACT 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 for ACT, IRTS and RCS. There are three different Tabs at the bottom of the Excel spreadsheet for IRMHS. Start with Tab 1.

Begin by entering your Program Name / Location, Service Location Address, Provider NPI, and Host County/AMHI at the top of the page. (This information will automatically flow to the other Tabs on the spreadsheet.) The information in this section will be used to create rate letters and must be accurate and fully completed.

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 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, Residential Crisis Stabilization, and Intensive Rehabilitative Mental Health 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. In most cases, bonuses that are not considered a distribution of profits are allowable. **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.
- clinical supervision for licensure

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,

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

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.

IRMHS/Youth ACT provides for billing Service-related Travel separately from the per diem, so DO NOT include any claims that were submitted for payment through H0046. IRMHS/Youth ACT may include (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 to relevant staff training events, including in-service training 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, you must include the total number of licensed beds for the program. **Note: If you are combining IRTS and RCS 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 (IRTS and RCS only)

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 (IRTS and RCS only)

Tab 3 applies to IRTS and RCS programs only – *not* ACT or IRMHS 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 (IRTS and RCS only)

Use Tab 4 to provide a breakout of the building space by room and designate the space as Residential, Tx/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 and Certification

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 and IRMHS 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 (if applicable).

Providers must complete the certification section within Tab 5 before submitting the report. If the certification section is not filled out, the report is incomplete and will be returned to the provider.

Note – if your copy of the spreadsheet does not contain a certification section, please contact the department.

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 IRMHS, and 37% for IRTS and RCS programs) will not change for CY2023 rate setting.

Appendix B

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. Please contact the division to discuss the Settle-up Process for ACT/IRTS/RCS.

Appendix C

Guidance for Completing the Program Expenditures Worksheet for New and Converted Programs

Overview

There are three separate Excel spreadsheets to be used when reporting anticipated expenditures – one for Assertive Community Treatment (ACT) services, one for Intensive Residential Treatment Services (IRTS), and one for Residential Crisis Stabilization (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 the Mental Health service rates page. Although you are reporting "proposed" costs, the same federal rules and regulations apply when determining proposed costs. Providers must familiarize themselves with these rules to avoid illegally overcharging the Medicaid program when submitting claims using a new/startup rate. In other words, if a cost is not allowed when you eventually submit the "existing provider" cost report—it must be treated as an unallowable cost for purposes of the new/startup rate as well.

Note – if you are a NEW Intensive Rehabilitative Mental Health Services (IRMHS) provider, please contact: Lorraine.Sellner@state.mn.us

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 2 CFR 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, (federal guidance that supersedes OMB A-122). Scroll down to "Chapter II – Office of Management and Budget Guidance" and click on "200".

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 additional documentation to determine if proposed expenses may be reimbursed by State or Federal funds through Medicaid or other Minnesota Health Care Programs (MHCP).***

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

Tab 1 – Direct Services Expenditures

You will notice that there are five 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 proposed full-time equivalents (FTEs)[3] salary and the annual expenditures, by the categories provided and for the time periods specified. Include roles such as MH Professional, MH practitioner, MH Rehab worker, Certified Peer Specialist (These entries should be for Direct Service staff on your payroll *only*; any contract staff should be included in the Contracts section. Include Benefits (retirement, insurance, etc.), Payroll Taxes (FICA, etc.), and Workers Compensation for the Direct Service staff identified. In most cases, bonuses that are not considered a distribution of profits are allowable. Note: Separation expense is considered an Administrative Expense and should not be included under Direct Services expenditures.

Specify the Contract staff (e.g., Psychiatrist, Registered Nurse, Interpreter, etc.) that will be 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:

[3] Throughout this document, FTE employment means 40 paid hours per week.

- 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.
- clinical supervision for licensure

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 anticipated total count of billable daily charges, for the time frames identified and by the categories listed. For IRTS and RCS you must include the total number of licensed beds for the program. Use the box at the bottom of the spreadsheet to provide additional information or explanation.

Tab 2 – Units of Service Breakout (IRTS and RCS only)

Tab 2 applies to programs providing IRTS and RCS at the same location. Provide a separate breakout of the anticipated days for IRTS and RCS. This Tab calculates the total units of service provided and compares 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 (IRTS and RCS only)

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 categories listed below. **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
- medication/health services space
- 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 (IRTS and RCS only)

Use Tab 4 to provide a breakout of the building space by room and designate the space as Residential, Tx/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. A floor plan must be included and labelled to match the space designation reported on Tab 4.

Tab 5 – Summary of Rate Calculation and Certification

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.

Providers must complete the certification section within Tab 5 before submitting the report. If the certification section is not filled out, the report is incomplete and will be returned to the provider.

Note – if your copy of the spreadsheet does not contain a certification section, please contact the department.