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Reimbursement methodology for sign language interpreter services for the deaf or hearing-impaired as described in Title 22, California Code of Regulations, Section 51503.3.

1. Reimbursement rates have been established for sign language interpreter services, based on a specific unit of time and shall be reimbursed only when the sign language interpreter service has actually occurred on behalf of a Medi-Cal beneficiary, and when it is incident to another Medi-Cal covered service billed by a Medi-Cal enrolled provider that employs fewer than fifteen employees as a means of providing effective, accurate and impartial communication, as determined by the beneficiary and the provider, in a medical setting.

2. Reimbursement rates have been established and shall be paid on an hourly rate for a minimum of two hours. Services in excess of two hours shall be paid in 15 minute increments based on an hourly rate, exclusive of mileage as described in number 8. The two-hour minimum is the standard minimum currently charged by sign language interpreters. In order to ensure participation of this group in the Medi-Cal Program, it is necessary to meet this standard.

3. Sign language interpreters who provide interpreter services to the deaf or hearing-impaired can be either certified or non-certified interpreters. Certified sign language interpreters hold a current certification by one of the following: 1) The National Registry of Interpreters for the Deaf (RID); 2 The National Association of the Deaf (NAD)/California Association of the Deaf (CAD) at a competency Level IV or V only; or 3) The California Department of Rehabilitation at a competency Level III and posses a certificate from RID, NAD/CAD at a competency Level IV or V only. Non-certified sign language interpreters do not hold a certification in one of the areas noted above.

4. A separate and distinct rate has been established for the certified and the non-certified interpreter.

5. Only small Medi-Cal providers, who employ less than fifteen (15) employees, are eligible for reimbursement as a "medical assistance" cost for sign language interpreter services.

6. The certified sign language interpreter rate shall be calculated based on the State's civil service pay scale, using the civil service classification code number 9820 titled, Support Services Assistant (Interpreter,) and the maximum monthly salary rate for the classification of $2,760.00.

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7. A 30 percent benefit factor of $828.00 consisting of Old Age Security Disability Insurance, Health Insurance and Retirement is added to the maximum monthly salary rate to equal $3,588.00. This amount is divided by the actual number of hours worked of 148 hours to equal $24.24.

The 148 hours is arrived at as follows:

40	Hours in a work week
52	Multiplied by the number of weeks in a year
2,080	Equals number of hours in a year
120	Less vacation hours @ three weeks per year
80	Less sick leave hours @ two weeks per year
104	Less holidays @ 13 days per year
1,776	Equals work hours per year
12	Divided by months per year
148	Equals work hours per month

8. Reimbursement for sign language interpreter services shall be for a minimum of two hours of service. The two hour rate is calculated as follows:

$24.24	Hourly salary & benefits
2.0	Multiplied by number hours/visit
$48.48	Equals salary & benefits/visit
$13.00	Plus estimated mileage @ 50 miles round trip--0.26 cents per mile
$61.48	Equals base rate/visit
$1.05	Multipled by agency referral add-on factor ($3.07)
$64.55	**Equals rate/visit, certified interpreter**
60%	Multipled by average fee differential
$38.73	**Equals rate/visit, noncertified interpreter**

Additional sign language interpreter services shall be billed in 15-minute increments as follows:

$6.06	Hourly salary & benefits—15 minute increments ($24.24 per hour)
1.05	Multipled by agency referral add-on factor ($0.30)
6.36	**Each additional 15-minutes, certified interpreter**
60%	Multiplied by average fee differential
$3.82	**Each additional 15-minutes, noncertified interpreter**

9. Only Medi-Cal enrolled providers that employ fewer than fifteen employees can bill Medi-Cal for sign language interpreter rates for deaf or hearing-impaired beneficiaries when another Medi-Cal service has been rendered, or for an adult who is deaf or hearing-impaired when necessary to facilitate medically necessary services to a beneficiary. Medi-Cal enrolled providers that employ fewer than fifteen employees are responsible for making payment to the sign language interpreter. Regulations governing reimbursement for sign language interpreter services will be amended to require that a Medi-Cal enrolled provider that employs fewer than fifteen employees, maintain files in accordance with Title 22, California Code of Regulations, Section 51476, which shall contain records of reimbursements made to sign language interpreters.

10. The Department will ensure "free care" and "third-party liability" requirements are met.

11. Limitations have been established to ensure that physicians and physician groups and other Medi-Cal enrolled providers do not claim for these charges inappropriately.

    Certified and non-certified sign language interpreter services for a basic, two-hour minimum are limited to one per day, per provider, per beneficiary. Each additional 15 minute increment when the interpreter service exceeds the basic two-hour minimum service due to lengthy or multiple medical appointments is limited to a total of 24 increments per provider, per beneficiary, per day. System changes have been established to track specific procedure codes entered on claims submitted for reimbursement.

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SUPPLEMENTAL REIMBURSEMENT FOR PUBLIC OUTPATIENT HOSPITAL SERVICES

This program provides supplemental reimbursement for an outpatient department of a general acute care hospital that is owned or operated by a city, county, city and county, the University of California, health care district, or hospital authority, which meets specified requirements and provides outpatient hospital services to Medi-Cal beneficiaries.

Supplemental reimbursement under this program is available only for costs that are in excess of the payments the hospital receives per visit or per procedure for outpatient hospital services from any source of Medi-Cal reimbursement.

A. Definition of an Eligible Hospital

A hospital is determined eligible only if the local agency continuously has all of the following additional characteristics during the Department's rate year beginning August 1, 2002, and subsequent rate years:

1. Provides services to Medi-Cal beneficiaries.

2. Is an acute care hospital providing outpatient hospital services. For purposes of this section, "acute care hospital" means the facilities described at subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

3. Is owned or operated by a city, county, city and county, the University of California, health care district organized pursuant to Chapter 1 of Division 23 (commencing with Section 32000) of the Health and Safety Code, or hospital authority described in Section 101850 or 101852, et seq., of the Health and Safety Code.

Local agencies of eligible hospitals must provide certification to the state that the amount claimed by them is eligible for federal financial participation.

B. Supplemental Reimbursement Methodology

Supplemental reimbursement provided by this program to an eligible hospital is intended to allow federal financial participation for certified

1. As described in paragraph A, the expenditures certified by the local agency to the State shall represent the payment eligible for federal financial participation. Allowable certified public expenditures shall determine the amount of federal financial participation.

2. In no instance shall the amount certified pursuant to paragraph C.1, when combined with the amount received and payable from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of the costs for outpatient hospital services at each hospital.

3. The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on outpatient hospital services provided to Medi-Cal patients at the eligible hospital. Pursuant to paragraph C.1, the hospital shall certify to the Department, on an annual basis, the amount of its eligible costs for providing Medi-Cal outpatient hospital services.

4. Costs for outpatient services that are otherwise payable by or reimbursable under the prospective payment reimbursement for federally qualified health centers and rural health clinics set forth earlier in this Attachment, or the cost based reimbursement methodology set forth in Supplement 5 to this Attachment, are not eligible as certified public expenditures under this supplemental reimbursement methodology.

5. Los Angeles County hospitals will use the hospital relative value unit (RVU) system to apportion hospital costs to Medi-Cal. Los Angeles County hospitals will use RVUs wherever there is a reference to charges in this subsection. This is the same RVU system that is used by Los Angeles County hospitals for Medicare and Medi-Cal cost-reporting purposes.

6. The hospital’s Medicaid outpatient costs for the subject year will be computed in a manner consistent with Medicare cost accounting principles and will not include any Medi-Cal program non-reimbursable cost centers.

7. The hospital Medicaid outpatient costs will be derived by reducing each hospital's Medicaid outpatient charges less any amounts not payable by Medicaid including but not limited to third party payments and co-payments made by patients. The data used for the computations will come from each hospital's most recently available completed HCFA 2552 Medicare/Medicaid cost report and survey data provided by each hospital. The Medi-Cal cost report data will be reported in a manner consistent with the methods used to complete the Medicare cost report.

   The State will reconcile annually, and for three years after the period for which the claim was submitted, cost information from filed hospital cost reports to cost information from settled/audited cost reports. In addition, the State will reconcile actual expenditures and payments to any amounts used initially to determine the supplemental payment. When any reconciliation results in an underpayment or overpayment to a facility, no

less than annually the State will adjust the affected facility's supplemental payment.

8. Consistent with Medicare cost accounting principles and excluding any Medi-Cal program non-reimbursable costs center, for the hospital facility component (excluding professional component costs but including the provider based component of physician costs determined under Medicare cost-reporting), the following items will be identified at the hospital departmental level:

   - Total facility cost to total charges, regardless of payer type, ratios by department.

   - Total Medicaid outpatient charges less any amounts not payable by Medicaid including but not limited to third party payments and co-payments made by patients.

   The departmental cost to charge ratios will be multiplied by Medicaid outpatient hospital charges to derive cost. These departmental level totals will be added to yield the hospital's Medicaid outpatient costs. The cost-to-charge ratios, as reflected in the Medi-Cal Cost Report, will be used to reduce Medicaid outpatient charges to Medicaid outpatient costs by hospital department. A department is equivalent to a cost center on the Medicare Form 2552 hospital cost report.

9. The hospital's total Medi-Cal payments for outpatient hospital services for the facility component will be determined using Medi-Cal paid claims data for the same fiscal period. The hospital's total Medicaid outpatient costs determined under paragraph 7 will be reduced by the hospital's total Medi-Cal payments, less amounts paid by Medi-Cal for the professional component of the services, yielding the certified public expenditure amount.

C. Hospital Reporting Requirements

The local agency reporting on behalf of any eligible hospital must do all of the following:

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for hospital outpatient hospital services are eligible for federal financial participation.

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for hospital outpatient hospital services are eligible for federal financial participation.

2. Provide evidence supporting the certification as specified by the Department.

3. Submit data as specified by the Department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

4. Keep, maintain and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible hospital is entitled, and any other records required by the Centers for Medicare & Medicaid Services.

Standards for Supplemental Reimbursement

1. The Department may require that any general acute care hospital owned or operated by a city, county, city and county, the University of California, or health care district receiving supplemental reimbursement under this program enter into a written interagency agreement with the Department for the purposes of implementing this program.

2. Supplemental reimbursement paid under this program must comply with the requirements of Section B, above.

A. Department's Responsibilities

1. The Department will submit claims for federal financial participation for the expenditures for services that are allowable expenditures under federal law.

2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

3. The State share of the supplemental reimbursement under this program will be equal to the amount of the federal financial participation of eligible expenditures paid by city, county, city and county, the University of California or health care district funds and certified to the state as specified in Section C.1, above.

§447.321. For purposes of determining the reasonable estimates of the amounts that would be paid for outpatient hospital services under Medicare payment principles required by the UPL, only the facility component of outpatient services will be considered. Medi-Cal payments for the facility component of hospital outpatient services, which will consist of the non-federal and federal share of the outpatient supplemental payments under this section for the facility component combined with all other Medi-Cal outpatient payments for the facility component, will be aggregated by hospital group and compared to the UPL determined for each group.

ENHANCED PAYMENTS TO PRIVATE TRAUMA HOSPITALS

This segment of the State Plan describes an enhanced Medi-Cal payment for outpatient hospital trauma and emergency services to private hospitals within Los Angeles County and Alameda County that have demonstrated a need for assistance in ensuring the availability of essential trauma services for Medi-Cal beneficiaries, and that meet the requirements in Section A, below.

A. DEFINITION OF AN ELIGIBLE TRAUMA HOSPITAL

A Trauma Hospital is eligible only if it is a privately owned hospital and continuously has all of the following characteristics during the period for which payments are made:

1. Is capable of treating one or more types of potentially seriously injured persons and has been designated as part of the regional trauma care system by the local Emergency Medical Service (EMS) agency, in accordance with Health & Safety Code section 1798.160.

2. Maintains specialized equipment and a panel of physician specialists available at all times to treat trauma patients, as required by California Code of Regulations, Title 22, sections 100259 [for Level I and Level II Trauma Centers], 100261 [for Level I and Level II Pediatric Trauma Centers], 100263 [for Level III Trauma Centers], and 100264 [for Level IV Trauma Centers].

3. Provides trauma and emergency medical services to Medi-Cal beneficiaries.

4. Has a contract in effect with the local EMS agency.

5. Has received certification from the local EMS agency that the enhanced trauma hospital payments would help ensure continued access to trauma services for Medi-Cal beneficiaries within Los Angeles County or Alameda County.

6. Has a contract in effect with the California Department of Health Services (DHS) that complies with the requirements set forth in Section B, below.

B. ENHANCED TRAUMA HOSPITAL PAYMENTS -- AUTHORITY AND METHODOLOGY

Notwithstanding any other provision of this Attachment, DHS may contract to provide enhanced trauma payments to Eligible Trauma Hospitals pursuant to Welfare and Institutions Code sections 14087.3 or any similar or successor statutory authority.

1. The enhanced trauma hospital payments provided by DHS shall be specified in the contract and shall be based on negotiated amounts for Medi-Cal trauma and emergency room services provided in a hospital outpatient department of the Eligible Trauma Hospital, except when such services are immediately followed by an inpatient admission.

2. (a) The enhanced trauma hospital payments that are negotiated will take into account the recommendation of the local EMS agency and will not exceed the aggregate of all Eligible Trauma Hospitals' uncompensated costs of providing outpatient hospital services to Medi-Cal beneficiaries within the participating county. For purposes of determining this payment limit, each Eligible Trauma Hospital's uncompensated costs for Medi-Cal outpatient hospital services will be determined for the immediately prior fiscal year (based on the hospital's most recently filed Medi-Cal cost report, in a format specified by DHS), and will include the uncompensated costs of trauma and emergency services, and all other Medi-Cal outpatient hospital services rendered to Medi-Cal beneficiaries.

   (b) A Trauma Hospital's uncompensated costs will also include Medi-Cal's proportionate share of the uncompensated costs incurred for physician availability for trauma and emergency services,

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whether or not such costs are recognized as allowable under Medicare reasonable cost principles.

(c) The Uncompensated costs described in Paragraph B.2(a), will be determined in accordance with cost reimbursement principles identified in 42 C.F.R. Part 413, and to the extent not governed by Part 413, by Generally Accepted Accounting Principles.

(d} Subject to the payment limits set forth in Paragraph B.2(a), an Eligible Trauma Hospital may receive enhanced trauma hospital payments in excess of its individual uncompensated costs, as calculated pursuant to Paragraph B.2(a)-(c), so long as the aggregate Medi-Cal payments to all private hospitals do not exceed the applicable upper payment limit established in 42 C.F.R. section 447.321.

3. Differences between the cost data used for purposes of determining the enhanced trauma hospital payment amounts and the final cost information from the settled/audited cost reports will not be reconciled.

4. Payments will be made on a quarterly, semi-annual or annual lump sum basis or may be made on any other federally allowable basis provided for in the Eligible Trauma Hospital's contract with DHS. Payments will be directly related to the fiscal year in which services are rendered.

5. The enhanced trauma hospital payments will supplement, and will not supplant, any current Medi-Cal payments for trauma or emergency services.

6. Total Medi-Cal reimbursement provided to an Eligible Trauma Hospital will not exceed applicable federal upper payment limits as described in 42 C.F.R. 447.321.

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