Instructions:
Behavioral Health Provider Service Expense Data Collection Tool, State Fiscal Year 2022

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State of Michigan

Department of Health and Human Services

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Milliman

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Overview

The purpose of this Behavioral Health Provider Service Expense Data Collection Tool (Tool) is to collect service utilization and cost information from each of the behavioral health contracted providers (Provider) receiving significant Medicaid revenue. Your participation is essential as the information collected in this Tool will allow the Michigan Department of Health and Human Services (MDHHS) to better understand costs incurred by providers contracting with the community mental health services programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs). Additionally, it will help support an understanding of the utilization of services for each entity that can be used to validate the encounter data each entity submits to MDHHS' data warehouse.

Deadline for Tool submission: February 28, 2023

Questions about completing the Tool?

Contact Milliman at: BH.Provider.Survey@milliman.com

How to submit the Survey Tool?

Please send your completed tool to **BH.Provider.Survey@milliman.com** with your entities name saved in the file name (e.g., BH Provider Service Expense Template – ABC Provider)

PROVIDERS REQUIRED TO COMPLETE THE DATA COLLECTION TOOL

Behavioral health providers contracting with community mental health services programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs) are required to submit this tool if they received more than $1 million in Medicaid revenue in the prior State Fiscal Year (SFY), SFY 2021, and have not materially reduced their Medicaid business in SFY 2022.

SCOPE OF DATA COLLECTION

Costs, revenue, service units, and direct minutes reported should represent those for the billing provider entity, including all individual providers and reflecting all payor sources unless otherwise indicated. Entities should only complete one template on a statewide basis. Entities with multiple billing provider NPIs can combine experience into a single template. The reporting period is SFY 2022 (October 1, 2021 to September 30, 2022).

WORKSHEETS INCLUDED IN TOOL

The Tool contains five separate tabs, listed below.

1. **Provider Revenue and Attestation** – The worksheet includes questions regarding overall Provider revenue designed to determine if the Provider is required to complete the tool and, if so, which worksheets the Provider should complete. The worksheet also includes an attestation that the information submitted in the Tool is current, complete, accurate, and in compliance with 42 CFR § 438.8 and 2 CFR § 200.

2. **Service to Cost Center Crosswalk** – This worksheet collects the number of service units and the corresponding direct minutes associated with each service rendered by the Provider. These services are automatically associated with a standard cost center, but the Provider may choose to override the standard cost center assignment.

3. **Summary of Provider Costs, >$5 Million** – This worksheet must be completed by a Provider with $5 million or more in Medicaid revenue, and collects provider costs by standard cost center with administrative and program support costs reported separately.

4. **Summary of Provider Costs, <$5 Million** – This worksheet must be completed by a Provider with $1 million or more in Medicaid revenue but less than $5 million, and collects Provider costs by major cost category.

5. **Notes** – This worksheet is included to provide a place for the Provider to document additional notes or information that may help MDHHS better understand the data provided.

The following sections provide detailed instructions for preparing and reporting information for each of the worksheet tabs, including what should be reported in each of the requested fields. Please provide information for all the requested fields on each applicable worksheet.

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Worksheet 1: Provider Revenue and Worksheet

The first two questions of the worksheet confirm if the Provider should complete the tool (based on a $1 million Medicaid revenue threshold), and the worksheets the Provider should complete. Exhibit 1 illustrates the worksheets must be completed based on the Provider's total Medicaid revenue from the most recent SFY.

FIGURE 1: WORKSHEETS FOR COMPLETION, BY MEDICAID REVENUE LEVEL

MEDICAID REVENUE IN THE MOST RECENT SFY	WORKSHEET 1 Revenue and Attestation	WORKSHEET 2 Service to Cost Center Crosswalk	WORKSHEET 3 Summary of Provider Costs, >$5 Million	WORKSHEET 4 Summary of Provider Costs, <$5 Million	WORKSHEET 5 Notes
$5 million or more	X	X	X		X
Less than $5 million	X			X	X

In the attestation section of this worksheet, your Provider representative is required to attest that the information submitted in the Tool is current, complete, accurate, and in compliance with 42 CFR § 438.8 and 2 CFR § 200. It should be signed by a representative of your entity that is familiar with the information being reported and has the authority to make the attestation (for example, the Chief Executive Officer, Chief Operating Officer or Chief Financial Officer). It should also include the contact information of the individual(s) responsible for preparing the Tool as submitted and the billing provider NPIs and Medicaid Provider IDs associated with the experience included within the Tool. Entities including experience from more than one NPI or Medicaid ID should separate the numbers with a comma.

Worksheet 2: Service to Cost Center Crosswalk

Use the *Service-Cost Center Crosswalk* worksheet tab to record units and the total direct care minutes for each full-service code (HCPCS/modifier combination). The following is a description of the columns included in this worksheet:

- **Prepopulated Reference Columns (A through M)** – These columns contain service information for reference purposes and may not be modified. These columns include the index number, full code (HCPCS and modifier combinations), HCPCS, modifier(s), service category, service category detail, reporting unit type, if the service is teams-based, and the assigned standard cost center.

- **Cost Center Overrides (Column N)** – This column allows a Provider to modify the cost center assigned to each full code (HCPCS and modifier combination) if the Provider-specific cost centers used internally are different than the pre-defined cost centers. Only use this column if needed, and for the specific rows where an override is needed. To apply overrides, record the new cost center(s) in Worksheet 3 first (see provider-defined rows at the bottom of the worksheet) so they are available to select in the drop-down menu in Column N.

- **Medicaid Paid Units (Column O)** – For each full code (HCPCS/modifier combination), record the number of Medicaid paid units related to the service provided during the reporting period.

- **Non-Medicaid Paid Units (Column P)** – For each full code (HCPCS/modifier combination), record the number of non-Medicaid paid units related to the service provided during the reporting period.

- **Direct Minutes (Column Q)** – For each full code (HCPCS/modifier combination), record the number of direct minutes related to the service (excluding indirect time) provided during the reporting period.

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Worksheet 3: Summary of Provider Costs, >$5 Million

There are two sections within Worksheet 3, as described below.

SECTION 1: TOTAL, ADMINISTRATIVE AND PROGRAM SUPPORT COSTS

In Exhibit 1, record the different types of administrative and program support costs in **Rows A and C**, using the associated standard expense categories listed in Figure 2 below. In **Row B,** record costs associated with performing managed care administrative functions on behalf of a CMHSP and/or PIHP. Costs related to managed care administration are administrative costs to fulfill the obligations of contracts to organize, arrange, and coordinate clinical service delivery. Non-exhaustive examples of managed care functions include eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities.

Row D automatically sums the administrative and program support costs recorded in Rows A through C. **Row E** captures the room and board as well as any other non-allowable Medicaid costs.

For purposes of this survey, allowable costs based on federal Medicaid regulations are the reasonable costs necessary to provide services to individuals eligible for Medicaid services. Determinations of allowable costs must be consistent with 2 CFR § 200, and in principle, the term “reasonable” relates to the prudent and cost-conscious buyer concept that purchasers of services will seek to economize and minimize costs whenever possible. The term “necessary” relates to the necessity of the service. To be “necessary”, it must be a required element for providing care to individuals as specified by the relevant Medicaid authorities. The following are examples of non-allowable costs:

- Room and board (including all client-related facility and facility maintenance costs, food, and personal expenses)
- Bad debts
- Charitable contributions
- Entertainment costs, including costs of alcoholic beverages
- Federal, state, or local sanctions or fines
- Fund-raising costs

SECTION 2: COSTS BY STANDARD COST CENTER

Report provider costs for each of the major cost categories listed in Columns C through H. Exhibit 2 also includes additional columns that automatically calculate based on other inputs.

- **Direct Staff Salaries & Wages (Column C)**
- **Direct Employee Related Expenses (Column D)**
- **Supervisory Salaries & Wages (Column E)**.
- **Supervisory Employee Related Expenses (Column F)**
- **Transportation (Column G)**
- **Total Costs (Column H)** – This column automatically sums Columns C through G.
- **Total Direct Minutes (Column I)** – This column automatically populates based on the minutes reported in Worksheet 2.

Figure 2 below identifies the expense categories that are applicable for each category. In some cases, an expense category applies to more than one major cost category. For example, the *Employee Insurance and Other Fringe Expenses* expense category will apply to direct staff, supervisory staff, and administrative and program support staff.

These expense categories are described in Appendix 1 of the PIHP and CMHSP Standard Cost Allocation Methodology, available online at [location to be inserted].

FIGURE 2: CROSSWALK OF EXPENSE CATEGORIES TO EACH MAJOR COST CATEGORY

MAJOR COST CATEGORY	EXPENSE CATEGORY CODE	EXPENSE CATEGORY DESCRIPTION
Direct Staff Salaries & Wages	01	Salaries and Wages, Clinical Direct Service Staff
	04	Compensation, Contractual Clinical Direct Service Staff
Direct Staff Employee Related Expenses	07	Federal and State Payroll Taxes and Fees *(specific to direct staff)*
	08	Employee Insurance and Other Fringe Expenses *(specific to direct staff)*
	09	Pension and Retirement Expenses *(specific to direct staff)*
Supervisory Salaries & Wages	03	Salaries and Wages, Clinical First- and Second- Line Supervision
	05	Compensation, Contractual Clinical First- and Second- Line Supervision
Supervisory Employee Related Expenses	07	Federal and State Payroll Taxes and Fees *(specific to direct staff)*
	08	Employee Insurance and Other Fringe Expenses *(specific to direct staff)*
	09	Pension and Retirement Expenses *(specific to direct staff)*
Transportation	14	Travel Expenses, Client-related
	18	Vehicle Expenses *(specific to client services)*
Room and Board and Other Non-Allowable Costs	17	Facility and Equipment-Related Expenses *(specific to room and board)*
	N/A	Other costs as identified
Administrative and Program Support	02	Salaries and Wages, Service Support Staff
	06	Salaries and Wages, Administration
	07	Federal and State Payroll Taxes and Fees *(specific to administrative and program support staff)*
	08	Employee Insurance and Other Fringe Expenses Fees *(specific to administrative and program support staff)*
	09	Pension and Retirement Expenses Fees *(specific to administrative and program support staff)*
	11	Contracted Services, Administrative
	12	Contracted Services, Other
	15	Travel Expenses, Administrative
	16	Clinical Program and Support Expenses
	17	Facility and Equipment-Related Expenses *(specific to administrative and program support)*
	18	Vehicle Expenses *(specific to administration and program support)*
	19	Other Expenses

Worksheet 4: Summary of Provider Costs, <$5 Million

Report Provider costs for each of the major cost categories listed in Rows A through G, using information shown in Figure 2 above to identify the types of expenses that are applicable for each row. **Row H** (Total Costs) calculates automatically as a sum of Rows A through G. Costs should be separately identified for Medicaid covered services (Column C) and non-Medicaid covered services (Column D).

Row I allows for reporting of the costs associated with contracted administrative functions on behalf of a CMHPS and/or PIHP (if applicable). Costs related to managed care administration are administrative costs to fulfill the obligations of contracts to organize, arrange, and coordinate clinical service delivery. Non-exhaustive examples of managed care functions include eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities.

Worksheet 5: Notes

This worksheet allows the Provider entity to explain different responses in the Tool and convey information that was not necessarily requested in the Tool. If the Provider wants to provide clarification or additional information not requested in the Tool, select Information Not Listed on Survey in the drop-down under the worksheet column and insert the information in the comments section.

If the Provider entity wants to provide a comment or additional information related to specific information specified in the Tool that is related to a particular worksheet, column or row, please select the worksheet and if applicable, provide the line number and/or column reference to help us accurately understand the information provided.

Limitations

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved September 13, 2019.

The information contained in this letter, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

This information is being shared for discussion purposes only.

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