SHORT-DOYLE/MEDI-CAL RATE ESTABLISHMENT PROCESS

Introduction:

Negotiated rate providers under Short-Doyle/Medi-Cal (SD/MC) will adhere to specific procedures as outlined below in establishing rates with the State Department of Mental Health (DMH). Rate establishment is based on historical costs similar to the cost reimbursement providers. The Negotiated Rate providers are governed by the provisions and requirements in the State Plan for Medicaid services. The annual rate establishment results in fixed SD/MC reimbursement rates for each service, which provide incentives for productivity and efficiency at the local provider level. A separate negotiated rate will **not** be allowed for Therapeutic Behavioral Services (Mode 15, service function code 58). The approved Negotiated rates are **not** included in the annual performance contracts between the state and the counties.

DMH Control Methodology:

1. The base will be the most recent cost report and other cost information. Using SD/MC providers only, actual cost will be determined for each specific service function by legal entity (county and each contract provider will be separately calculated).
2. For each of the service functions and legal entities, using the most recent cost report, divide the total adjusted gross cost by the total number of actual service units (time base units) for all programs within that group to compute base service rates.
3. Update the base service rates by using inflation factors. Medical Consumer Price Index will be used for hospital acute inpatient and Home Health Agency Market Basket Index will be used for all non-hospital services.
4. New service requests for a negotiated rate will not be honored unless prior years' cost report data and actual units are submitted to DMH at the same time.
5. When a provider of service is being eliminated, the applicable costs and units of service shall be excluded from the calculation of the countywide or contract provider rate(s).
6. For existing programs that have had changes which significantly affect the rates from the most recent cost report, other factors may be considered by DMH, such as utilization changes, client profile shifts which impact costs of services delivery, union contracts, changes in program design, and other unforeseen documented factors which impact the cost of service delivery. Quantifiable documentation must be provided for DMH to evaluate such changes.
7. The legal entity rates for each service function shall not exceed the approved Schedule of Maximum Allowances for the applicable period.
8. According to the State Plan, if reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, 50 percent of Federal Financial Participation (FFP) that exceeds actual costs will be returned to the Federal government.

   The remaining 50 percent of FFP, including local interest, shall be retained by the county mental health program and utilized exclusively for mental health service delivery and support costs. This may include capital expenses specific to mental health programs.