Washington State

Public Hospital Medicaid Administrative Claiming

Interpreter Services Program Manual

July 2013

Public Hospital
Medicaid Administrative Claiming
Interpreter Service Program Manual

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Section I – Introduction

Medicaid Administrative Claiming (MAC) Program Overview

The Medicaid Outreach program contracts with governmental entities in the state of Washington to perform administrative outreach and linkage activities. The program currently contracts with federally-recognized Tribes, school districts, local health jurisdictions, and the Washington State Department of Health.

MAC Program Goals:

- Administer an effective, efficient statewide MAC program that supports the goals of the Medicaid State Plan and is in compliance with federal claiming guidelines.
- Assist children and families in accessing needed Medicaid Services.
- Increase the number of children and adults receiving preventive care.
- Increase consumer access to Medicaid providers in Washington communities.

Medicaid Administrative Claiming in Public Hospitals in the State of Washington

The State of Washington Public Hospital Medicaid Administrative Claiming Interpreter Services Program (program) is administered by the State Medicaid Agency. The State Medicaid Agency is the State of Washington Health Care Authority (HCA), or successor organization. Public Hospital and Public Hospital Districts (PH-PHDs) are able to participate in the program by signing an Interagency Agreement with HCA. MAC Contractors receive partial reimbursement representative of their administrative costs for providing interpreter services to Medicaid eligible Limited English Proficient clients who receive health care from the PH-PHD.

Note: Although not technically a PH-PHD, University of Washington School of Dentistry and the Pacific Hospital Preservation Development Authority participate in the program.

Purpose of this Manual

This Manual provides information concerning the certification, billing and claiming processes, and contractual requirements of the Program.

Interpreter Services provided through the Public Hospital Medicaid Administrative Claiming Program

"Eligible Interpreting Staff" means an employee of the Contractor, qualified as stated in Special Terms and Conditions (ST&C) Section 1 (Subsections f, h, j, or jj) of the Interagency Agreement, whose job description identifies them as providing Interpreting services.

"Interpreting" mean the process by which a neutral third party facilitates communication between speakers of different languages through an interpreter including language interpretation, language translation, and/or signing.

"Limited English Proficient" means a limited ability or inability to speak, read or write the English language in order to understand and communicate effectively. Being deaf, deaf-blind or hearing impaired is also included in the meaning of being Limited English Proficient (LEP).

An interpreter service encounter is an interpreting appointment arranged by the PH-PHD or Subcontractor to run concurrently with a healthcare appointment for a LEP client. The encounter can also include time spent on the same day providing necessary interpreting before or after the LEP client's appointment if that time relates to the appointment.

PH-PHDs may subcontract for these services however the PH-PHD must ensure the Subcontractor follows all of the requirements of the Interagency Agreement and this Manual.

Section II – Interpreter Services Qualifications

1. Language Interpreter and Translator Code of Professional Conduct

All participating PH-PHD and subcontracted interpreters must read, agree to (by signing and dating the form), and comply with the Department's Language Interpreter and Translator Code of Professional Conduct found at:

http://www.dshs.wa.gov/ltc/ethics.shtml

All participating PH-PHD and subcontracted sign language interpreters must also read, agree to (by signing and dating a copy of the form), and comply with the National Association of the Deaf (NAD) Registry of Interpreters for the Deaf (RID) Code of Professional Conduct found at:

http://www.rid.org/UserFiles/File/NAD_RID_ETHICS.pdf

2. Interpreter Services Quality Assurance Requirements

PH-PHDs and Subcontractors providing face-to-face, telephone based and/or video remote interpreter services for LEP individuals whose interpreter services are covered by the Interagency Agreement must:

- Comply with the standards set forth in the Interagency Agreement and this manual
- Meet the quality assurance standards for medical interpreters, privacy, and accessibility
- Use the most appropriate mode of interpreting, face-to-face, telephone based or video remote deemed by the Contractor and medical professional to be the safest, most effective and successful mode of interpreting for the medical professional/patient encounter
- Provide safe, efficient, effective and successful equipment and communications set up and use for the interpreting encounter
- Use interpreters who have a proven record of highly successful medical professional/patient interpreting encounters contributing to positive patient outcomes

To ensure a professional, trusted link between medical professionals and LEP patients, the PH-PHDs and Subcontractors providing interpreter services to LEP individuals covered by the Interagency Agreement must ensure the services used comply as applicable with the:

- Office of Civil Rights (OCR);
- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
- National Committee for Quality Assurance (NCQA);
- Medicare and Medicaid regarding adherence to standards for medical interpreters, privacy requirements and accessibility guidelines
- Health Insurance Portability and Accountability Act (HIPAA)
- Title VI of the Civil Rights Act of 1964

3. Interpreter Certification Requirements

The Contractor can only claim for interpreting performed by their own "Eligible Interpreter Staff" or that of a Subcontractor that meet one or more of the

qualifications defined in Special Terms and Conditions (ST&C) Section 1 (Subsections f, h, j, or jj) of the Interagency Agreement.

The qualifications defined in the Special Terms and Conditions (ST&C) Section 1 (Subsections f, h, j, or jj) of the Interagency Agreement are:

- "Authorized Interpreter" means an interpreter who has passed the language fluency test of Washington State Department of Social and Health Services' (DSHS) Language Testing and Certification Program (LTC Program) or other recognized interpreter testing body such as, but not limited to, the State of Washington Administrator of the Courts, or the Federal Courts.

  Note: As further clarification for this "Authorized Interpreter" qualification, this may also include interpreters who have passed testing and certification from a non-profit, non-self-serving organization whose credible interpreter testing and certification process is recognized by the DSHS LTC.

  For other than the State of Washington Administrator of the Courts, or other Federal Courts, to determine if an interpreter can be considered an "Authorized Interpreter" by HCA through the Interagency Agreement, the MAC Contractor or Subcontractor must submit to the DSHS LTC Program the following about the non-profit, non-self-serving organization whose credible interpreter testing and certification process has been used to certify the interpreter:

  1. Name and contact information for the non-profit, non-self-serving organization.
  2. An examination manual/narrative of the organization's testing and certification process, including:
     a. Why the tests were constructed the way they were
     b. How the tests were finalized
     c. Supporting documentation such as test validation and/or test reliability statistics
  3. Tools and guidelines employed to evaluate the tests; and
  4. The benchmark for passing each test.

These documents may be emailed to DSHS LTC at: dshsct@dshs.wa.gov or mailed to: DSHS LTC, P.O. Box 45820, Olympia, WA 98504-5820.

The DSHS LTC does not recognize any certificates issued by interpreter service agencies, academic institutions, or interpreter training entities due to actual or perceived conflict of interest. But, it will review these documents to determine adequacy of the testing and certification process for designation of an interpreter as "Authorized Interpreter" for the Public Hospital Medicaid Administrative Claiming Interpreter Services Program, where it is evidenced that DSHS certified/authorized interpreters are not available.

- "Certified Interpreter" means an interpreter who has passed the LTC Program language fluency examination in one of the eight (8) LTC Program certified languages (Spanish, Chinese-Cantonese, Chinese-Mandarin, Vietnamese, Korean, Russian, Cambodian, or Laotian), and is certified as a medical interpreter.

- "Certified Sign Language Interpreter" means an interpreter who has passed either the Registry of Interpreter for the Deaf or National Association or the Deaf certification process for American Sign Language.

- "Qualified Interpreter" means an interpreter who has passed the LTC Program screening examination in languages other than the eight (8) LTC Program certified languages or another Washington State Department of Social and Health Services' recognized qualification process.

4. Telephone Based Interpreter Services Requirements

Telephone based interpreter services have additional requirements.

PH-PHDs and Subcontractors using telephone based interpreter services for LEP individuals whose interpreter services are covered by the ST&C of the Interagency Agreement must ensure the services used are through participation in the State's Department of Enterprise Services (DES) contract #03508, **WSCA Telephone Based Interpreter Services** Western States Contracting Alliance (WSCA), or successor contract. The WSCA web site is:

Western States Contracting Alliance (WSCA)

The interpreting agencies authorized to provide telephone based interpreter services through contract #03508 went through an intensive review of their interpreter testing and quality assurance standards before contract award. Based on this and their contract liability and insurance clauses, their telephonic

interpreters are considered to have met the standard of "Authorized Interpreter" defined in section 1.f. of the Interagency Agreement.

Web link for the DES contract is at:

http://www.des.wa.gov/services/ContractingPurchasing/Pages/default.aspx

Contact phone number for the contract is: (360)407-9405

Note: Interpreting agencies not listed in the State's Department of Enterprise Services (DES) contract #03508, or successor contract, are not authorized to provide telephone based interpreter services through the PH-PHD MAC Interpreter Services Program. If the Contractor uses such agencies for telephone based interpreter services, the costs of those services cannot be claimed through this program or reimbursed through HCA.

5. Video Remote Interpreting (VRI) Interpreter Services Requirements

As stated in the Interpreter Certification Requirements on page 6 of this manual, the Contractor can only claim for interpreting performed by their own "Eligible Interpreter Staff" or that of a Subcontractor that meet one or more of the qualifications defined in Special Terms and Conditions (ST&C) Section 1 (Subsections f, h, j, or jj) of the Interagency Agreement.

PH-PHDs and Subcontractors providing VRI interpreter services for LEP individuals whose interpreter services are covered by the Interagency Agreement must comply with the Interpreter Services Quality Assurance Requirements on page 6 of this manual. Detailed communication and equipment specifications may be identified and added at a later date.

6. Background Checks

"Client" means an applicant, recipient, or former applicant or recipient of any service or program administered by HCA.

The Contractor shall ensure concerning any employee, volunteer, Eligible Interpreting Staff, Independent Interpreters, interpreters from Interpreting Agencies or Subcontractors, (including, but not limited to, all interpreters and sign language interpreters), who may have access to children, vulnerable adults or other Clients served under the Interagency Agreement that:

a. A current criminal history background check exists for each interpreter

prior to their first instance of providing services to requestors, and annually thereafter. The initial criminal history background check may be waived if the interpreter has had a criminal history background check performed within one (1) year prior to providing services under this Agreement. The background check performed by the Washington State Patrol is considered the minimum standard for this program. Washington State Patrol criminal history background checks are good for one (1) year from date of issue.

b. The Contractor has ready access to, and provides upon the Request of HCA, a copy of the current criminal history background check for any Eligible Interpreting Staff, Independent Interpreters, interpreters from Interpreting Agencies, or Subcontractors performing services under the Interagency Agreement.

c. The Contractor reports immediately any changes in the criminal history or criminal history background check of Eligible Interpreting Staff, Independent Interpreters, interpreters from Interpreting Agencies, or Subcontractors to HCA when it becomes known to the Contractor.

d. The Contractor requires Eligible Interpreting Staff, Independent Interpreters, interpreters from Interpreting Agencies, and Subcontractors to report to the Contractor immediately any changes in their criminal history or criminal history background check.

If the Contractor or a Subcontractor determines they or Eligible Interpreting Staff, Independent Interpreters, Interpreters from Interpreting Agencies, or a Subcontractor fails their background check, or the background check has been revoked or rescinded, the Contractor and any applicable Subcontractor are to immediately prohibit any interpreter from providing services under the Interagency Agreement if the background check results indicate:

- The interpreter may pose a risk to children, vulnerable adults or other Clients served under the Interagency Agreement.

- A crime or negative action from the then current "DSHS Secretary's List of Crimes and Negative Actions For Use by All," (which can be found at http://www.dshs.wa.gov/bccu/bccucrimeslist.shtml), regardless of whether the interpreter will or will not have unsupervised access to children, vulnerable adults or other Clients served under the Interagency Agreement.

Section III – Medicaid Eligibility Rate (MER) Calculation Process

1. MER calculation process

The MER calculation process includes the Contractor's completion of the following to determine and document the MER:

- Provide, document, keep record of, and place where indicated on the:
  - **75% FFP Match Public Hospital/Public Hospital District (PH-PHD) CHIPRA-Medicaid Eligibility Rate (MER) Worksheet and Certification Form:**
    - Numerator: The total unduplicated number of LEP child Medicaid Clients served by the Contractor during the Quarter who are children (under 21 years of age) of families for whom English is not the primary language.
    - Denominator: The total unduplicated number of LEP individuals served by the Contractor during the Quarter.
  - **50 % FFP Match Public Hospital/Public Hospital District (PH-PHD) nonCHIPRA-Medicaid Eligibility Rate (MER) Worksheet and Certification Form** the related number of:
    - Numerator: The total unduplicated number of LEP Medicaid Clients served by the Contractor during the Quarter who are not children (under 21 years of age) of families for whom English is not the primary language, **or if not claiming 75% FFP Match**, the total unduplicated number of all LEP Medicaid Clients (adults and children) served by the Contractor during the Quarter.
    - Denominator; The total unduplicated number of LEP individuals served by the Contractor during the Quarter.

The 75% match for interpreter services provided for children less than 21 years of age is only authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) through September 30, 2015. Application of this 75% match for HCA MAC claiming beyond September 30, 2015 is contingent upon those CHIPRA 2009 provisions being extended by the United States Congress to a date certain beyond that date.

See samples of the MER Worksheet and Certification Forms in the sample Billing Workbook Worksheets in Section IX of this Manual.

The Contractor must determine if the LEP Individual provided services has MAC Medicaid eligibility using guidance provided to the contractor by HCA's Medicaid Outreach Unit. For any service coverage groups (coverage group is returned on the 270/271) where some Recipient Aid Category (RAC) codes are MAC Medicaid eligible and some are not, the provider would take the additional step to look up the RAC codes assigned to the client using the Benefit Inquiry page in ProviderOne.

This can be determined by accessing ProviderOne to submit an eligibility inquiry using one of these methods:

- Search for eligibility information via ProviderOne at

  http://www.providerone.wa.gov

- Submit an electronic individual or batch 270/271 inquiry to ProviderOne.
- Swipe the client services card using a magnetic card reader
- Use a Medical Eligibility Vendor to access information on your behalf

The Contractor must keep and provide for program review, adequate records to identify all LEP Individuals, LEP Medicaid Clients and the unduplicated counts for both groups that are used in the MER calculation process for the Billing Quarter.

Section IV – Claiming/Payment/Administrative Fee

1. Claiming Process

Participating PH-PHDs must agree to comply with the billing and claiming guidelines provided in the Interagency Agreement and this manual.

Cost Allocation is the claiming methodology utilized to determine payment to a Contractor in this program. Direct and Indirect Costs are allocated using a MER applied to the costs being claimed. See Section III and also page 9 of this section.

The Contractor's claims and documentation of MAC Program activities must clearly demonstrate that the activities/services directly support the

administration of the Title XIX Medicaid State Plan. The Contractor and Subcontractors must maintain/retain these and other adequate source documentation to support the Medicaid payments for MAC claiming. The basis for this requirement can be found in federal statute and regulations.[1] Administrative claiming records must be made available for review by state and federal staff upon request during normal working hours.[2] The State Medicaid Agency has responsibility to ensure that policies are applied uniformly throughout the state, and that claims submitted to CMS are in conformance with such requirements.

[1]Section 1902(a) (4) of the Social Security Act and 42 CFR 431.17; see also 45 CFR 95 and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 95 and 42 CFR 433.32(b and c) (retention period for records).
[2]Section 1902(a)(4) of the Act, implemented at 42 CFR 431.17.

The burden of proof and validation for claiming remains the responsibility of HCA, the Contractor and Subcontractors.
Note:

(1) Any activities related to training the interpreter so that they will qualify as an interpreter, are not reimbursable by Medicaid. If the interpreter incurs costs to become a certified, qualified, or authorized interpreter as defined in Section 1 of the Interagency Agreement, those costs may not be submitted for reimbursement for Medicaid FFP.

(2) The Contractor may not include HCA's administrative fee as a cost/expenditure when billing for the quarter in the Billing workbook worksheets and A19-1A.

2. Allowable Activities/Matchable Activities

Allowable Activities/Matchable Activities related to the Interagency Agreement that can be claimed by Contractors and Subcontractors include time spent:

a. Interpreting for an LEP client either face to face, by telephone or by VRI during preparation for and/or follow up on, and actual delivery of inpatient and outpatient healthcare services within the client's authorized scope of care.

b. Coordinating and completing Medicaid Administrative Claiming Interpreter service billings.

c. Copying and distributing necessary forms and materials.

d. Filing required documentation.

e. Attending Program required training.

f. Conducting Program required training of Contractor and Subcontractor staff.

g. Developing policies and plans necessary for the implementation of the Program.

h. Calculating reimbursable costs and completing required Billing Forms.

3. Allowable Cost or Matchable Cost

Allowable Costs or Matchable Costs are Direct Costs and/or Indirect Costs reimbursable in accordance with the Interagency Agreement. They are incurred by the PH-PHD to provide interpreter service Allowable/Matchable Activities. A Direct Cost activity is an activity performed by the PH-PHD's Eligible Interpreting Staff, Eligible Designated Support Staff, an Independent Interpreter, or Independent Interpreting Agency, and meets the definition of an interpreter service Allowable/Matchable Activities.

Allowable Direct Costs are:

a. Eligible Interpreting Staff and Eligible Designated Support Staff payroll costs, personnel costs, and travel costs

b. Operations Costs

   These are Direct Costs of supplies and equipment incurred only by a distinct Administrative Claiming Unit that the Contractor documents were incurred exclusively for providing Interpreting for LEP Clients while receiving Medicaid Covered Services.

c. Subcontracted Interpreting Costs

Allocated Direct Costs

Allowable Direct Costs convert to Allocated Direct Costs when multiplied by the respective Medicaid Eligibility Rate (MER).

Allocated Indirect Costs

Allocated Eligible Interpreting Staff Costs, Allocated Eligible Designated Support Staff Costs, and Allocated Operations Costs, may be multiplied by an Indirect Cost Rate that has been calculated in accordance with OMB Circular A-87 to

determined Allocated Indirect Costs. You must ensure that costs claimed as Direct Claimable Costs do not duplicate costs claimed through the application of the Indirect Rate.

If the Contractor intends to claim Indirect Costs, on an annual basis the Contractor must have and provide HCA with the Certificate of Indirect Costs.

Note:

- There isn't a requirement to claim Indirect Costs. However, Indirect Costs may be claimed on the Title XIX Cost Summary LEP Worksheet and be included in costs claimed on the A19-1A Invoice Voucher.

- Indirect Costs cannot be claimed for Allocated Subcontracted Interpreting Costs or for 75% FFP Match.

Calculating the Billing Quarter FFP Claimable Amount

Calculate your FFP Claimable Amount for each Billing Quarter by entering the required information and cost data in the Title XIX Cost Summary LEP Worksheet located in the Billing Workbook Worksheets.

See samples of the Agency Information Worksheet, MER Worksheet and Certification Forms, Title XIX Cost Summary LEP in the sample Billing Workbook Worksheets in Section IX of this Manual. Review of these forms will aid in understanding the conversion of Allowable Direct Costs to Allocated Direct Costs and determination of Allocated Indirect Costs.

Allocated Direct Costs and any Allocated Indirect Costs claimed are multiplied by the 50 % FFP percentage factor (adult interpreting services) or 75% FFP percentage factor (child interpreting services) to determine the FFP Claimable Amount that will be transferred to the A19-1A Invoice Voucher for reimbursement.

Note: The 75% match percentage factor for child interpreting services is for allocated direct costs only. Any indirect costs associated with child interpreting services are reimbursed at the 50% match percentage factor. The Billing workbook worksheets are designed to calculate indirect costs in this manner.

The 75% match for interpreter services provided for children less than 21 years of age is only authorized through September 30, 2015. Contingent upon the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) concerning this level of match being extended by the United States Congress and the Administration beyond that date, the 75% match might continue to be authorized beyond that date under this Agreement.

4. Indirect Cost Rate Review and Approval

HCA, or successor Medicaid agency, is the federal Cognizant Agent for review and approval of the Indirect Cost Rate. When you intend to claim Indirect Costs as part of your FFP Claimable Amount, you must submit with Contractor Intake documents before preparation of the Interagency Agreement the following for review and approval of your hospital's MAC Indirect Cost Rate:

- Current MAC indirect cost rate
- A detailed process description of the rate calculation process and how it complies with OMB Circular A-87 requirements
- Data and data sources used during the calculation process
- All electronic files related to the calculation process

After the review and approval process is completed by HCA you must provide a copy of your Indirect Cost Rate Certificate to:

Accounting Office
Financial Services
Health Care Authority
PO Box 45500
Olympia, Washington 98504-5500

Subsequent to execution of the Interagency Agreement any new rate or change to your Indirect Cost Rate must go through the same review and approval process, and a new Indirect Cost Rate Certificate must be received by HCA before the new or revised Indirect Cost Rate can be used to claim for MAC in this Program. The certificate must be prospective and cannot be used to claim for a previous quarter's claim for MAC reimbursement.

Note: Indirect Rates vary by PH/PHD and are reviewed and reapproved periodically at your or HCA's request.

See a sample of the Certificate of Indirect Costs form in Section IX of this Manual.

5. Non-Duplication of Payments

Federal, state and local government resources should be expended in the most cost-effective manner possible. PH-PHDs may not claim FFP for the costs of MAC Allowable Activities that are duplicative.

A listing of example activities, that is not all-inclusive, for which costs may not be claimable as MAC due to the potential for duplicate payments follows:

a. Activities that are integral parts or extensions of direct medical services, such as patient follow-up, patient assessment, patient education, or counseling.

b. An activity that has been, or will be, paid for as a service of another (non-Title XIX/non-Medicaid) program.

c. An activity that has been, or will be, paid for as a Medicaid administrative cost through another MAC program.

d. An activity that is included as part of a managed care rate and is reimbursed by the managed care organization.

e. Costs claimed when billing HCA through the Billing Workbook Worksheets if the Contractor claims Indirect Costs for Eligible Interpreting Staff, Eligible Designated Support Staff and/or Operations Costs, if all or any of those costs have been claimed as Direct Costs.

f. Indirect Costs for Subcontractor costs.

g. Costs for social services interpreting.

It is important to distinguish between duplicate payments for the same activity and an inefficient use of resources, which may result in the unnecessary repeated performance of an activity.

Duplicate performance of services or administrative activities must be mitigated through coordination of activities.

6. Offset of Revenues

Certain revenues must offset allocation costs in order to reduce the total amount of costs in which the federal government will participate. To the extent the funding sources have paid or would pay for the costs at issue, federal Medicaid funding is not available and the costs must be removed from total costs (See OMB Circular A-87, Attachment A, Part C., Item 4.a.).

The following include some of the revenue offset categories which must be applied in developing the net costs:

a. All federal funds.

b. All state expenditures which have been previously matched by the federal government (includes Medicaid funds for medical assistance (such as the payment rate for services under fee-for-service and SCHIP funds).

c. Insurance and other fees collected from non-governmental sources must be offset against claims for Medicaid funds.

d. All applicable credits must be offset against claims for Medicaid funds. Applicable credits refer to those receipts or reduction of expenditure type transactions that offset or reduce expense items allocable to federal awards as direct or indirect costs.

Note: You may not claim any FFP for administrative activities if related costs have already been paid by one of the revenue sources above. A government program may not be reimbursed in excess of its actual costs, i.e., make a profit.

7. Submitting the Billing Forms and the A19-1A Invoice Voucher (new A19-1A billing forms)

Sample Billing Workbook Worksheets are found in Section IX of this Manual. Once the Interagency Agreement is executed you can also find your specific billing worksheets on line at the following link:

Public Hospital MAC Interpreter Services Program

At that web site, navigate to the Billing Documents web link to locate your PH-PHD's Billing Workbook Worksheets which include:

a. PH-PHD Agency Information Worksheet

b. 75% FFP Match Public Hospital/Public Hospital District (PH-PHD) CHIPRA-Medicaid Eligibility Rate (MER) Worksheet and Certification Form

c. 50% FFP Match Public Hospital/Public Hospital District (PH-PHD) nonCHIPRA Medicaid Eligibility Rate (MER) Worksheet and Certification Form

d. Medicaid Health Care Interpreting – Administrative Match Billing Report, Interpreting Services Cost Summary – LEP MER Method

e. A19-1A Invoice Voucher

Note: The 75% Match Medicaid Eligibility Rate (MER) Worksheet and

Certification Form should be left blank if the PH-PHD is claiming for both LEP children of families for whom English is not the primary language, and for LEP adults, using only 50% FFP Match. The 75% MER is representative of LEP child Medicaid Clients only.

As indicated in Section IV of this manual, the 75% match for interpreter services provided for children less than 21 years of age is only authorized through September 30, 2015. Contingent upon the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) concerning this level of match being extended by the United States Congress and the Administration beyond that date, the 75% match might continue to be authorized beyond that date under this Agreement.

Complete and include all of these forms when you mail your quarterly billing.

Submit claims to:

Public Hospital MAC Program Specialist
Medicaid Outreach Unit
Health Care Services
PO Box 45530
626 – 8th Avenue SE
Olympia, Washington 98504-5530

NOTE: Timely Billing
In order for your claim to be considered timely it must be received by the HCA MAC program manager no later than twelve (12) months following the end of the quarter being billed.

8. Administrative Fee

HCA charges a small administrative fee for the operation of this program. The administrative fee will not exceed costs of Program operations and therefore is adjusted for that purpose periodically. You must pay this fee with non-federal dollars within forty-five (45) days of the date on the Administrative Fee A19-1A Invoice Voucher. Mail administrative fee payments to the following address:

Accounting Office
Financial Services
Health Care Authority
PO Box 45500
Olympia, Washington 98504-5500

9. When the Department Receives Your Claim

The MAC Program Manager will review the completed and signed original A19-1A Invoice Voucher and its accompanying documentation as part of the claim review process. If a claim is incomplete, unsubstantiated or inaccurate, you will be contacted for additional documentation or asked to resubmit a corrected claim.

See a sample A19-1A Invoice Voucher in the sample Billing Workbook Worksheet Excel file located in Section IX of this Manual.

10. When the PH-PHD MAC Claim is approved by the MAC Program Manager:

On completion of the MAC Program Manager review, and when no changes are required, the A19-1A Invoice Voucher will be approved and sent to HCA's fiscal office for payment processing. The reimbursement will be sent to you within thirty (30) days of receiving and approving a properly executed claim.

11. Annual Certification of Total Computable and Local Matching Funds

Contractors must track and record the source of the Total Computable (Certified Public Expenditures) and Local Matching Funds for each quarter.

Annually, the contractor must sign and submit the Local Match Certification, and the signed original, April through June, A19-1A Invoice Voucher and accompanying Billing Workbook Worksheets. HCA's MAC program manager must receive them within twelve (12) months following the April through June Billing Quarter. This form certifies the Total Computable, FFP, and Local Matching totals for the state fiscal year.

Note: Local Matching Funds must meet the requirements of 42 CFR 433.50 and 433.51 which state that only governmental units may provide the Local Match used to claim FFP.

Also, HCA will not approve your April through June A19-1A Invoice Voucher each year, and any subsequent A19-1A Invoice Vouchers, until the Local Match Certification has been received and approved.

See Section IX of this Manual for a sample of the Local Match Certification form.

Section V – Program Requirements

1. Applicable Laws and Regulations

Activities shall be in accordance with the following rules and regulations, and all updates, revisions, or replacements. See the Statement of Work in the Special Terms and Conditions, Section 4, in the Interagency Agreement for applicable rules and regulations.

2. Claiming Requirements

Your PH-PHD must:

- Claim only activities that are necessary and directly support the administration of the Title XIX Medicaid State Plan.
- Complete and submit accurate Billing Workbook Worksheets for the Billing Quarter.
- Retain supporting documentation for the Billing Workbook Worksheets
- Not submit any claims for payment in connection with services and activities provided to all clients (both Medicaid and non-Medicaid) as free care, unless expressly authorized by federal law, Washington State law, the Interagency Agreement or this Manual
- Not claim for activities that are normally covered by other means, such as collateral or related activities
- Not claim for activities that are normally performed for the same individuals under another program
- Not claim for social services interpreting

3. Insurance Requirements

See Section 10 of the Special Terms and Conditions of the Interagency Agreement.

Section VI – Required Documentation and Audit File

1. Retention and Access to Records

See records retention requirements in the Special Terms and Conditions Statement of Work, Subsection 4. a. (1), and General Terms and Conditions (GT&C) in the Interagency Agreement. You must maintain records related to the Interagency Agreement and each quarterly claim for six (6) years. If any litigation, claim, or audit is started before the expiration of the six (6) year period, the records shall be retained for six (6) years beyond the date all litigation, claims, or audit findings involving the records have been resolved.

2. Claiming Documentation

You must maintain documentation related but not limited to the following:

- Certifications
- Claiming and billing processes
- Medicaid eligibility
- Unduplicated LEP Individuals served
- Unduplicated LEP Medicaid Clients served
- Eligible Staff salary and personnel records
- Cost determination
- Indirect cost rate
- Invoices

Note: You must be able to support claims for MAC Program reimbursement. Please see additional guidance below regarding documentation for compensation of salary and wages, as excerpted from the OMB Circular A-87, Attachment B Section 11.h (5):

Personnel activity reports or equivalent documentation for participating staff must meet the following standards:

- *They must reflect an after-the-fact distribution (i.e., distribution following*

completion of the activity) of the actual activity of each employee;

- *They must account for the total activity for which each employee is compensated;*
- *They must be prepared at least monthly and must coincide with one or more pay periods; and*
- *The Contractor must retain documentation to support the report.*

Principles related to documentation and documentation requirements are:

- *Documentation related to salaries and wages, including personnel activity reports is required;*
- *Accounting records are supported by source documentation such as canceled checks, paid bills, payrolls, contract and sub-grant award documents;*
- *Documentation related to administrative costs is required.*

3. Audit File Preparation – Monitoring, Technical Assistance, and Auditing

Maintaining a current Audit File for each state fiscal year is the best way to be prepared for on-site monitoring visits and receiving any technical assistance from your MAC Program Manager.

It is recommended that your Audit File follow the content suggested in the HCA Audit File Guide template found on the Public Hospital MAC Interpreter Services website at: Public Hospital MAC Interpreter Services Program

and include the following current records and documents:

- **All MAC Training Documentation, including:**
  - Training rosters with date, staff names, and signatures
  - For each training event, a list of trainers and all materials used to train staff participants on the MAC Program.
- **Completed the Local Match Certification form**
- **Complete Billing Documentation or reference to its location**

- **Copies of all the Billing Workbook Worksheets**
- **Original MAC Interagency Agreement (executed)**
- **Completed Certificate of Indirect Costs form and documentation supporting the calculation of the Indirect Cost rate**
- **Copies of All state and federal Audit Reports, including but not limited to:**
    - MAC Monitoring Visit or Audit Report(s) and Corrective Action Documents
    - State or Federal Reviews and Audit Reports and Corrective Action Documents
    - OMB Circular A-133 Single Audit Reports and Corrective Action Documents
- **Originals of any Contracts/Agreements with Medicaid Administrative Claiming organizations** (State Medicaid Agency or other entity)
- **Documentation that Interpreter Background Check Requirements are being met**

Note: Subcontractors should also maintain an Audit File of training materials, time study documents, certifications, and billing/claiming documents (in accordance with the Interagency Agreement and this manual), sufficient to justify all invoiced billings.

Section VII – Subcontracting

1. Subcontractor Requirements

You may provide Interpreting services through written subcontracts that meet the interpreter services requirements and qualifications identified in Section II of this Manual.

When you choose to provide Interpreting services either in whole or in part, through Subcontractors, the subcontracts must include the following requirements:

- Identity of the parties to the subcontract (e.g.; name, address, type of organization) and their legal basis to do business

- Description of the payment methodology and applicable rates

- Terms and conditions for providing Interpreting services

- Compliance with the Language Interpreter and Translator Code of Professional Conduct located at:

  http://www.dshs.wa.gov/ltc/ethics.shtml

- All participating PH-PHD and subcontracted sign language interpreters must remain in compliance with the National Association of the Deaf (NAD) Registry of Interpreters for the Deaf (RID) Code of Professional Conduct found at:

  http://www.rid.org/UserFiles/File/NAD_RID_ETHICS.pdf

- Subcontractor's proof of Authorization, Certification, or Qualification for all interpreters as indicated in the Statement of Work in the Interagency Agreement and Section II of this Manual

- Subcontractor's signed statement that they and their employees/affiliates will not seek payment separate from HCA, or from LEP Clients or other contract service providers, for Interpreting services performed under the subcontract

- Requirement to retain all invoices and documentation for six (6) years that is used to calculate invoices for MAC Interpreting services billed to the Contractor and eventually by the Contractor to the State Medicaid Agency.

- Requirement for interpreter background checks consistent with this manual and the Contractor's Interagency Agreement.

Subcontracted Independent Interpreters and Interpreting Agencies must:

- Comply with the interpreter qualifications required in Section II of this manual and the Interagency Agreement.
- Comply with the background check requirements indicated in the Interagency Agreement and this manual.

- Verify, prior to billing, that the service being provided to the client is within the scope of care of the LEP Client's health care program at the time the care and Interpreting was provided.

- Accept full fiscal responsibility for their billings. In the event of a state or federal audit or review, the subcontracted Independent Interpreter and Interpreting Agencies will be responsible for any required repayments.

The Subcontractor may determine if the LEP individual has Medicaid eligibility by accessing ProviderOne to submit an eligibility inquiry using one of the methods identified in Section III.

Section VIII – Program/Contract Management and Monitoring

1. PROGRAM MANAGEMENT REQUIREMENTS

HCA's MAC Program Manager:

- Oversees monitoring of activities for the PH-PHD Medicaid Administrative Claiming (MAC) Interpreter Services Program

- Coordinates communication and processes between HCA and the PH-PHD, via the PH-PHD's MAC Coordinator, regarding all requirements described in the Interagency Agreement and this Manual

- Provides "Train the Trainer" MAC training to the PH-PHD's MAC Coordinator as applicable for the MAC program

- If requested and as available, provides MAC training to interpreter staff

- Conducts on-site monitoring or desk review. Provides technical assistance as needed/requested to PH-PHD's MAC Coordinator as availability permits

- Oversees any Amendments to or further development of the Interagency Agreement

- As needed/required, updates program documents

- Communicates by e-mail and/or phone with the PH-PHD's MAC Coordinator regarding impending contract modifications/amendments

- E-mails necessary documents to the PH-PHD's MAC Coordinator

2. CONTRACT MONITORING PLAN

Scope of the Monitoring Plan

This monitoring plan covers all PH-PHD Medicaid Administrative Claiming Interpreter Services Program Interagency Agreements for MAC Program reimbursement. These activities include, but are not limited to:

- Eligibility determinations
- Interpreting for LEP Clients for services within the client's healthcare plan scope of care
- Training on:
  - Medicaid services
  - Related Interpreting processes
  - Certifications
  - Insurance coverage
  - MAC claiming and billing processes

See Section IV on page 10 of this Manual regarding costs of training related to interpreters.

Monitoring Coordinator

HCA's MAC Program Manager for the PH-PHD Medicaid Administrative Claiming Interpreter Services Program, or designee, is responsible for monitoring the related Interagency Agreement. HCA will periodically monitor the Contractor, and may monitor any Subcontractor, to ensure compliance with the terms of the Interagency Agreement. All documentation is subject to review. See Sections VI, VII and this section.

Risk Factors

Risk factors are the subject areas identified in the HCA Audit File Guide template and are accessed during scheduled monitoring reviews and onsite visits.

Monitoring Activities and Schedule

Contractor's Role:

The Contractor, and all Subcontractors to this interagency agreement, shall comply with the Special Terms and Conditions and General Terms and Conditions of the Interagency Agreement.

- The PH-PHD MAC Coordinator is responsible for:
  - Providing program training to interpreters, support staff, and subcontractors
  - Validity and completeness of all certification, claiming and billing documentation
  - Accurate completion of Billing Workbook Worksheets and Certification forms
  - Accuracy in the LEP MER calculation
  - Timely submission of all billing forms for review, authorization, and payment.

HCA's Role:

- During HCA's Claim and Billing Review of the PH-PHD's quarterly billing the MAC Program Manager is responsible for:
  - Reviewing the Billing Workbook Worksheets for the Billing Quarter once they are received from the PH-PHD's MAC Coordinator to identify any inconsistencies, needed corrections, and/or inappropriate claiming.
  - Requiring the PH-PHD's MAC Coordinator to make corrections to any Billing Workbook Worksheets needing correction and resubmit them for further review and approval.
  - Once satisfied the Billing Workbook Worksheets are accurate and correct, approving and forwarding them including the A19-1A Invoice Voucher signed and dated by HCA's MAC Program Manager, to the fiscal office for payment processing.

Section IX – Forms and Resources

1. Forms

The following forms are used in the Public Hospital/Public Hospital District Medicaid Administrative Claiming Interpreter Services Program. These documents may be located by going to the PH –PHD Interpreter Services MAC Program web site at: Public Hospital MAC Interpreter Services Program and looking for the web link listing for your PH-PHD.

At that web site you will find the Billing Workbook Worksheets for your PH-PHD which include:

- PH-PHD Agency Information Worksheet
- 75% FFP Match Public Hospital/Public Hospital District (PH-PHD) CHIPRA-Medicaid Eligibility Rate (MER) Worksheet and Certification Form
- 50 % FFP Match Public Hospital/Public Hospital District (PH-PHD) nonCHIPRA-Medicaid Eligibility Rate (MER) Worksheet and Certification Form
- Medicaid Health Care Interpreting – Administrative Match Billing Report, Interpreting Services Cost Summary – LEP MER Method
- A19-1A Invoice Voucher

The 75% MER is representative of LEP child Medicaid Clients only.

On pages 30-34 sample Billing Workbook Worksheets are provided:

Public Hospital/Public Hospital District (PH/PHD) Agency Information

Contractor is to complete the yellow sections.

Claiming Entity:	ABC Hospital
Address 1 (DBA)	100 Main
Address 2	PO BOX 1000
Address 3	Anytown, WA
Quarter:	July through September 2013
Prepared by Contact Name:	Larry Linn
Prepared by Telephone #:	360-725-1970
Prepared by Email Address:	larry.linn@hca.wa.gov

Vendor Number Assigned by HCA on Agency A19-1A: xxxxxxxxxx-xx

PH/PHD Contract Number	xxxx-xxxxx	PROJ PREFIX	PROJ	SUB PROJ	PROJ PHASE
	Project Prefix "8IN" for Public Hospital Interpreting	8IN	x	xx	xx

Completing the "Agency Information" Tab	1. Claiming entity (the name and address that appears above has been completed by HCA. If there is a discrepancy with the name and address, please contact Ralph Faulder. (See HCA Contact Information below) 2. Complete the Quarter. Use this format: July through September 2013, October through December 2013, etc. 3. Complete the Prepared by name, telephone number and email address of the Hospital billing contact. 4. The vendor number has been completed by HCA.
Printing the Original A19-1A and backup	Print the A-19. Sign the A19-1A in blue ink. Include copies of the backup documents: Agency Informmation Form, 75% FFP MER Certification Form, 50% FFP MER Certification Form, Title XIX Medicaid Cost Summary LEP MER Method.
Mailing the A19-1A & backup to HCA	Mail the original signed A-19 and the required backup to: Medicaid Outreach Unit Health Care Services Health Care Authority PO Box 45530 Olympia, WA 98504-5530. If *overnighting* send it to Larry Linn at: HCA-Medicaid Outreach Unit Health Care Services Cherry Street Plaza, 1st Floor 626 8th Ave SE Olympia, WA 98504-5530 If a telephone number is needed use 360-725-1726.
HCA Contact Information	If you have fiscal questions, call Ralph Faulder at 360-725-1872 or email him at ralph.faulder@hca.wa.gov. If you have program questions, call Larry Linn at 360-725-1970 or email him at larry.linn@hca.wa.gov.

75% FFP Match Public Hospital/Public Hospital District (PH-PHD)
CHIPRA-Medicaid Eligibility Rate (MER)
Worksheet and Certification Form

Contractor is to complete the yellow sections.

PH/PHD: ABC Hospital

DBA: 100 Main

Contract #: xxxx-xxxxx

Quarter: July through September 2013

MER: 30.00%

Provide Medicaid Eligibility Formula:

Insert numbers applied in the formula to determine the MER rate for the Quarter:

Numerator	300	=	30.00%
Denominator	1000		

Numbers inserted in this Sample Form are for illustration purposes only.

Numerator: The total unduplicated number of LEP child Medicaid Clients served by the Contractor during the Quarter who are children (under 21 years of age) of families for whom English is not the primary language.

Denominator: The total unduplicated number of LEP individuals served by the Contractor during the Quarter.

Supporting documentation of the MER must be kept on file for review/audit purposes as needed, including databases utilized.

I certify that the information provided above is true, and that documentation is available for review upon request.

Signature: _____

Job Title: _____

Date: _____

50% FFP Match Public Hospital/Public Hospital District (PH-PHD) nonCHIPRA-Medicaid Eligibility Rate (MER) Worksheet and Certification Form

Contractor is to complete the yellow sections.

PH/PHD: ABC Hospital

DBA: 100 Main

Contract #: xxxx-xxxxx

Quarter: July through September 2013

MER: 10.00%

Provide Medicaid Eligibility Formula:

Insert numbers applied in the formula to determine the MER rate for the Quarter:

Numerator	100	=	10.00%
Denominator	1000		

Numbers inserted in this Sample Form are for illustration purposes only.

Numerator: The total unduplicated number of LEP Adult Medicaid Clients served by the Contractor during the Quarter who are not children (under 21 years of age) of families for whom English is not the primary language, **or if not claiming 75% FFP Match**, the total unduplicated number of all LEP Medicaid Clients (children and adults) served by the Contractor during the Quarter.

Denominator: The total unduplicated number of LEP individuals served by the Contractor during the Quarter.

Supporting documentation of the MER must be kept on file for review/audit purposes as needed, including databases utilized.

I certify that the information provided above is true, and that documentation is available for review upon request.

Signature: _____

Job Title: _____

Date: _____

HEALTHCARE FACILITY NAME:	ABC Hospital		= Input Required	CONTRACT #:	xxxx-xxxxx
BILLING PERIOD:	July through September 2013			BILLING STATE FISCAL YEAR:	SFY 2012

IMPORTANT NOTE: Cost amounts placed in this Billing Form must be those related to providing Interpreting Services for all LEP Clients during the Billing Quarter. All amounts must be supported by billing forms, invoices, logs, salary and payroll information, work schedules, automated data, or other information acceptable to the Health Care Authority (State Medicaid Agency) to validate the amounts. The 75% LEP MER and 50% LEP MER must be applied to allocate Contractor Direct Costs and Subcontracted Interpreting Costs as part of determining the respective Grand Total Costs and FFP Claimable Amounts. The Indirect Cost Rate must be applied to the Allocated Contractor Direct Costs (lines 2a. + 2b. + 2c.) if you choose to claim Indirect Costs on line 6. Line 8a., 75% FFP Match, applies to Allocated Direct Costs and Subcontracted Interpreting Cost only, not to Indirect Costs.

Health Care Authority (HCA) Medicaid Administrative Match Healthcare Interpreting	MOS:	MOS:	MOS:	QUARTER
1a. 75% FFP Quarterly Medicaid Eligibility Rate from the 75 % MER Worksheet and Certification Form	30.00%	30.00%	30.00%	30.00%
1b. 50% FFP Quarterly Medicaid Eligibility Rate from the 50% MER Worksheet and Certification Form	10.00%	10.00%	10.00%	10.00%
2a. Allowable Direct Employee Interpreting Costs, log & payroll, but not also included in Indirect Cost Rate Calculation or Indirect Costs	$2,000.00	$2,500.00	$2,200.00	$6,700.00
2b. Allowable Direct Employee Support Costs, log & payroll, if any, but not also included in Indirect Cost Rate calcultation or Indirect Costs	$500.00	$400.00	$450.00	$1,350.00
2c. Allowable Direct Operations Costs, if any, but not also included in Indirect Cost Rate calculation or Indirect Costs	$500.00	$600.00	$500.00	$1,600.00
2d. Subcontracted Interpreting Costs	$1,500.00	$1,700.00	$1,300.00	$4,500.00
3. Sum: Contractor Direct Costs and Subcontracted Interpreting Costs. (2a. + 2b. + 2c. + 2d.)	$4,500.00	$5,200.00	$4,450.00	$14,150.00
4a. Allocated Direct Costs and Subcontracted Interpreting Costs at 75% LEP MER (1a. X 3.)	$1,350.00	$1,560.00	$1,335.00	$4,245.00
4b. Allocated Direct Costs and Subcontracted Interpreting Costs at 50% LEP MER (1b. X 3.)	$450.00	$520.00	$445.00	$1,415.00
5. Indirect Cost Rate (must have current Certification on file with DSHS)	20.00%	20.00%	20.00%	20.00%
6. Total Allocated Indirect Costs (((2a. + 2b. + 2c.) X 1b) X line 5.)	$60.00	$70.00	$63.00	$193.00
7. Sum: 50% FFP LEP MER Allocated Direct, Subcontracted and Indirect Costs (lines 4b. + 6.)	$510.00	$590.00	$508.00	$1,608.00
8a. Medicaid FFP Claimable Amount at 75% FFP Match (.75 X line 4a.)	$1,012.50	$1,170.00	$1,001.25	$3,183.75
8b. Medicaid FFP Claimable Amount at 50% FFP Match (.50 X line 7)	$255.00	$295.00	$254.00	$804.00
I CERTIFY: Amounts placed in this Billing Form are correct and comply with the **IMPORTANT NOTE** above in this Billing Form.	SIGNATURE:			DATE:

FORM **A19-1A**

STATE OF WASHINGTON
INVOICE VOUCHER

AGENCY USE ONLY		
AGENCY NO.	LOCATION CODE	P.R. OR AUTH NO.
1070		XXXX-XXXXX

AGENCY NAME

Health Care Authority
Health Care Services
Medicaid Outreach Unit
PO Box 45530
Olympia WA 98504-5530

INSTRUCTIONS TO VENDOR OR CLAIMANT: Submit this form to claim payment for materials, merchandise or services. Show comlete detail for each item.

VENDOR OR CLAIMANT

ABC Hospital
100 Main
PO BOX 1000
Anytown, WA

Vendor's certificate: I hereby certify under penalty of perjury that the items and totals listed herin are proper charges for materials, merchandise or services furnished to the State of Washington, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, or Vietnam era or disabled veterans Status

BY _____ (SIGN IN INK)

(TITLE) (DATE)

FEDERAL I.D. NO. OR SOCIAL SECURITY NO. (For Reporting Personal Services Contract Payments to I.R.S.)	RECEIVED BY	DATE RECEIVED

DATE	DESCRIPTION	QUANTITY	UNIT	UNIT PRICE	AMOUNT	FOR AGENCY USE
	For services rendered in performance under					
	Contract # xxxx-xxxxx					
	Quarter: July through September 2013					
	Total PH/PHD CHIPRA-MAM Claimable Cost				$4,245.00	
	FFP Claimed at Match Rate 75%				$3,183.75	
	Total PH/PHD non-CHIPRA MAM Claimable Cost				$1,608.00	
	FFP Claimed at Match Rate 50%				$804.00	
			Total Claimable		$5,853.00	
			Total FFP		$3,987.75	

I certify that these expenses were incurred following the requirements of the Centers for Medicare and Medicaid Services (CMS) and that the funds are not already being used to match federal funds of other federal programs, or being reimbursed by other federal grants.

PEREPARED BY	TELEPHONE NUMBER	DATE	AGENCY APPROVAL	DATE

EMAIL ADDRESS

DOC. DATE	PMT DUE DATE	CURRENT DOC. NO.	REF. DOC. NO.	VENDOR NUMBER	USE TAX	UBI NUMBER
		H3				

ACCOUNT NUMBER 30 CHARS

VENDOR MESSAGE 25 CHARS: Interpreter Services

TRANS CODE	FUND	MASTER INDEX: APPN INDEX	MASTER INDEX: PROGRAM INDEX	SUB OBJ	SUB SUB OBJ	ORG INDEX	ALLOC	MOS	PROJ	SUB PROJ	PHAS PROJ	AMOUNT	INVOICE DATE	INVOICE # 30 CHARS
	001		H1994	ER	9772	H710	5EBA		8IN			3,183.75		Contract # : 75%
	001		H1994	ER	9772	H710	5EAA		8IN			804.00		50%

ACCOUNTING APPROVAL FOR PAYMENT	DATE	WARRANT TOTAL	WARRANT NUMBER
		$3,987.75	

On the next page a sample Certificate of Indirect Costs form is provided.

Washington State Health Care Authority

Certificate of Indirect Costs

_____
NAME OF LOCAL GOVERNMENT

CONTACT'S NAME	
CONTACT'S TELEPHONE NUMBER ( )	CONTACT'S EMAIL ADDRESS
INDIRECT COST PROPOSAL RATE	TIME PERIOD THE RATE COVERS FROM _____ TO _____

This is to certify that I have reviewed the indirect cost rate submitted with this contract and to the best of my knowledge and belief:

1. All costs included in this rate proposal _____ to establish a billing or final
   (DATE)
   indirect costs rate(s) for _____ are allowable with the requirements
   (PERIOD COVERED BY RATE)
   of the Federal award(s) to which they apply and OMB Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." Unallowable costs have been adjusted for in allocating costs as indicated in the cost allocation plan.

2. All costs included in this proposal are properly allocated to Federal awards on the basis of a beneficial or causal relationship between the expenses incurred and the agreements to which they are allocated in accordance with applicable requirements. Further, the same costs that have been treated as indirect costs have not been claimed as direct costs. Similar types of costs have been accounted for consistently and the Federal Government will be notified of any accounting changes that would affect the predetermined rate.

I declare that the foregoing is true and correct.

SIGNATURE	DATE OF EXECUTION
PRINTED NAME OF OFFICIAL	TITLE

HCA 02-568 (6/12)

On this and next page sample Local Match Certification forms are provided.

LOCAL MATCH CERTIFICATION

Local Match for Hospitals Medicaid Adminstratvice Match Invoices

Claiming Entity: ABC Hospital

Contract Number xxxx-xxxxx

FFP 50% / 50%

Quarter	For the Period	FFP (50%)	Local Match (50%)	Total Computable
1	Jul through Sep 2011	$2,000.00	$2,000.00	$4,000.00
2	Oct through Dec 2011	$1,672.50	$1,672.50	$3,345.00
3	Jan through Mar 2012	$1,800.00	$1,800.00	$3,600.00
4	Apr through Jun 2012	$1,900.00	$1,900.00	$3,800.00
	Grand Total	$7,372.50	$7,372.50	$14,745.00

Type and Source of Funds used as Local Match

List only the funds eligible/available for local match per Title XIX Medicaid.

Name of Local Match	Type	Source	Amount
Self Pay Revenue	Cash	Patient Revenue	$372.50
Non Federal Revenue from Molina Healthcare	Cash	Health Plan Revenue	$7,000.00
Total Local Match			$7,372.50

Check Point: Net Zero $0.00

By signing, I certify that the information provided above is accurate.

(Place signature and date here) — Authorizing Representative's Signature Date

Business Manager — Title

I. M. Me — Printed Name of Authorized Representative

xxx-xxx-xxxx — Telephone Number

LOCAL MATCH CERTIFICATION

Local Match for Hospitals Medicaid Administrative Match Invoices

Claiming Entity: ABC Hospital

Contract Number xxx-xxxxx

FFP 50% / 50%

Quarter	For the Period	FFP (50%)	Local Match (50%)	Total Computable
1	Jul through Sep 2011	$1,800.00	$1,800.00	$3,600.00
2	Oct through Dec 2011	$1,672.50	$1,672.50	$3,345.00
3	Jan through Mar 2012	$1,550.00	$1,550.00	$3,100.00
4	Apr through Jun 2012	$1,600.00	$1,600.00	$3,200.00
	Grand Total	$6,622.50	$6,622.50	$13,245.00

FFP 75% / 25%

Quarter	For the Period	FFP (75%)	Local Match (25%)	Total Computable
1	Jul through Sep 2011	$2,500.00	$833.34	$3,333.34
2	Oct through Dec 2011	$3,183.75	$1,061.25	$4,245.00
3	Jan through Mar 2012	$3,000.00	$1,000.00	$4,000.00
4	Apr through Jun 2012	$3,800.00	$1,266.66	$5,066.66
	Grand Total	$12,483.75	$4,161.25	$16,645.00
			Total Computable	$29,890.00

Type and Source of Funds used as Local Match

List only the funds eligible/available for local match per Title XIX Medicaid.

Name of Local Match	Type	Source	Amount
Self Pay Revenue	Cash	Patient Revenue	$1,759.00
Non Federal Revenue from Molina Healthcare	Cash	Health Plan Revenue	$9,024.75
Total Local Match			$10,783.75

Check Point: Net Zero $0.00

By signing, I certify that the information provided above is accurate.

(Place signature and date here) — Authorizing Representative's Signature Date

Business Manager — Title

I. M. Me — Printed Name of Authorized Representative

xxx-xxx-xxxx — Telephone Number

2. Resources

Public Hospital MAC Interpreter Services Audit File

OMB Circular A-87

Public Hospital MAC Interpreter Services Program

DSHS Language Testing Center

Registry of Interpreters for the Deaf (RID)

National Association of the Deaf (NAD)

CMS Medicaid School-Based Administrative Claiming Guide (dated May 2003)