# Instructions:
# Behavioral Health Provider Service Expense Data Collection Template, State Fiscal Year 2022 v1.1

**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 Template (Template) is to collect service utilization and cost information from each of the contracted behavioral health providers (Provider) with significant Medicaid expenditures. Your participation is essential as the information collected in this Template 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) and the results could be used to support or adjust the behavioral health fee schedule rate component assumptions. 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 Template submission: February 28, 2023**

**Questions about completing the Template?**

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

**How to submit the Survey Template?**

Please send your completed template 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 TEMPLATE

Contracted behavioral health providers with community mental health services programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs) are required to submit the Template if they had more than $1 million in Medicaid expenditures, including expenditures under self-directed arrangements, in the prior State Fiscal Year (SFY), SFY 2021, and have not materially reduced their Medicaid business in SFY 2022.

### SCOPE OF DATA COLLECTION

Reported costs, service units, and direct minutes should represent those for the billing provider entity (defined at the Tax ID level), including all individual providers and reflecting all payor sources unless otherwise indicated. Entities should only complete one template per Tax ID number and values should be reported on a statewide basis. Entities with multiple billing provider NPIs can, but are not required to, combine their experience into a single template; the Template will ask an entity to report whether they are reporting for one or multiple NPI numbers. **The reporting period for all information is SFY 2022 (October 1, 2021 to September 30, 2022).**

### WORKSHEETS INCLUDED IN THE TEMPLATE

The Template contains six separate tabs, listed below. Please note the term ***line of business*** is used on Worksheets 2, 3 and 4. For purposes of this template, each line of business corresponds to multiple service codes, which are defined on Worksheet 2 (for Medicaid Behavioral Health Services). To complete Worksheet 4, certain costs will need to be aggregated at the line of business level.

1. **Provider Costs and Attestation** – The tab includes questions regarding overall Provider expenditures and is designed to help the Provider identify if they are required to complete the Template and, if so, which worksheets the Provider should complete. The worksheet also includes an attestation that the information submitted in the Template is current, complete, accurate, and in compliance with 42 CFR § 438.8 and 2 CFR § 200.
2. **Service Utilization** – This tab collects the number of service units associated with each service rendered by the Provider. These services are automatically associated with a line of business.
3. **Direct and Indirect Minutes** – This tab collects feedback on the assumed direct and indirect minute assumptions for codes included within the Behavioral Health Comparison Rate Report (https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Reporting-Requirements/BH_Comparison_Rate_Development_Report_SFY_2023.pdf).

4. **Summary of Provider Costs, >$5 Million** – This tab must be completed by a Provider with $5 million or more in Medicaid expenditures, and collects provider costs by line of business with administrative and program support costs reported separately.
5. **Summary of Provider Costs, <$5 Million** – This tab must be completed by a Provider with $1 million or more in Medicaid expenditures but less than $5 million, and collects Provider costs by major cost category.
6. **Licensed Residential Staff Hours by LARA ID** – This tab must be completed a Licensed Residential Provider (i.e., delivers H2016/T1020 services) with $1 million or more in Medicaid expenditures (including expenditures from self-directed arrangements), and collects billed days and staff hours by LARA ID.
7. **Notes** – This tab is included for the Provider to document additional notes or information that may help MDHHS better understand the reported data.

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

# Worksheet 1: Provider Costs and Attestation

The first three questions of this tab confirm if the Provider should complete the Template (based on a $1 million Medicaid expenditure threshold) and identifies the specific tabs the Provider should complete based upon the responses to the three questions. Figure 1 summarizes the worksheets that must be completed based on the Provider's total Medicaid expenditures from SFY 2022 and whether they are a Licensed Residential Provider.

**FIGURE 1: WORKSHEETS FOR COMPLETION, BY MEDICAID EXPENDITURE LEVEL**

| MEDICAID EXPENDITURES FROM SFY 2022 | WORKSHEET 1 Costs and Attestation | WORKSHEET 2 Service Utilization | WORKSHEET 3 Direct and Indirect Minutes | WORKSHEET 4 Summary of Provider Costs, >$5 Million | WORKSHEET 5 Summary of Provider Costs, <$5 Million | WORKSHEET 6 Licensed Residential HRS | WORKSHEET 7 Notes |
|---|---|---|---|---|---|---|---|
| Less than $1 million | *NOT REQUIRED TO COMPLETE THE TEMPLATE* | | | | | | |
| Less than $5 million | X | | | | X | X[1] | X |
| $5 million or more | X | X | X | X | | X[1] | X |

1. Only Providers with more than $1 million Medicaid expenditures who also provide Licensed Residential services are required to completed Worksheet 6.

In the attestation section of this worksheet, your Provider representative is required to attest that the information included in the Template is current, complete, accurate, and in compliance with 42 CFR § 438.8 and 2 CFR § 200. It should be submitted 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 Template as submitted and the billing provider NPIs and Medicaid Provider IDs associated with the experience included within the Template. Entities including experience from more than one NPI or Medicaid ID should separate the numbers with a comma. Providers should identify if they are submitting a Template for multiple Tax IDs, a single Tax ID, or other arrangement (a description is required for an *Other* arrangement)

# Worksheet 2: Service Utilization

Use the *Service Utilization* tab to record units for each procedure code combination (HCPCS/Hospital Type/Revenue Code) that aligns with a line of business. The following is a description of the columns included in this tab:

- **Prepopulated Reference Columns (A through K)** – These columns contain service information for reference purposes and may not be modified. These columns include the index number, procedure code combination, whether the service is MH or SUD related, HCPCS code, hospital type and revenue code (when applicable), service category, service category detail, reporting unit type, if the service is teams-

based, and the assigned line of business. Units are not required for services not covered under Michigan's Medicaid Behavioral Health program, but costs associated with other services will be captured on the *Non-Behavioral Health Medicaid Services* or the *All Other Non-Medicaid Services* rows of *Worksheet 4*.

- **Medicaid Behavioral Health Paid Units (Column L)** – For each procedure code combination, record the number of Medicaid behavioral health paid units related to the service provided during the reporting period.
- **All Other Payor Source Paid Units (Column M)** – For each procedure code combination, record the number of all other payor source paid units (e.g., units paid by Commercial insurance) related to the service provided during the reporting period.

## Worksheet 3: Direct and Indirect Minutes

Use the *Direct and Indirect Minutes* tab to compare actual time spent administering a service with time assumed within the development of the Behavioral Health Comparison Rate Report. The following is a description of the columns included in this tab:

- **Prepopulated Reference Columns (A through I)** – These columns contain service information for reference purposes and may not be modified. These columns include the index number, HCPCS code, whether the service is MH or SUD related, service category, service category detail, reporting unit type, assigned line of business, and the direct and indirect minutes assumed when developing the Behavioral Health Comparison Rate Report.
- **Direct Minutes Variation (Column J)** – For each HCPCS code, select the option in the dropdown which you believe best fits the variation between our assumed direct time and the actual direct time taken to administer a given service. For example, if our assumption is that there are 60 minutes of direct time for administering a service and you estimate the direct time administering the service to be closer to 50 minutes, you would select the '10% to 25%' option from the dropdown ((60 minutes / 50 minutes) - 100%) = 16.7%).
- **Indirect Minutes Variation (Column K)** – For each HCPCS code, select the option in the dropdown which you believe best fits the variation between our assumed indirect time and the actual indirect time taken to administer a given service.
- **Comments (Column L)** – Provide any comments you consider useful within this column.

If an entity is unable to provide an estimate for direct and indirect minutes for a given service, the entity may leave the direct and indirect variation fields blank.

## Worksheet 4: Summary of Provider Costs, >$5 Million

There are two sections within Worksheet 4, as described below.

### SECTION 1: TOTAL, ADMINISTRATIVE AND PROGRAM SUPPORT COSTS

In Section 1, record the different type of administrative and program support costs in **Rows A and D**. Please reference Figure 2 below to support identification of administrative and program support costs. In **Row B,** record costs associated with performing managed care administrative functions for Behavioral Health services on behalf of a CMHSP and/or PIHP. In **Row C,** record costs associated with performing managed care administrative functions for non-Behavioral Health services 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 E** automatically sums the administrative and program support costs recorded in Rows A through D. **Row F** captures room and board and 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 LINE OF BUSINESS

Report provider costs for each of the major cost categories listed in Columns C through D. Section 2 also includes Columns E and F that automatically calculate based on other inputs.

- **Direct Staff and Supervisory Salaries, Wages, and Employee Related Expenses (Column C)**
- **Transportation (Column D)**
- **Total Costs (Column E)** – This column automatically sums Columns C and D.
- **Total Units (Column F)** – This column automatically populates based on the service units reported in Worksheet 2.

Costs by line of business should correspond to the service units reported on Worksheet 2. Costs for services not covered under Michigan's Medicaid Behavioral Health program (i.e., costs associated with service units not reported on Worksheet 2) should be reported on the *Non-Behavioral Health Medicaid Services* or the *All Other Non-Medicaid Services* rows.

Providers must follow cost allocation methodologies that are consistent with federal rules promulgated in the Code of Federal Regulations (CFR) at 2 CFR 200, and all other federal and State regulations and requirements. **Providers may reference, but are not required to follow, the cost allocation principles of the Standard Cost Allocation (SCA) methodology, which is outlined in the following paragraph.**

**Reference Information from Standard Cost Allocation**

Figure 2 below identifies the expense categories that are applicable for each cost category used within the Template. 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 the MDHHS Mental Health & Substance Use Director Reporting Requirements webpage (go to https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html and Policy 21-39 Reporting Requirements/Standard Cost Allocation Model SFY2022 or by go directly to https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder43/Folder3/Folder143/Folder2/Folder243/Folder1/Folder343/Appendix_1_and_2.xlsx).

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

| MAJOR COST CATEGORY | EXPENSE CATEGORY CODE | EXPENSE CATEGORY DESCRIPTION |
|---|---|---|
| Direct Staff and Supervisory Salaries, Wages, and Employee Related Expenses | 1 | Salaries and Wages, Clinical Direct Service Staff |
| | 3 | Salaries and Wages, Clinical First- and Second- Line Supervision |
| | 4 | Compensation, Contractual Clinical Direct Service Staff |
| | 5 | Compensation, Contractual Clinical First- and Second- Line Supervision |
| | 7 | Federal and State Payroll Taxes and Fees *(specific to Direct Service and Supervision staff)* |
| | 8 | Employee Insurance and Other Fringe Expenses *(specific to Direct Service and Supervision staff)* |
| | 9 | Pension and Retirement Expenses *(specific to Direct Service and Supervision 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) |
| | 20 | Wages Paid to Individuals Receiving Services |
| | N/A | Other costs as identified |
| Administrative and Program Support | 2 | Salaries and Wages, Service Support Staff |
| | 6 | Salaries and Wages, Administration |
| | 7 | Federal and State Payroll Taxes and Fees (specific to administrative and program support staff) |
| | 8 | Employee Insurance and Other Fringe Expenses Fees (specific to administrative and program support staff) |
| | 9 | 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 5: 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 D** (Total Costs) calculates automatically as a sum of Rows A through D. Costs should be separately identified for Medicaid covered Behavioral Health services (Column C), Medicaid covered non-Behavioral Health services (Column D), and All Other non-Medicaid services (Column E).

**Row F** allows for reporting of the costs associated with contracted administrative functions on behalf of a CMHSP 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 6: Licensed Residential Staff Hours by LARA ID

This tab captures billed and staff hours for Licensed Residential Providers only. Licensed Residential Providers use procedure codes H2016 and T1020 to bill for their residential services. Entities should list each Licensing and Regulatory Affairs License Number (LARA ID) in Column B operated by your organization and their total billed days (Medicaid and non-Medicaid) in Column C. For each LARA ID and staffing type, report the total annual staff hours in Columns D through I. Please note that only staff who are regularly face-to-face with individuals residing in the facility should be captured in the staff hours.

If an employee has both supervisory and direct care service responsibilities, a Provider should report the direct care service time in the table. The staff hours reported in Columns D through I will flow through to Column K to capture Total Direct Care Hours.

## Worksheet 7: Notes

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

If the reporting entity wants to submit a comment or additional details related to specific information in the Template 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 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.