
ACT, IRTS and RCS Rate Setting Manual

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Introduction

This manual describes the rate-setting procedures for ACT, IRTS, and RCS in accordance with applicable Minnesota statutes and federal Medicaid requirements.

The Behavioral Health Administration (BHA) utilizes provider cost reports in the annual ACT, IRTS and RCS rate-setting process. Provider-reported costs used to determine federal Medicaid rates must be allowable, allocable, reasonable, and consistent with federal reimbursement requirements under 48 C.F.R. Part 31 and 2 C.F.R. Part 200. Costs are subject to Commissioner approval per Sec. under Minnesota Statutes, Sections 256B.0622, 256B.0632, and 256B.0624..

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.

Individuals preparing ACT, IRTS, and RCS cost reports should have knowledge and experience with generally accepted accounting principles (GAAP) and financial reporting. If the provider does not have qualified internal personnel, the provider should consider engaging a qualified accounting professional or accounting firm to prepare or review the cost report.

Provider Authorization Requirements

Only providers authorized by the Commissioner of the Minnesota Department of Human Services (DHS) are eligible for Medicaid (MA) 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 differ by service type.

A statutory reference for each service is provided below.

Provider Authorization Requirements for Assertive Community Treatment (ACT)

ACT provider certification and contract requirements are established in [Minnesota Statutes, section 256B.0622](#), subdivision 3a. Medical Assistance payment authority is established in subdivision 8.

Provider Authorization Requirements for Intensive Residential Treatment Services (IRTS)

IRTS provider entity licensure and contract requirements are established in [Minnesota Statutes, section 256B.0632](#), subdivision 2. Medical Assistance payment authority is established in subdivision 3.

Provider Authorization Requirements for Residential Crisis Stabilization (RCS)

RCS provider entity standards are established in [Minnesota Statutes, section 256B.0624](#), subdivision 4. Medical Assistance payment and rate-setting authority for residential crisis stabilization are addressed in subdivision 7.

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 Department of

Human Services 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 New ACT, IRTS, or RCS Programs

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. 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 procedures to establish a new ACT program, or for technical assistance with the initial steps, a county, Adult Mental Health Initiative (AMHI), Tribe, or service provider must contact Behavioral Health Division ACT policy staff at dhs.adulthmact_irts@state.mn.us.

Intensive Residential Treatment Services and Residential Crisis Stabilization

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

A program service description that addresses DHS licensing requirements for IRTS and RCS services under Minnesota Statutes, chapter 245I. The description must explain the intent of the program, including any program specialties designed to meet the needs of a target population.

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

Evidence of ongoing relationships with other service providers that will 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.

A DHS 245I program license to provide IRTS and/or RCS.

For additional technical assistance, contact the Behavioral Health Division Adult Intensive Services team at dhs.adultmhact_IRTS@state.mn.us.

Client Eligibility Requirements

Eligibility for Medicaid coverage varies by service.

Client Eligibility Requirements for ACT

Eligibility requirements for clients of ACT are established in Minnesota Statutes [256B.0622](#), subdivision 2a and are included in the [MHCP Provider Manual](#).

Client Eligibility Requirements for IRTS

Eligibility requirements for clients of IRTS are established in Minnesota Statutes [245I.23](#), subdivision 15 and are included in the [MHCP Provider Manual](#).

Client Eligibility Requirements for RCS

Eligibility requirements for clients of RCS are established in Minnesota Statutes [245I.23](#), subdivision 16 and are included in the [MHCP Provider Manual](#).

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 submit evidence to the Behavioral Health Division demonstrating 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](#).
- Submission of program design to the Behavioral Health Administration that is in compliance with 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.

DHS Behavioral Health Policy Division will make the final determination regarding the proposed provider's ability to operate as an ACT team.

ACT Program Conversions

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

ACT programs seeking a conversion must submit the following information in writing to DHS ACT Policy staff:

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 with 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

DHS makes the final determination as to whether a program meets the definition of a program conversion. DHS will notify the provider of the decision in writing so the appropriate 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 federal Medicaid 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 Administration. 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 people 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 ACT, IRTS, and RCS rates in accordance with Minnesota Statutes, sections 256B.0622 and 256B.0947.

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

To begin the rate-setting process for a new or converted ACT, IRTS, or RCS program, a provider uses a modified version of the existing-program cost report spreadsheet and enters projected expense and utilization data when actual data are not available. The new-program-development spreadsheet is available on the Mental Health Service Rates page.

Initial Rate Setting Procedures for IRTS and RCS Programs:

DHS establishes rates for new IRTS and RCS programs after reviewing the following information:

- New Program Expenditure Worksheet.
- Statement of Need in compliance with MS section 256B.0622, subdivision 4(d).
- Program services description MS 245I.23 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.
- Floor plan which identifies square footage and room types within the facility; and
- Additional supporting documentation, as necessary, to determine the expected expenses and utilization are within reasonable limits. DHS also uses existing programs with actual reported expenditures, occupancy, and rates to determine that the expected expenses and utilization are reasonable in comparison to similar programs with established rates.

Rate-Setting Process for Existing Programs

ACT, IRTS and RCS Process

ACT, IRTS and RCS providers authorized by the DHS Commissioner for federal 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.

ACT, IRTS, RCS Dates	Action
On or around September 1	DHS notifies providers of the rate-setting process.
October 15	Providers submit to DHS their actual costs for the previous state fiscal year (July 1 to June 30).
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	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 and RCS 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. Contact DHS using the contact information provided on that page to request the applicable spreadsheet.

See Appendix A for additional information on completing the spreadsheets.

Rate-Setting Methodology

The prospective federal 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 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

Room-and-board expenses are not included in the Other Program and Overhead Expense percentage calculation.

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 complying with Minnesota Statutes, section 256B.0622, subdivision 8(c)(2), and applicable federal cost principles, including 48 CFR Part 31.2 for for-profit entities and 2 CFR Part 200 for nonprofit entities.

The following requirements apply when reporting allowable actual costs for ACT, IRTS, and RCS services.

Clarification of Allowable, Allocable, and Reasonable Costs

For purposes of completing the cost report, a reported cost must be allowable, allocable to the program, reasonable in nature and amount, necessary for covered services, efficiently incurred, attributable to the applicable reporting period, and adequately supported by the provider's books and records.

Allowable cost. A reported cost must be permitted under applicable Minnesota statutes, federal cost principles, the rate-setting methodology, and the instructions in this manual. The cost is not allowable merely because the provider incurred or paid for it.

Allocable cost. A reported cost must be assigned to the ACT, IRTS, or RCS program based on the benefit received. Costs benefiting more than one program or organizational function must be limited to the portion attributable to the reported program using a reasonable, consistently applied, and documented allocation method.

Reasonable cost. A reported cost must be ordinary and necessary for operation of the program and must not exceed the amount a prudent organization would incur under similar circumstances. DHS may request additional documentation and rationale and may limit costs determined to be unreasonable. In assessing reasonableness, DHS may consider the nature and amount of cost, established provider practices, market conditions, material year-over-year changes, unusual, calculated wages, and comparison with similar programs. An outlier does not automatically make a cost unallowable; the provider may submit documentation and rationale supporting the cost.

Necessary and proper cost. A reported cost must be appropriate and helpful to delivering or supporting covered program services, must support the efficient delivery of covered services, and must be efficiently incurred and reported in the proper cost category.

Adequately supported cost. Providers must maintain documentation sufficient to demonstrate that each reported cost was incurred, paid, or accrued in accordance with the provider's accounting practices, attributable to the reporting period and program, reported in the appropriate category, and not reimbursed or funded through another source. DHS may request additional documentation when the information submitted does not sufficiently support the reported amount.

Examples:

- Salary for a direct-service employee may be reported when the employee performs covered program responsibilities, and the amount is supported by payroll records.
- A cost that benefits several programs may not be reported entirely to Intensive Services unless the provider can demonstrate that the full cost is attributable to the program.
- A cost paid with restricted grant funding, billed separately to Medicaid, or reimbursed by another payer may not also be included in the cost build-up.
- An expense may be necessary to the organization but belong within Other Program and Overhead Expense rather than Direct Services Expenditures.

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.

Cost Report Completeness, Documentation, and Review

DHS may perform completeness, consistency, and reasonableness review procedures before relying on submitted information for rate setting. These procedures are intended to determine whether required information has been submitted and whether reported amounts are adequately supported; they do not limit DHS's authority to request additional information or conduct further review when necessary.

Review procedures may include, but are not limited to:

- confirming that required cost report fields, supplemental schedules, explanations, and certifications are complete.
- reconciling reported FTEs and compensation to detailed payroll registers.
- comparing employee and contracted staff reporting for consistency.
- reviewing material year-over-year changes, unusually calculated hourly wages, or amounts that differ significantly from similar programs.
- confirming that grant-funded, separately billed, or otherwise reimbursed costs were excluded.
- requesting supporting detail for material "Other" categories, contracted services, training, travel, or unusual compensation; and
- confirming that IRTS and RCS space and physical plant costs are supported by the required floor plan, space designation, and financial documentation.

When a cost or FTE amount cannot be reconciled to the provider's records, DHS may request clarification, correction, or additional support before completing the rate-setting review.

Rates Paid by Other Payers

The federal Medicaid rate established by DHS for a provider must not exceed the rate the provider charges other payers for the same service (Minnesota Statutes, section 256B.0622, subdivision 8(g), and section 256B.0947, subdivision 7(d)).

IRTS, ACT, RCS 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 an adjustment are spelled out in Minnesota Statutes [256B.0622](#), subdivision 8(k). Refer to Appendix B for additional information.

Appendix A

Guidance for Completing the Expenditure Reporting Spreadsheets for Existing Programs

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 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 on the Mental Health service rates page. Contact DHS using the contact information provided on that page to request the applicable spreadsheet.

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 the 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).***

Minimum Supporting Documentation Expectations

Providers must retain records that allow each material amount reported on the cost report to be traced to the provider's accounting, payroll, contract, and operational records. Unless DHS specifies otherwise, supporting records must cover the full reporting period, identify the applicable program or cost center, and be produced within five business days of a DHS request. If requested documentation is not produced by the deadline, DHS will disallow or adjust the unsupported amount.

Depending on the reported cost, supporting documentation may include:

- detailed payroll registers and employee listings.
- general ledger detail and trial balance reports.
- contracts, invoices, statements of work, and proof of payment.
- training invoices, agendas, attendance records, and descriptions of the program relationship.
- mileage logs, vehicle-use records, lease agreements, and related travel documentation.
- grant agreements, award notices, and records showing excluded grant-funded expenditures.
- floor plans, lease agreements, depreciation schedules, utility records, and space designations for IRTS and RCS programs; and
- other records necessary to explain the nature, amount, timing, and program relationship of a reported cost.

Equivalent records may be used when the provider's accounting or payroll system uses different report names, provided the records contain sufficient detail for DHS to validate the reported amounts.

Naming Your Files

Before preparing the expenditure report, rename the Excel file using the format applicable to 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

This naming convention helps DHS distinguish the program from other programs submitting financial information during the same period.

Tab 1 – Direct Services Expenditures

The ACT, IRTS, and RCS Excel spreadsheets contain six tabs. Begin with Tab 1.

Enter the Program Name/Location, Service Location Address, Provider NPI, and Host County/AMHI at the top of Tab 1. This information automatically populates the other tabs and is used to create rate letters, so all fields must be complete and accurate.

Next, enter the actual full-time equivalents paid (FTEs) and the annual expenditure, by the categories provided and for the time periods specified. (Two years are required for comparison purposes.) These entries must be for Direct Service staff on your payroll only; any contract staff must be included in the Contracts section. Refer to the [Assertive Community Treatment](#), [IRTS](#), and [Residential Crisis Stabilization](#) sections of the MHCP Provider Manual for information regarding authorized provider types.

FTE Calculation

For cost reporting purposes, an FTE is calculated using total paid hours attributable to the program during the reporting period divided by 2,080 hours. Throughout this document, 1.00 FTE means 2,080 paid hours, equivalent to 40 paid hours per week for a full year. Report FTEs consistently to at least two decimal places. Total paid hours may include regular hours, paid leave, holidays, training or orientation hours, and overtime hours when those hours and the related compensation are attributable to the program. Overtime hours must not be converted to time-and-one-half hours for the FTE calculation; use the actual paid hours worked.

Examples:

- 2,080 paid hours attributable to the program equals 1.00 FTE.
- 1,040 paid hours attributable to the program equals 0.50 FTE.
- An employee with 2,080 regular paid hours and 120 overtime hours attributable to the program equals 1.06 FTE (2,200 divided by 2,080).
- A position that was vacant for part of the year is not reported as a full FTE unless paid hours support the reported amount.
- An employee who supports more than one program is reported only for the portion attributable to the Intensive Services program, supported by payroll coding, time records, or another consistent documented method.

- Contracted staff are reported in the Contract section and are not included in employee FTE totals.

Payroll Documentation

Payroll documentation is separate from the FTE calculation and must reconcile to the FTEs and compensation reported on the cost report.

Detailed payroll register. The payroll documentation submitted or made available to DHS should identify, as available from the provider's payroll system:

- employee name or unique employee identifier, job title, program, or cost center, and pay period.
- regular, overtime, paid leave/PTO, holiday, training/orientation, and on-call or standby hours, when applicable.
- regular wages, overtime wages, shift differentials, bonuses or incentives, on-call or standby pay, and other compensation types.
- gross compensation and employer payroll taxes and benefits, when available at the employee level.
- hire and termination dates when the employee worked only part of the reporting period; and
- the distribution of compensation and paid hours among programs for shared employees.

Providers may submit equivalent payroll reports or a combination of reports when a single payroll register does not contain every element, provided the documentation collectively supports the FTEs and compensation reported on the cost report.

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.**

Example: If a direct-service employee receives regular wages, significant overtime, and on-call pay during the reporting year, the payroll registers or accompanying schedule should separately identify each pay type. The actual paid hours are used in the FTE calculation, while the separately identified overtime and on-call compensation allow DHS to review the calculated wage and the reasonableness of the reported cost.

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.

Contracted Direct Service Staff

Report a contractor in the Contract section only when the contractor performs direct-service responsibilities that correspond to an authorized program role. Temporary agency personnel performing direct service roles should also be reported in this section rather than employee wages.

Do not report maintenance vendors, housekeeping vendors, management or administrative contractors, training vendors, information technology vendors, or other non-direct-service vendors as contracted direct service staff. Those costs should be reported, if applicable, in the cost category consistent with the services performed and the existing rate methodology.

Supporting documentation should identify the contractor, position or service performed, dates and hours of service, rate charged, total amount paid or accrued, and any portion funded or billed separately. Acceptable

support may include an executed agreement, statement of work, invoices, time records, and proof of payment.

Example: A psychiatrist retainer may be reported as a contracted direct-service cost when the psychiatrist performs, or is contractually required to be available for, an authorized clinical function necessary for covered patient care. A retainer for administrative oversight, organizational quality improvement, or general best-practice development is not a direct-service cost. Similarly, treatment supervision by a mental health professional may be a direct-service cost when it directly supports covered services delivered by program staff; general administrative or organizational supervision is included in Other Program and Overhead Expense. Classification must be supported by the documented duties, service obligation, and relationship to covered patient care.

Training for Direct Service Staff includes the following expenses when they 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; and
- clinical supervision for licensure.

Additional Guidance for Direct-Service Training

Training specifically provided to authorized direct-service staff and directly related to the knowledge or skills needed to deliver covered program services may be reported on Tab 1: Training for Direct Service Staff.

If the training is direct service in nature, then costs associated with the training, including travel, should also be reported as direct-service training costs on Tab 1. Conversely, if the training is administrative in nature, the travel costs must be reported on the Other Program and Overhead Expense tab and must not be reported on Tab 1.

Only costs that are paid or reimbursed by the employer may be reported. Training costs paid by the employee and not reimbursed by the employer must not be reported on the cost report.

Examples:

Example 1: Direct-Service Training Paid by Employer (Allowed on Tab 1). An ACT provider pays for a mental health professional to attend continuing education on motivational interviews, suicide risk assessment, trauma-informed care, substance use disorder treatment, de-escalation techniques, or other clinical skills used to deliver covered services. The employer pays the registration fee and reimburses mileage, lodging, and meals. Because the training is direct service in nature and the employer incurred the expenses, the training and related travel costs may be reported on Tab 1: Training for Direct Service Staff.

Example 2: Administrative or General Training Paid by Employer (Not Allowed on Tab 1). An ACT provider pays for an employee to attend leadership development, supervisor training, human resources training, compliance training, workplace harassment training, payroll training, budgeting training, management certification, or similar administrative training. The employer also pays or reimburses related travel. Because the training is administrative in nature, the training and related travel costs must be reported on the Other Program and Overhead Expense tab and must not be reported on Tab 1.

Example 3: Direct-Service Training Not Paid or Reimbursed by Employer (Not Allowed). A licensed clinician independently enrolls in continuing education on cognitive behavioral therapy, integrated care, or another clinical topic and pays the registration and travel costs personally. The employer does not reimburse the

expense. Although the training relates to direct-service activities, the provider did not incur the cost; therefore, neither the training nor the travel costs may be reported on the cost report.

Example 4: Administrative Training Not Paid or Reimbursed by Employer (Not Allowed). An employee independently attends a leadership conference, management workshop, or professional networking event and pays all registration and travel expenses without employer reimbursement. Because the provider did not incur the expense and the training is administrative in nature, no costs may be reported on the cost report.

Additional Guidance for Service-Related Travel

Unreimbursed Service-Related Travel for ACT, IRTS, and RCS includes expenses that are directly connected to providing covered services, are not funded by another source, and are not billed separately to Medicaid.

Service-related travel is travel directly connected to providing covered patient care. Examples include traveling from a provider's location to meet with a patient, traveling between patient-service locations while providing care, accompanying a patient to an appointment, or traveling to another location to perform a covered service for a patient. Travel paid or reimbursed separately by Medical Assistance; a grant, another payer, or another funding source must not be included.

Provider-owned or leased vehicles. Report actual vehicle costs only to the extent attributable to covered patient care. Supporting documentation must include, as applicable, mileage or trip logs, lease or depreciation support, fuel receipts, insurance, maintenance, repair records, and a documented allocation for shared use. Example: A leased vehicle used for ACT home visits and administrative errands must be allocated using documented patientcare and non-patient-care use.

Personally owned vehicles. Report on the documented mileage reimbursement paid under the provider's established policy. When the mileage reimbursement rate covers vehicle operating costs, do not separately report fuel, depreciation, maintenance, insurance, or other vehicle costs. Example: If an employee is reimbursed for documented patient-care mileage, report the mileage reimbursement and retain the mileage log and reimbursement record; do not also report the employee's gas receipts.

Program-related or administrative travel includes travel that supports program operations but is not directly connected to providing covered patient care. Examples include travel between provider locations for meetings, supervision, administrative work, staffing support, training, management activities, or organization-wide meetings. Travel between two programs may be allocated as an administrative or shared program cost when supported by a reasonable and documented allocation method, but it is not service-related travel unless it is directly connected to providing covered patient care. These costs are included in Other Program and Overhead Expense. Ordinary commuting between an employee's residence and regular work location is not reportable. See Tab 6 for the reporting on administrative and other non-service-related travel.

Service-related travel does not include ordinary commuting between an employee's residence and regular work location, personal vehicle expenses beyond an approved mileage or travel reimbursement, fines or penalties, or costs already reimbursed through another payment source.

Example: A leased vehicle used exclusively and documented for ACT home visits may be included in unreimbursed service-related travel. If the vehicle is shared by ACT, case management, and administrative staff, the full lease and operating cost must not be reported to ACT without records supporting the ACT

portion.

Do not include expenses funded by federal or state grants. Grant-funded expenditure must be excluded from the cost build-up to prevent duplicate payment through both the grant and the rate.

Grant-Funded and Otherwise Reimbursed Costs

Exclude the portion of any reported expense paid with federal, state, county, local, or private grant funds when the grant is intended to support the same expenditure. Also exclude costs billed separately to Medicaid or another payer, reimbursed under another funding arrangement, or reported in another program's cost build-up.

When the cost is only partially grant funded, the provider may report the non-grant-funded portion if that portion is attributable to the program and supported by the provider's accounting records. The provider must retain documentation showing the total cost, grant-funded amount, excluded amount, and amount reported on the cost report.

Example: If grant funds 40% of an employee's compensation and the remaining 60% is supported by program operating funds, only the documented non-grant-funded portion attributable to the Intensive Services program may be reported.

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

Tab 2 applies when a program provides IRTS and RCS at the same location and combines FTEs and expenditures on one spreadsheet. Report on IRTS and RCS units of service separately. Tab 2 calculates total units of service and compares the result with Tab 1. If the difference is not zero, correct the units reported on Tab 1 or Tab 2.

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 explanations and to report the total number of clients served.

Tab 3 – Allocated Space Costs (IRTS and RCS only)

Tab 3 applies to IRTS and RCS programs only and is not used for ACT programs. Report annual Physical Plant Costs and Utilities by period. Physical Plant Costs include rent, building depreciation, depreciation of allowable building improvements, interest, property taxes, and property insurance. Utilities include electricity, water, garbage, telephone, and heat.

Contracted maintenance and facility operating costs are not reported as Physical Plant Costs or Utilities on Tab 3. These costs must be reported in the applicable Other Program and Overhead Expense category on Tab 6. Examples include groundskeeping, snow removal, janitorial services, custodial services, cleaning or housekeeping services, pest control, routine maintenance, and repairs that do not qualify as a capital

improvement under the provider's applicable accounting policies.

Shared or partially program-related costs must be allocated using a reasonable, consistently applied, and documented method.

Example: A provider contracts with vendors for snow removal, lawn care, janitorial services, housekeeping services, pest control, HVAC maintenance, and routine building repairs. These costs are reported on Tab 6 as Other Program and Overhead Expenses, not as Physical Plant Costs or Utilities on Tab 3. Conversely, building rent, property taxes, property insurance, building depreciation, allowable building-improvement depreciation, and utility bills are reported on Tab 3.

A provider may not report both building rent and building depreciation for the same space and reporting period. Report rent when the provider leases the space. Report building depreciation when the provider owns the building and records allowable depreciation. Depreciation of leasehold improvements may be reported only when separately supported and not duplicative of rent or another reported cost. Providers seeking to report both rent and depreciation for the same space and reporting period should maintain supporting documentation and obtain DHS approval prior to reporting both costs.

Example: A provider leasing an IRTS facility reports allowable rent, not depreciation on the building. A provider that owns the facility may report allowable building depreciation, not rent. In limited circumstances, a provider leasing a facility may also report allowable depreciation associated with separately supported leasehold improvements if approved by DHS.

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)
- resident hallways and corridors
- 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
- staff 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:

- Classify each room or defined area by its primary use and assign the entire area to the category representing more than 50 percent of documented use. For open floor plans, identify reasonable functional boundaries on the floor plan and report each defined area consistently on Tab 4. A required residential living room remains residential even when used for treatment. Seasonal or non-year-round space may not be treated as full-year treatment space without a documented adjustment. The floor plan and Tab 4 designations must agree.
- 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. Apply the primary-use, open-floorplan, required-living-room, and seasonal-space rules stated under General considerations for all types of space in Tab 3.

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 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.
- “CMS Medicare Economic Index (MEI) inflationary Adjustment” is the percentage calculated using data from CMS.gov - Market Basket Data per [Sec. 256B.0622 MN Statutes](#).
- “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), and the MEI inflationary adjustment.
- Identify below all sources, purpose of, and amounts of grant funding (federal and state) received in the Fiscal Year for this program.

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.

Certification Expectations

By completing the certification, the certifying official affirms that the cost report is complete and prepared from the provider’s books and records in accordance with the applicable instructions. This includes confirming that costs are reported in the appropriate categories, supported by provider records, limited to the applicable program and reporting period, and reduced for grant-funded, separately reimbursed, or otherwise duplicate-funded amounts.

The provider must make supporting documentation available to DHS upon request. This manual clarification does not replace or modify the certification language contained in the cost report. Any substantive revision to the certification form is subject to separate DHS legal review.

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 37% for IRTS and RCS programs) will not change for current-year rate setting.

Distinguishing Direct Services from Other Program and Overhead Expense

Tab 6 is used to review costs that support program operations but are not included as direct service expenditures on Tab 1. Report costs according to the nature of the service or function performed, not merely

the title of the vendor invoice, employee, or general ledger account.

Examples of costs generally reported within Other Program and Overhead Expense include:

- program administration and office support salaries and benefits.
- housekeeping and maintenance staff or contracted maintenance services.
- background checks, credential verification, and general onboarding costs.
- organization-wide learning management systems or training attributable to non-direct-service staff.
- non-service-related transportation and ordinary administrative travel.
- supplies, equipment, communications, information technology, and electronic record costs; and
- central office and administrative support functions identified on Tab 6.

A cost must not be moved to Tab 1 solely because it is necessary to operate the program. Direct Services Expenditures are limited to the direct service employee and contractor categories, direct service training, and unreimbursed service-related travel described in this manual.

Example: A contracted maintenance worker's cost is reported as maintenance or other program expenses on Tab 6, not as contracted direct service staff on Tab 1.

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 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

Three Excel spreadsheets are available for reporting projected expenditures: one each for ACT, IRTS, and RCS. Select the applicable spreadsheet and enter data only in non-shaded cells; shaded cells may contain formulas and may be locked. The spreadsheets are available on the Mental Health service rates page. The same federal cost principles that apply to actual costs also apply to projected costs. A cost that would be unallowable on an existing-provider cost report must also be treated as unallowable when establishing a new or startup rate.

Unless Appendix C states otherwise, the definitions, categorization guidance, examples, and documentation expectations in Appendix A govern the preparation of proposed expenditures for a new or converted program, adapted as necessary for projected rather than historical costs. Proposed FTEs and expenditures must be reasonable and necessary, supported by reasonable assumptions, staffing plans, compensation estimates, contracts or proposals, and other available documentation, and are subject to Commissioner approval.

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).

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 preparing the expenditure report, rename the Excel file using the format applicable to 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

The projected-expenditure spreadsheet contains five tabs. Begin with Tab 1.

Enter the Program Name, Provider Number, and Host County/AMHI at the top of Tab 1. This information automatically populates the other tabs.

Enter projected FTEs, salaries, and annual expenditures by the categories and periods specified. Direct service roles may include Mental Health Professionals, Mental Health Practitioners, Mental Health Rehabilitation Workers, and Certified Peer Specialists. Report only payroll employees in the employee section; report contracted staff in the Contracts section. Include applicable benefits, payroll taxes, and workers' compensation for direct-service employees. Bonuses that are not distributions of profit are generally allowable. Separation expense is an administrative expense and must not be reported as a Direct Services Expenditure.

Report projected contracted direct-service staff, such as psychiatrists, registered nurses, and interpreters, in the Contracts section. Include benefits, payroll taxes, or contractor administrative charges paid directly by the provider, if applicable. Exclude direct service training and service-related travel, which must be reported in their applicable categories.

Training for Direct Service Staff includes the following expenses when they 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

Apply the service-related and program-related travel definitions, vehicle-cost methods, reimbursement exclusions, documentation requirements, and examples in Appendix A when preparing projected travel expenditures.

In the Units of Service Provided area, report projected billable daily charges for the periods and categories specified. For IRTS and RCS, they also report the total number of licensed beds. Use the box at the bottom of the spreadsheet for additional information or explanations.

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

Tab 2 applies to programs providing IRTS and RCS at the same location. Report projected IRTS and RCS days separately. Tab 2 calculates total projected units of service and compares the result with Tab 1. If the difference is not zero, correct the units reported 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 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)
- resident hallways and corridors
- 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
- staff 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:

- Classify each room or defined area by its primary use and assign the entire area to the category representing more than 50 percent of documented use. For open floor plans, identify reasonable functional boundaries on the floor plan and report each defined area consistently on Tab 4. A required residential living room remains residential even when used for treatment. Seasonal or non-year-round space may not be treated as full-year treatment space without a documented adjustment. The floor plan and Tab 4 designations must agree.
- **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. Apply the primary-use, open-floorplan, required-living-room, and seasonal-space rules stated under General considerations for all types of space in Tab 3.

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 labeled 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.