WHATCOM COUNTY
CONTRACT INFORMATION SHEET

Whatcom County Contract Number: 202601020

Originating Department:	85 Health and Community Services
Division/Program: *(i.e. Dept. Division and Program)*	8510 Administration / 851000 Administration
Contract or Grant Administrator:	Lorri Vining
Contractor's / Agency Name:	Washington State Health Care Authority

Is this a New Contract?		If not, is this an Amendment or Renewal to an Existing Contract?	Yes ☐	No ☐
Yes ☒	No ☐	If Amendment or Renewal, (per WCC 3.08.100 (a)) Original Contract #:		

Does contract require Council Approval?	Yes ☒	No ☐	If No, include WCC:	
Already approved? Council Approved Date:			(Exclusions see: Whatcom County Codes 3.06.010, 3.08.090 and 3.08.100)	

Is this a grant agreement?		If yes, grantor agency contract number(s):	K8643	ALN#	93.778
Yes ☒	No ☐				

Is this contract grant funded?		If yes, Whatcom County grant contract number(s):	
Yes ☐	No ☐		

Method of Procurement:	N/A – Interlocal	Contract Cost Center:	

Is this agreement excluded from E-Verify?	No ☐	Yes ☒	

If YES, indicate exclusion(s) below:

☐ Professional services agreement for certified/licensed professional.	☐ Goods and services provided due to an emergency.
☐ Contract work is for less than $100,000.	☐ Contract for Commercial off the shelf items (COTS).
☐ Contract work is for less than 120 days.	☐ Work related subcontract less than $25,000.
☒ Interlocal Agreement (between Governments).	☐ Public Works - Local Agency/Federally Funded FHWA.

Contract Amount:(sum of original contract amount and any prior amendments):

Fee for service with no maximum revenue

Council approval required for; all property leases, all Interlocal agreements, contracts or bid awards **exceeding $75,000**, and grants exceeding $40,000 and professional service contract amendments that have an increase greater than $10,000 or 10% of contract amount, whichever is greater, **except when:**

1. Exercising an option contained in a contract previously approved by the council.
2. Contract is for design, construction, r-o-w acquisition, prof. services, or other capital costs approved by council in a capital budget appropriation ordinance.
3. Bid or award is for supplies.
4. Equipment is included in Exhibit "B" of the Budget Ordinance
5. Contract is for manufacturer's technical support and hardware maintenance of electronic systems and/or technical support and software maintenance from the developer of proprietary software currently used by Whatcom County.

Summary of Scope: This agreement provides funding for Medicaid related outreach and linkage activities performed by WCHCS to Whatcom County residents.

Contract Term Ends: 12/31/2029

Contract Routing:				
1. Prepared by:	J. Thomson	Date:	12/01/2025
2. Attorney signoff:	Kimberly A. Thulin	Date:	12/01/2025
3. AS Finance reviewed:	bbennett	Date:	12/05/2025
4. IT reviewed (if IT related):		Date:	
5. Contractor signed:		Date:	
6. Executive Contract Review:	Initial JL	Date:	1/20/2026
7. Council approved (if necessary):	AB2026-001	Date:	01/13/2026
8. Executive signed:		Date:	1/19/2026
9. Original to Council:		Date:	

WHATCOM COUNTY
Health and Community Services

Champ Thomaskutty, MPH, Director
Amy Harley, MD, MPH, Co-Health Officer
Meghan Lelonek, MD, Co-Health Officer

Memorandum

TO: Satpal Sidhu, County Executive

FROM: Charlene Ramont, Assistant Director

RE: Washington State Health Care Authority – Medicaid Administrative Claiming Interlocal Agreement

DATE: **JANUARY 15, 2026**

Attached is a contract between Whatcom County and Washington State Health Care Authority (HCA) for your review and signature.

- **Background and Purpose**
  This four-year interlocal agreement outlines the requirements for the provision of Medicaid-related outreach and linkage activities performed by Whatcom County Health and Community Services (WCHCS) to Whatcom County residents. These activities assist residents who have no or inadequate coverage, and includes explaining the benefits of the Medicaid program, assisting them in them Medicaid application and renewal process, and linking them to Medicaid covered services.

- **Funding Amount and Source**
  This agreement is funded by the United States Department of Health and Human Services Medical Assistance Program (ALN 93.778). This is a fee-for-service agreement without a not-to-exceed amount. The contract reimburses WCHCS at 50% of the cost of assisting County residents in accessing Medicaid services. The required match for this agreement is satisfied through the activities performed by WCHCS and does not necessitate a monetary contribution. Council authorization is required per RCW 39.34.030(2), for agreements between public agencies.

- **Differences from Previous Contracts**
  This is a new agreement; however, similar agreements have been continuously executed since 2011. There are no substantive differences between this agreement and the previous agreement, which ended on 12/31/2025 (WC Contract #202011085).

Please contact Lorri Vining, Administrative Services Supervisor at LVining@co.whatcom.wa.us or 360-778-6107 if you have any questions.

Encl.

Washington State Health Care Authority	**INTERAGENCY AGREEMENT for** Medicaid Administrative Claiming	HCA Contract Number: K8643 Contractor Contract Number: 202601020

THIS AGREEMENT is made by and between Washington State Health Care Authority (HCA) and Whatcom County, (Contractor), pursuant to the authority granted by Chapter 39.34 RCW.

CONTRACTOR NAME		CONTRACTOR DOING BUSINESS AS (DBA)		
Whatcom County				
CONTRACTOR ADDRESS 311 Grand Avenue	Street	City Bellingham	State WA	Zip Code 98225
CONTRACTOR CONTRACT MANAGER Lorri Vining	CONTRACTOR TELEPHONE (360) 778-6107	CONTRACTOR E-MAIL ADDRESS LVining@co.whatcom.wa.us		

HCA PROGRAM	HCA DIVISION/SECTION
Medicaid Administrative Claiming	Medicaid Programs Division/Community Services
HCA CONTRACT MANAGER NAME AND TITLE Jon Brogger, Health Care Program Manager	HCA CONTRACT MANAGER ADDRESS Health Care Authority 626 8th Avenue SE Olympia, WA 98504
HCA CONTRACT MANAGER TELEPHONE (360) 725-1647	HCA CONTRACT MANAGER E-MAIL ADDRESS jon.brogger@hca.wa.gov

CONTRACT START DATE	CONTRACT END DATE	TOTAL MAXIMUM CONTRACT AMOUNT
January 1, 2026	December 31, 2029	No Maximum

PURPOSE OF CONTRACT:

The purpose of this Contract is to support Medicaid related outreach and linkage activities performed by Local Health Jurisdictions (LHJ) to Washington State residents who live within its jurisdiction. These activities assist residents who have no or inadequate medical coverage, and includes explaining the benefits of the Medicaid program, assisting them in the Medicaid application and renewal processes, and linking them to Medicaid covered services. This Agreement provides a process for partially reimbursing the Contractor for allowable and reasonable expenses associated with the time its staff spend performing Medicaid Administrative Claiming (MAC) activities.

The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract will only be binding upon signature by both parties. The parties may execute this contract in multiple counterparts, each of which is deemed an original and all of which constitute only one agreement. E-mail (electronic mail) transmission of a signed copy of this contract shall be the same as delivery of an original.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE
DocuSigned by: Satpal Singh Sidhu 1192C7C18B664E3...		1/20/2026
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE
DocuSigned by: Andria Howerton F2EF77E93FBC4D7...	Andria Howerton Deputy Contracts Administrator	11/25/2025

WHATCOM COUNTY:

DEPARTMENT HEAD APPROVAL: Signed by: Charlene Ramont C1DD9BF6CCAC4DC... 1/16/2026

Charlene Ramont, Assistant Director — Date
Whatcom County Health and Community Services

APPROVAL AS TO FORM: Signed by: Kimberly Thulin 521AC93A1AE340D... 1/15/2026

Kimberly A. Thulin, Senior Civil Deputy Prosecutor — Date

Washington State Health Care Authority
626 8th Avenue SE
Olympia, WA 98504-2730
360-725-1647
Jon.Brogger@hca.wa.gov

Table of Contents

1. DEFINITIONS

"A19-1A Invoice Voucher" or **"A19"** means the state of Washington Invoice Voucher used by Contractors and vendors to submit claims for payment in return for goods and/or Services provided to Health Care Authority (HCA) or its clients.

"Activity Code" or **"Code"** means the code assigned to the daily activities performed by Contractor staff in order to identify the percentage of time spent on any given activity.

"Administrative Fee" means the dollar amount charged to a contractor by HCA based on a percentage of each contractor's billing for Federal Financial Participation (FFP) claimed at the federally approved match rate, to offset HCA's costs incurred in administering this Contract.

"Apple Health" or **"Medicaid"** means the Washington State Medicaid program funded by the federal and state government, which pays for medical coverage for children and adults who meet specific income criteria.

"Audit" means an investigation of a contractor's MAC program and financial information to ensure compliance with state, federal, and local laws.

"Authorized Representative" means a person to whom signature authority has been delegated in writing acting within the limits of the person's authority.

"Billing Quarter" means a calendar quarter consisting of three (3) consecutive calendar months beginning with the first date of the calendar quarter during which this Agreement starts. The Contractor shall use Billing Quarters as the time periods for which claims for FFP are made.

"Budget Unit" means the individual contractor eligible to submit a claim for reimbursement to HCA, and includes all of its subunits.

"Budgeting, Accounting and Reporting System" or **"BARS"** or **"BARS Manual"** The BARS Manual prescribes accounting and reporting for local governments in accordance with RCW 43.09.200 and found at this website https://sao.wa.gov/.

"Business Days" means Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the state of Washington.

"Centers for Medicare and Medicaid Services" or **"CMS"** means the federal office under the Secretary of the United States Department of Health and Human Services, responsible for the Medicare and Medicaid programs.

"Certified Public Expenditure" or **"CPE"** means the sources of funds certified as actual expenditures by a local or public governmental entity and used as the State share in order to receive federal matching Medicaid funds, or Federal Financial Participation (FFP).

"Client" means an individual who is eligible for or receiving services through HCA program(s).

"Code of Federal Regulations" or "C.F.R." means all references in this Contract to C.F.R. chapters or sections include any successor, amended, or replacement Regulation. The C.F.R. may be accessed at http://www.eC.F.R..gov/cgi-bin/EC.F.R.?page=browse.

"Cognizant Agency" means the federal agency responsible for reviewing, negotiating, and approving Indirect Cost Rates.

"Confidential Information" means information that may be exempt from disclosure to the public or other unauthorized persons under chapter 42.56 RCW or chapter 70.02 RCW or other state or federal statutes or regulations. Confidential Information includes, but is not limited to, any information identifiable to an individual that relates to a natural person's health, finances, education, business, use or receipt of governmental services, names, addresses, telephone numbers, social security numbers, driver license numbers, financial profiles, credit card numbers, financial identifiers and any other identifying numbers, law enforcement records, HCA source code or object code, or HCA or State security information.

"Contract" or "Agreement" means the entire written agreement between HCA and the contractor, including any exhibits, documents, or materials incorporated by reference. MContract and Agreement may be used interchangeably.

"Contracts Administrator" means the HCA individual designated to receive legal notices and to administer, amend, or terminate this Contract.

"**Contractor"** means [Contractor Name], its employees and agents. Contractor includes any firm, provider, organization, individual or other entity performing services under this Agreement. It also includes any Subcontractor retained by Contractor as permitted under the terms of this Agreement.

"Corrective Action" or **"Corrective Action Plan"** means the written description of the plan the Contractor will complete in order to correct any finding or deficiency as identified by HCA or government entity.

"Cost Allocation Plan" or **"CAP"** means the official document which describes the procedures that states use in identifying, measuring, and allocating state agency costs incurred in support of all programs administered or supervised by the state agency. The Cost Allocation Plan makes explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues pertinent to the allocation of costs and submission of claims by MAC Contract acts. The Cost Allocation Plan must be reviewed and approved by CMS.

"Covered Entity" has the same meaning as defined in 45 C.F.R. 160.103.

"CPE Local Match Certification" means HCA's form the Contractor must submit with each quarterly invoice to report the source of funds certified as public expenditures and therefore eligible to be used as match for the MAC program.

"Data" means information disclosed, exchanged or used by Contractor in meeting requirements under this Agreement. Data may also include Confidential Information as defined in this Contract.

"Data Breach" means the acquisition, access, use, or Disclosure of Data in a manner not permitted under law or by this Contract, including but not limited to the HIPAA Privacy Rule which compromises the security or privacy of the Protected Health Information, with the exclusions and exceptions listed in 45 C.F.R. 164.402.

"Direct Charge Method" means the method of accounting for Direct Costs without a stepdown allocation for single funding sources expenses wholly attributed to the MAC program.

"Direct Cost" means an operating expenese that is wholly attributable to the MAC program and is not already included in the Indirect Cost Rate.

"**Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming**" or "**CMS Guide**" means the document issued by CMS in 2023 and any supplements, amendments, or successor; incorporated herein by reference which provides guidance to States for developing and managing MAC programs.

"Designated Record Set" means a group of records maintained by or for a Covered Entity as defined in 45 C.F.R. 160.103, that is: the medical and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used in whole or part by or for the Covered Entity to make decisions about individuals.

"Disclosure" means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

"Effective Date" means the first date this Contract is in full force and effect. It may be a specific date agreed to by the parties; or, if not so specified, the date of the last signature of a party to this Contract.

"Electronic Protected Health Information" or **"ePHI"** means Protected Health Information that is transmitted by electronic media or maintained in any medium described in the definition of electronic media at 45 C.F.R. § 160.103.

"Eligible Participant" or **"Participant"** or **"RMTS Participant"** means an employee of the Contractor that is in compliance with all federal, state, and HCA regulations including this Contract, the CAP, the Manual, CMS guidance, and any other requirements for participation in the MAC program and whose costs are eligible for claiming their staff time costs for conducting MAC activities.

"Federal Financial Participation" or **"FFP"** means the federal payment (or federal "match") that is available at a rate of 50% for amounts expended by a state "as found necessary by the Secretary for the proper and efficient administration on the state plan" per 42 CFR § 433.15(b)(7). An enhanced FFP rate of seventy five percent (75%) is available for certain SPMP or interpretation administrative costs. Only permissible, non-federal funding sources are allowed to be used as the state match for FFP.

"Fiscal Coordinator" means the Contractor's employee who is assigned to be the liaison between HCA and the Contractor for the accounting purposes of this Agreement. The Contractor may assign the fiscal and RMTS coordinator roles to the same staff if desired.

"HCA Contract Manager" means the individual identified on the cover page of this Contract who will provide oversight of the Contractor's activities conducted under this Contract.

"Health Care Authority" or **"HCA"** means the Washington State Health Care Authority, any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

"Health Insurance Portability and Accountability Act of 1996" or "**HIPAA"** means, as codified at 42 USC 1320d-8, as amended, and its attendant Regulations as promulgated by the U.S. Department of Health and Human Services (HHS), CMS, the HHS Office of the Inspector General, and the HHS Office for Civil Rights. HIPAA inlcudes the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

"Individual(s)" means the person(s) who is the subject of PHI and includes a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

"Indirect Cost" means an operating expense that is allocated across more than one program.

"Indirect Cost Rate" means the ratio, expressed as a percentage, of the Indirect Costs to a Direct Cost base as approved by the Contractor's Cognizant Agency.

"Information and Communication Technology" or **"ICT"** means information technology and other equipment, systems, technologies, or processes, for which the principal function is the creation, manipulation, storage, display, receipt, or transmission of electronic data and information, as well as any associated content. Examples include computers and peripheral equipment; information kiosks and transaction machines; telecommunications equipment; customer premises equipment; multifunction office machines; software; applications; websites; videos; and electronic documents.

"LHJ Claiming Manual" or **"Manual"** means the HCA document or its successor including any updates, that describes how the Contractor must manage their MAC program and provides program guidance.

"Limited Data Set(s)" means a Data set that meets the requirements of 45 C.F.R. §§ 164.514(e)(2) and 164.514(e)(3).

"Linkage" means connecting Clients to Medicaid Covered Services.

"Local Matching Funds" means the Contractor's non-federal tax dollars that are not otherwise obligated and are designated or certified to match the FFP rate of reimbursement.

"MAC Activity" or **"Allowable Activity"** or **"Reimbursable Activity"** or **"Claimable Activity"** means an activity that is administrative in nature, and necessary for the proper and efficient administration for the Medicaid state plan which must be in compliance as described in applicable federal, state, HCA and CMS Regulations, the CAP, Manual, and this Agreement.

"Medicaid Administrative Claiming" or **"MAC"** means the source of funding for reimbursements provided in this Agreement shared between the Contractor and the Federal Financial Participation (FFP).

"Medicaid Covered Services" means the array of federally required and Washington State legislatively appropriated medical and social services available to Medicaid Clients through the State Medicaid Plan (Apple Health).

"Medicaid Eligibility Rate" or **"MER"** means the proportional share of Medicaid individuals to the total number of individuals in the target population (Contractor's jurisdiction) as defined in the CAP, Manual and this Agreement.

"Minimum Necessary" means the least amount of PHI necessary to accomplish the purpose for which the PHI is needed.

"Monitoring" means review of a Contractor's MAC program to ensure program integrity.

"Office of Management and Budget" or **"OMB"** means a division under the Executive Office of the President of the United States.

"Operating Expense" means those costs incurred by the Contractor to perform business activities and includes both Direct Costs and Indirect Costs. Only operating expenses necessary to operate the Contractor's MAC program are allowable for FFP reimbursement.

"Outreach" means activities undertaken by the Contractor to inform individuals, families and community members within its jurisdiction about Services available and encourage access to these Services.

"Permissible Use" means only those uses authorized in this Contract and as specifically defined herein.

"Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses (including or excluding zip code), telephone numbers, social security numbers, driver's license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

"Position Description" means a document summary of specific dutes and responsibilites assigned to a staff position.

"Proprietary Information" refers to any information which has commercial value and is either: (1) technical information, including patent, copyright, trade secret, and other Proprietary Information, techniques, sketches, drawings, models, inventions, know-how, processes, apparatus, equipment, algorithms, software programs, software source documents, and formulae related to the current, future, and proposed products and services; or (2) non-technical information relating to products, including without limitation pricing, margins, merchandising plans and strategies, finances, financial and accounting Data and information, suppliers, customers, customer lists, purchasing Data, sales

and marketing plans, future business plans, and any other information which is proprietary and confidential. Contractor's Proprietary Information is information owned by Contractor to which Contractor claims a protectable interest under law.

"**Protected Health Information**" or **"PHI"** means information that relates to the provision of health care to an Individual; the past, present, or future physical or mental health or condition of an Individual; or past, present or future payment for provision of health care to an Individual. 45 C.F.R. 160 and 164. PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe, can be used to identify the Individual. 45 C.F.R. 160.103. PHI is information transmitted, maintained, or stored in any form or medium. 45 C.F.R. 164.501. PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USC 1232g(a)(4)(b)(iv).

"Random Moment Time Study" or **"RMTS"** or **"System"** or **"Time Study"** means an electronic System that quantifies the daily activities of eligible time study Participants through a statistically valid sampling methodology and allocates allowable participant costs to the MAC program. The System calculates the amount of FFP reimbursement based on the Contractors RMTS results, staff costs, MER, costs and other applicable calculations as described in the CAP, Manual and this Agreement.

"RCW" means the Revised Code of Washington. All references in this Contract to RCW chapters or sections include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at: http://apps.leg.wa.gov/rcw/.

"Regulation" means any federal, state, or local Regulation, rule, or ordinance.

"RMTS Consortium" or **"RMTS Consortia"** or **"Consortium"** or **"Consortia"** means a group of Contractors who have organized together based on similar duties their staff perform, organizational structure, type of programs, scope of work, or regional working relationships and will participate in a single time study together in order to achieve statistical validity.

"RMTS Coordinator" means an employee of the Contractor who is assigned to be the time study liaison between HCA and the Contractor for purposes of this Agreement. The Contractor may assign the fiscal and RMTS coordinator roles to the same staff if desired.

"Skilled Professional Medical Personnel" or **"SPMP"** means an individual who has completed a two-or-more-year program leading to an academic degree or certificate in a medically related profession, demonstrated by possession of a medical license, certificate or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization.

"State Fiscal Year" or **"SFY"** means a twelve (12) month period beginning on July 1st of one calendar year and ending on June 30th of the following calendar year. The SFY is broken into four (4) Billing Quarters.

"State Medicaid Plan" means the comprehensive written commitment by HCA, submitted under 1902(a) of the Social Security Act and approved by CMS, to administer the Washington State Medicaid program in accordance with federal and state requirements.

"Statement of Work" or **"SOW"** means a detailed description of the work activities the Contractor is required to perform under the terms and conditions of this Contract, including the deliverables and timeline, and is included as Attachment 1.

"Subcontractor" means a person or entity that is not in the employment of the Contractor, who is performing all or part of the business activities under this Agreement under a separate contract with Contractor. The term "Subcontractor" means subcontractor(s) of any tier.

"Sub-unit" means an individual cost center or budget unit within a budget unit (LHJ).

"Successor" means any entity or individual which, through amalgamation, consolidation, or other legal succession becomes invested with rights and assumes burdens of the first contractor/vendor or any person who succeeds to the office, rights, responsibilities or place of another.

"USC" means the United States Code. All references in this Contract to USC chapters or sections will include any successor, amended, or replacement statute. The USC may be accessed at http://uscode.house.gov/.

"WAC" means the Washington Administrative Code. All references to WAC chapters or sections will include any successor, amended, or replacement Regulation. Pertinent WACs may be accessed at: http://app.leg.wa.gov/wac/.

2. STATEMENT OF WORK

Contractor will furnish the necessary personnel, equipment, material and/or service(s) and otherwise do all things necessary for or incidental to the performance of work set forth in Attachment 1.

3. PERIOD OF PERFORMANCE

Subject to its other provisions, the period of performance of this Contract will commence on **January 1, 2026**, and be completed on **December 31, 2029**, unless terminated sooner or extended upon written agreement between the parties.

4. PAYMENT

Compensation for the work provided in accordance with this Agreement has been established under the terms of RCW 39.34.130. Compensation for services will be based on the following rates or in accordance with the following terms.

4.1. Source of Funds for Administrative Claiming are as follows:

4.1.1. Fifty percent (50%) of funds is received from the United States Department of Health and Human Services under Medical Assistance Program CFDA 93.778; and

4.1.2. Fifty percent (50%) is received from the Contractor's Local Matching Funds.

4.2. Source of funds for Administrative Claiming for appropriately documented Skilled Professional Medical Personnel and appropriately documented Interpreter staff Administrative Claiming are as follows:

4.2.1. Seventy-five percent (75%) of funds is received from the United States Department of Health and Human Services under Medical Assistance Program CFDA 93.778; and

4.2.2. Twenty-five percent (25%) is received from the contractor's local matching funds.

4.3. Local matching funds must meet CPE requirements and must be in the Contractor's budget and under the Contractor's control. These funds cannot be contributed by or certified by healthcare providers or subcontractors.

4.4. HCA will not issue reimbursement for any quarters where HCA receives credible evidence or suspected evidence of a system failure that has the potential to impact the integrity of the reimbursement request. This includes but is not limited to failures related to the time study, MER calculation, claim calculation, or reconciliation.

4.4.1. HCA will pursue corrective action as needed and will restore payment after any issues related to the reimbursement request are resolved, and the requested amount is accurate.

5. BILLING PROCEDURE

5.1. Contractor must submit accurate invoices to the HCA Contract Manager for all amounts to be paid by HCA via e-mail to the HCA Contract Manager email address listed on the cover of this Agreement. Include the HCA Contract number in the subject line of the email.

5.2. All invoices will be reviewed and must be approved by the Contract Manager or designee prior to payment.

5.3. Contractor shall only submit invoices for Services or deliverables as permitted by this section of the Contract. The Contractor shall not bill HCA for Services performed under this Contract, and HCA shall not pay the Contractor, if the Contractor is entitled to payment or has been or will be paid by any other source, including grants, for such Services or deliverables.

5.4. Contractor must submit properly itemized invoices to include the following information, as applicable:

5.4.1. The HCA Contract number;

5.4.2. Contractor name, address, phone number;

5.4.3. Description of Services;

5.4.4. Date(s) of delivery;

5.4.5. Net invoice price for each item;

5.4.6. Applicable taxes;

5.4.7. Total invoice price; and

5.4.8. Payment terms and any available prompt payment discount.

5.5. HCA will return incorrect or incomplete invoices for correction and reissue. The Agreement number must appear on all invoices, bills of lading, packages, and correspondence relating to this Agreement.

5.6. Payment will be considered timely if made within thirty (30) calendar days of receipt of properly completed invoices. Payment will be directly deposited in the bank account or sent to the address Contractor designated in this Agreement.

5.7. Upon expiration or termination any claims for payment for costs due and payable under this Agreement that are incurred prior to the expiration date must be submitted by Contractor within sixty (60) calendar days after the expiration date. There will be no obligation to pay any claims that are submitted sixty-one (61) or more calendar days after the expiration date ("Belated Claims"). Belated Claims will be paid at HCA's sole discretion, and any such potential payment is contingent upon the availability of funds.

6. ACCESSIBILITY

6.1. REQUIREMENTS AND STANDARDS. Each information and communication technology (ICT) product or service furnished under this Contract shall be accessible to and usable by individuals with disabilities in accordance with the Americans with Disabilities Act (ADA) and other applicable Federal and State laws and policies, including OCIO Policy 188, et seq. For purposes of this clause, Contractor shall be considered in compliance with the ADA and other applicable Federal and State laws if it satisfies the requirements (including exceptions) specified in the regulations implementing Section 508 of the Rehabilitation Act, including the Web Content Accessibility Guidelines (WCAG) 2.1 Level AA Success Criteria and Conformance Requirements (2008), which are incorporated by reference, and the functional performance criteria.

6.2. DOCUMENTATION. Contractor shall maintain and retain, subject to review by HCA, full documentation of the measures taken to ensure compliance with the applicable requirements and functional performance criteria, including records of any testing or simulations conducted.

6.3. REMEDIATION. If the Contractor claims that its products or services satisfy the applicable requirements and standards specified in this Section and it is later determined by HCA that any furnished product or service is not in compliance with such requirements and standards, HCA will promptly inform Contractor in writing of noncompliance. Contractor shall, at no additional cost to HCA, repair or replace the non-compliant products or services within the period specified by HCA. If the repair or replacement is not completed within the specified time, HCA may cancel the contract, delivery, task order, or work order, or purchase line item without termination liabilities or have any necessary changes made or repairs performed by employees of HCA or by another contractor, and Contractor shall reimburse HCA for any expenses incurred thereby.

6.4. INDEMNIFICATION. Contractor agrees to indemnify and hold harmless HCA from any claim arising out of failure to comply with the aforesaid requirements.

7. AGREEMENT CHANGES, MODIFICATIONS AND AMENDMENTS

This Agreement may be amended by mutual agreement of the parties. Such amendments are not binding unless they are in writing and signed by an Authorized Representative of each party.

8. SUBCONTRACTING

Neither the Contractor nor any Subcontractor shall enter into subcontracts for any of the work contemplated under this Agreement without obtaining HCA's prior written approval. HCA shall have no responsibility for any action of any such Subcontractors.

9. ASSIGNMENT

The work to be provided under this Agreement, and any claim arising thereunder, is not assignable or delegable by either party in whole or in part, without the express prior written consent of the other party, which consent will not be unreasonably withheld.

10. CONTRACT MANAGEMENT

The Contract Manager for each of the parties, named on the face of this Contract, will be responsible for and will be the contact person for all communications and billings regarding the performance of this Agreement. Either party must notify the other party within thirty (30) days of change of Contract Management. Changes in Contract Management shall require an amendment.

11. DISALLOWED COSTS

The Contractor is responsible for any audit exceptions or disallowed costs incurred by its own organization or that of its Subcontractors.

12. DISPUTES

In the event that a dispute arises under this Agreement, it will be determined by a dispute board in the following manner: Each party to this Agreement will appoint one member to the dispute board. The members so appointed will jointly appoint an additional member to the dispute board. The dispute board will review the facts, Agreement terms and applicable statutes and rules and make a determination of the dispute. The dispute board will thereafter decide the dispute with the majority prevailing. The determination of the dispute board will be final and binding on the parties hereto. As an alternative to this process, either of the parties may request intervention by the Governor, as provided by RCW 43.17.330, in which event the Governor's process will control.

13. GOVERNANCE

This Agreement is entered into pursuant to and under the authority granted by the laws of the state of Washington and any applicable federal laws. The provisions of this Agreement will be construed to conform to those laws.

In the event of an inconsistency in the terms of this Agreement, or between its terms and any applicable statute or rule, the inconsistency will be resolved by giving precedence in the following order:

13.1. Applicable Federal and State of Washington statutes and regulations;

13.2. Attachment 1: Statement of Work; and

13.3. Any other provisions of the agreement, including materials incorporated by reference.

14. INDEPENDENT CAPACITY

The employees or agents of each party who are engaged in the performance of this Agreement will not be considered for any purpose to be employees or agents of the other party.

15. RECORDS MAINTENANCE

15.1. The parties to this Agreement will each maintain books, records, documents and other evidence which sufficiently and properly reflect all direct and indirect costs expended by either party in the performance of the services described herein. These records will be subject to inspection, review or audit by personnel of both parties, other personnel duly authorized by either party, the Office of the State Auditor, and federal officials so authorized by law. All books, records, documents, and other material relevant to this Agreement will be retained for six years after expiration and the Office of the State Auditor, federal auditors, and any persons duly authorized by the parties will have full access and the right to examine any of these materials during this period.

15.2. Records and other documents, in any medium, furnished by one party to this Agreement to the other party, will remain the property of the furnishing party, unless otherwise agreed. The receiving party will not disclose or make available this material to any third parties without first giving notice to the furnishing party and giving it a reasonable opportunity to respond. Each

party will use reasonable security procedures and protections to assure that records and documents provided by the other party are not erroneously disclosed to third parties.

16. RIGHTS IN DATA

Unless otherwise provided, data which originates from this Agreement will be "works for hire" as defined by the U.S. Copyright Act of 1976 and will be owned by HCA. Data will include, but not be limited to, reports, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes and/or sound reproductions. Ownership includes the right to copyright, patent, register and the ability to transfer these rights.

17. CONFIDENTIALITY

Each party agrees not to divulge, publish or otherwise make known to unauthorized persons confidential information accessed under this Agreement. Contractor agrees that all materials containing confidential information received pursuant to this Agreement, including, but not limited to information derived from or containing patient records, claimant file and medical case management report information, relations with HCA's clients and its employees, and any other information which may be classified as confidential, shall not be disclosed to other persons without HCA's written consent except as may be required by law.

18. SEVERABILITY

If any provision of this Agreement or any provision of any document incorporated by reference will be held invalid, such invalidity will not affect the other provisions of this Agreement, which can be given effect without the invalid provision if such remainder conforms to the requirements of applicable law and the fundamental purpose of this agreement, and to this end the provisions of this Agreement are declared to be severable.

19. FUNDING AVAILABILITY

HCA's ability to make payments is contingent on funding availability. In the event funding from state, federal, or other sources is withdrawn, reduced, or limited in any way after the effective date and prior to completion or expiration date of this Agreement, HCA, at its sole discretion, may elect to terminate the Agreement, in whole or part, or to renegotiate the Agreement subject to new funding limitations and conditions. HCA may also elect to suspend performance of the Agreement until HCA determines the funding insufficiency is resolved. HCA may exercise any of these options with no notification restrictions.

20. TERMINATION

Either party may terminate this Agreement upon 30-days' prior written notification to the other party. If this Agreement is so terminated, the parties will be liable only for performance rendered or costs incurred in accordance with the terms of this Agreement prior to the effective date of termination.

21. TERMINATION FOR CAUSE

If for any cause, either party does not fulfill in a timely and proper manner its obligations under this Agreement, or if either party violates any of these terms and conditions, the aggrieved party will give the other party written notice of such failure or violation. The responsible party will be given the opportunity to correct the violation or failure within 30 days. If failure or violation is not corrected, this Agreement may be terminated immediately by written notice of the aggrieved party to the other.

22. WAIVER

A failure by either party to exercise its rights under this Agreement will not preclude that party from subsequent exercise of such rights and will not constitute a waiver of any other rights under this Agreement unless stated to be such in a writing signed by an Authorized Representative of the party and attached to the original Agreement.

23. ALL WRITINGS CONTAINED HEREIN

This Agreement contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement will be deemed to exist or to bind any of the parties hereto.

24. SURVIVORSHIP

The terms, conditions and warranties contained in this Agreement that by their sense and context are intended to survive the completion of the performance, expiration or termination of this Agreement shall so survive. In addition, the terms of the sections titled Rights in Data, Confidentiality, Disputes and Records Maintenance shall survive the termination of this Agreement.

Attachments

Attachment 1: Statement of Work

ATTACHMENT 1: STATEMENT OF WORK

The purpose of this Agreement is to support Medicaid related outreach and linkage activities performed by Local Health Jurisdictions (LHJ) to Washington State residents who live within its jurisdiction. These activities assist residents who have no or inadequate medical coverage, and includes explaining the benefits of the Medicaid program, assisting them in the Medicaid application and renewal processes, and linking them to Medicaid covered services. This Agreement provides a process for partially reimbursing the Contractor for allowable and reasonable expenses associated with the time its staff spend performing Medicaid Administrative Claiming (MAC) activities.

The Contractor must provide staff and perform all activities necessary to do the work outlined in this Agreement.

1. Contractor Responsibilities

The Contractor is responsible for monitoring its MAC program to ensure compliance with all applicable laws, regulations and guidelines specific to the MAC program as described in this Agreement and comply with all roles, responsibilities, limitations, restrictions, and documentation requirements described in the CAP, Manual, associated federal and state regulations, and this Agreement. Only expenses that are reasonable and allowable, are permitted for reimbursement. HCA expects the MAC program to be managed similarly to other federal awards and expects the RMTS and Fiscal coordinators to report to, or work closely, with an administrator assigned oversight authority of the LHJ.

The Contractor must:

1.1. Provide the necessary staff to perform the allowable MAC activities described in the Cost Allocation Plan (CAP), and perform the work necessary to ensure all applicable laws, regulations and guidelines specific to the MAC program and this Agreement are in compliance including but not limited to:

1.1.1. Code of Federal Regulation (CFR) Title 42 and Title 45;

1.1.2. 1903(w)(6)(A) of the Social Security Act;

1.1.3. Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming 2023;

1.1.4. Revised Code of Washington (RCW);

1.1.5. The LHJ MAC Claiming Manual;

1.1.6. HCA-approved LHJ MAC training documents;

1.1.7. 2 CFR 225 Cost Principles for State, Local, and Indian Tribal Governments;

1.1.8. OMB Compliance Supplements;

1.1.9. Washington State Medicaid Plan; and

1.1.10. Secretary of State (SOS) records retention schedule.

1.2. Maintain documentation to support each administrative claim submitted to HCA for reimbursement as required by federal, state, HCA and CMS Regulations, the CAP, the Manual and this Agreement. The documentation must be sufficiently detailed in order to determine whether the activities are necessary for the proper and efficient administration of the Medicaid State Plan and support the appropriateness of the administrative claim.

The Contractor must:

1.2.1. Maintain all documentation related to staff participation in the RMTS according to section 1902(a)(4) of the Act and 42 CFR § 431.17; see also 45 CFR § 74.53 and 42 CFR § 433.32(a) (requiring source documentation to support accounting records) and 45 CFR § 74.20 and 42 CFR § 433.32(b and c) (retention period for records) and as described in Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming 2023;

1.2.2. Maintain all documentation related to MAC claiming, according to section 1902(a)(4) of the Act and 42 CFR § 431.17; see also 45 CFR § 74.53 and 42 CFR § 433.32(a) (requiring source documentation to support accounting records) and 45 CFR § 74.20 and 42 CFR § 433.32(b and c) (retention period for records) and as described in Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming 2023;

1.2.3. Comply with the SOS records retention schedule;

1.2.4. Assure all documentation is immediately accessible and available, must be in a useful and readable format, and must be stored electronically within the System at every opportunity as determined by HCA;

1.2.5. Provide any and all information and documentation requested by HCA within thirty (30) business days, or within a written, mutually agreed upon time frame; and

1.2.6. Submit any Audit related to its MAC program to HCA within thirty (30) business days of receipt of the final report. This includes but is not limited to SAO Audits, OMB Circular Compliance Supplement Audits,

Federal Reviews or Federal Audits. The contractor must provide to HCA, any corrective action related to MAC findings and questioned costs within thirty (30) business days of submission.

1.3. Abide by all roles, responsibilities, limitations, restrictions, and documentation requirements including but not limited to those described in the CAP, the Manual, and this Agreement.

1.4. Only include staff in the claimed reimbursement (through the RMTS or direct charge method) who are eligible to participate. The Contractor is prohibited from including any staff in the RMTS or the claimed reimbursement unless their job positions comply with the criteria described in the CAP, the Manual, and this Agreement.

Staff who may be eligible to be included in the RMTS or claimed reimbursement must:

1.4.1. Not be included in another MAC time study or reimbursement claim;

1.4.2. Be directly employed or contracted by the LHJ, or an HCA approved Subcontractor;

1.4.3. Be reasonably expected to perform MAC related activities;

1.4.4. Have all federal dollars appropriately off-set according to the CAP and Manual;

1.4.5. Not be included in the calculation of an indirect cost rate that is used to calculate FFP reimbursement;

1.4.6. Not include any Federally Qualified Health Clinic (FQHC) staff (or expenses) whose costs are included in the FQHC cost report; and

1.4.7. Be job positions that fit within these job categories: nurses, other medical professionals, other professional classifications, community outreach and linkage classifications, manager/supervisor/administrator classifications, or administrative support classifications as described in the CAP and Manual.

1.5. Designate staff for an RMTS Coordinator and a Fiscal Coordinator to be responsible for daily oversight and management of the Contractor’s MAC program.

1.5.1. The RMTS and Fiscal Coordinator roles may be assumed by one individual if desired.

1.5.2. The Contractor must submit contact information to the HCA Contract Manager for each coordinator, including their assigned role, name, telephone number, fax number, email, and address prior to participation in the MAC program, within seven (7) calendar days of the change.

1.5.3. The Contractor must ensure the Coordinators accurately perform all responsibilities listed in the CAP, the Manual, and this Agreement. Including but not limited to the following:

1.5.3.1. The Coordinators must participate in any scheduled RMTS consortium conference calls; and

1.5.3.2. The Coordinators must ensure federal, state, and HCA MAC policies are implemented.

1.6. Certify all data entered into the System is true and accurate, and based on actual expenditures incurred during the period of performance of the invoice. This certification must be maintained within the System. This includes, but is not limited to: calendaring, Staff/Participant lists, salary and benefits, direct charges or other claimed costs, indirect rate, MER, and any other data used to generate a claim to HCA for reimbursement.

1.7. Verify all data that is determined necessary to be stored electronically within the System or other associated websites, or databases as described in the CAP, Manual and this Agreement is physically entered and stored according to the SOS Retention Schedule. This data includes, but is not limited to: calendaring, Staff/Participant lists, salary and benefits, direct charges or other claimed costs, indirect rate, MER, and any other data used to generate a claim to HCA for reimbursement.

1.8. Prepare an annual MER proposal by using HCA form 13-954 (Medicaid Administrative Claiming Local Health Jurisdiction Medicaid Eligibility Rate Proposal) to include the MER calculation and formula, the data sources used to determine the MER, the data collection process, the Contractor's monitoring process to ensure accuracy of the MER and any other relevant information.

1.8.1. The proposal must be submitted to HCA no later than December first of each year.

1.8.2. The proposal must be updated and re-submitted if the data source or collection, calculations, or monitoring changes thirty (30) business days prior to the change.

1.9. Submit a quarterly CPE certification identifying the revenue account codes as found in the BARS manual with each invoice validating the accuracy of the CPE.

1.10. Submit an annual certificate of indirect costs by using HCA form 02-568 (Certificate of Indirect Costs) that certifies the accuracy of indirect cost rate proposal submitted to their Cognizant Agency each January.

1.11. Certify the accuracy of all data used to determine a quarterly MAC reimbursement by signing the A19 by an Authorized Representative. This certification extends to all RMTS data, MER data and financial data.

1.12. Complete a one hundred percent (100%) code review of all RMTS moments to ensure the code and narrative correlate, within forty five (45) calendar days after the end of the quarter.

1.13. Finalize and certify the accuracy of the 10% quality assurance review no more than 10 (ten) calendar days after the 10% review is received.

1.14. Monitor the RMTS non response rate, identify and take corrective action to resolve any deficiencies in staff responses.

Corrective action must:

1.14.1. Be implemented within ten (10) business days; and

1.14.2. Be documented and available to HCA upon request.

1.15. Use a System that is statistically valid and in compliance with all state, and federal laws and Regulations whether through a third-party or other means as stated in the CAP.

1.16. Not participate in a time study or claiming process for the HCA MAC program with any entity that does not have an executed agreement with HCA.

1.17. Not participate in an RMTS consortium without prior written approval from HCA and express, written approval of the Consortia organization and membership.

1.18. If identified as a Lead Agency for the RMTS Consortium, the Contractor must perform the Lead Agency duties described in the CAP and Manual and participate in the current statewide LHJ Steering Committee, including attending LHJ MAC work group meetings hosted by HCA.

1.19. Ensure all interpreter staff have been tested and certified by Washington State Department of Social and Health Services (DSHS) as defined by DSHS. The Contractor is prohibited from claiming the enhanced seventy five percent (75%) rate for any interpretation activities unless:

1.19.1. The staff has been certified by DSHS;

1.19.2. The MAC activities performed are part of the staff's assigned job duties; and

1.19.3. The allowable MAC activity was performed on behalf of children under twenty one (21).

1.20. Ensure all Coordinators and Participants have completed and have certified their understanding of the training prior to participating in the MAC program, and annually thereafter. The contractor is prohibited from allowing any staff to participate in the program unless they have completed and have certified their understanding of the training.

The Contractor must:

1.20.1. Ensure all Coordinators receive HCA approved training prior to participation;

1.20.2. Only use training materials that have been approved in writing by HCA;;

1.20.3. Ensure all Participants certify completion of the online training before performing any duties within the System or participating in the RMTS;

1.20.4. Ensure all Participants fully understand each RMTS Activity Code and how to answer moments according to what activity they were doing during the interval of the sampled moment;

1.20.5. Train all Participants to maintain proper documentation for MAC related activities; and

1.20.6. Track the completion and certification of training within the System, and must be available upon request by HCA.

1.21. Comply with all HCA revisions to RMTS/claiming requirements as described in the CAP and Manual.

1.22. Only use the RMTS Activity Codes (or their successors) in the CAP or Manual as approved by HCA, for participation in MAC.

2. Documentation and Forms

2.1. Contractor must use all forms and documentation as outlined in this Contract and within the Manual, including but not limited to the following:

2.1.1. Utilize the RMTS System for the time study and claims calculation;

2.1.2. Utilize the current State of Washington A19-1A Invoice Voucher (A19) produced by the System for submitting quarterly A19s to HCA;

2.1.3. Provide, maintain, and have available all supporting documentation for the time study and claiming in a readable and usable format as required in this Contract and Manual; and

2.1.4. Create and maintain quarterly documents reconciling all costs claimed for each A19.

2.2. Submit all Audit reports within thirty (30) calendar days of issuance to HCA including, but not limited to State Auditor Office (SAO) Audits, OMB Circular A-133 Single Audit Guidance, Federal Reviews, or Federal Audits.

2.2.1. Submit to HCA any corrective action related to MAC findings and questioned costs within thirty (30) calendar days of submission.

2.3. Maintenance of Records

During the term of any contract and for six (6) years following the termination or expiration of the Contract, the parties must maintain records sufficient to:

2.3.1. Document performance of all acts required by any Contract and applicable statutes, Regulations, and rules;

2.3.2. Substantiate the Contractor's statement of its organization's structure, tax status, administrative capabilities, and performance;

2.3.3. Demonstrate accounting procedures, practices, and records which sufficiently and properly document all invoices, expenditures, and payments;

2.3.4. Maintain all documentation related to MAC claiming and staff participation in the RMTS according to section 1902(a) (4) of the Act and 42 CFR 431.17. See also 45 CFR 74.53 and 42 CFR 433.32(a), requiring source documentation to support accounting records, and 45 CFR 74.20 and 42 CFR 433.32(b) and (c), retention period for records, and as described in Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming; and

2.3.5. Provide any and all information and documentation as requested by HCA, state and/or federal Auditors and reviewers in a readable and usable format.

3. Billing and Claiming

The Contractor must submit invoices for reimbursement to HCA for review and approval within one hundred twenty (120) calendar days following the end of each Billing Quarter. Upon approval, the Contractor must submit a signed A19-1A invoice voucher within thirty (30) calendar days.

3.1. Invoices submitted after one hundred twenty (120) calendar days following the end of the Billing Quarter may result in corrective action.

3.2. HCA will not offset negative balances against future A19s. The Contractor must immediately remit a check to HCA for any funds requiring repayment.

3.3. HCA is not a recovery agent and any overpayments that are at or beyond the one hundred eighty (180) calendar day mark will be turned over to the Office of Financial Recovery (OFR).

3.4. HCA will not seek reimbursement for any invoice received after the 23rd month of the two-year federal filing deadline.

3.4.1. Contractor must not bill and HCA must not pay for Services performed under this Contract if the Contractor has charged or will charge another agency of the State of Washington or any other party for the same Services.

4. Calculating the FFP and Generating an Invoice

The Contractor is responsible for ensuring all data (including all RMTS and financial data) used to calculate the amount of FFP submitted to HCA for reimbursement is accurate, based on actual expenses incurred during the period of performance, and complies with all federal, state, HCA and CMS Regulations, the CAP, Manual, and this Agreement. The Contractor must certify the accuracy of all data used to calculate the amount of FFP by an Authorized Representative signing the A19-1A Invoice Voucher (A19). The Contractor must use a System that is statistically valid and in compliance with all state, and federal laws and Regulations whether through a third- party or other means as stated in the CAP to calculate the amount of FFP and generate a claim.

4.1. The Contractor must submit invoices to HCA for FFP on a quarterly basis.

4.2. All data used to calculate the FFP must be from the same period of service.

4.3. All data used to calculate the FFP must be the actual cost/expenditure and not approximated.

4.4. The FFP is determined by calculating the total adjusted costs, multiplying these costs by the adjusted RMTS results, and the applicable Medicaid Eligibility Rate (MER), adding any direct charges, and then applying the appropriate FFP rate.

4.5. The invoice must be generated within one hundred twenty (120) business days of the end of the quarter and generated based on following five components:

4.5.1. Cost pool construction;

4.5.2. Calculating allowable Medicaid administrative time via the System or direct charge method and documentation;

4.5.3. Calculation and application of the pertinent MER;

4.5.4. Calculation and application of the indirect cost rate; and

4.5.5. Application of the appropriate FFP rate.

4.6. Cost Pool Construction

4.6.1. The Contractor must comply with all federal, state, HCA and CMS Regulations, the CAP, Manual, and this Agreement when constructing cost pools.

4.6.2. The Contractor is prohibited from including any unallowable costs in any cost pool.

4.6.3. The Contractor must include all costs used to calculate the FFP reimbursement to one of these six (6) cost pools:

4.6.3.1. Cost Pool 1: MAC SPMP;

4.6.3.2. Cost Pool 2: MAC Non-SPMP;

4.6.3.3. Cost Pool 3a and 3b: Non-MAC;

4.6.3.4. Cost Pool 4: MAC Direct Charge – enhanced;

4.6.3.5. Cost Pool 5: MAC Direct Charge – non-enhanced; and

4.6.3.6. Cost Pool 6: Allocated.

4.6.4. Costs included in the calculation of an indirect cost rate are prohibited from being assigned to any of the six cost pools except by application of the indirect cost rate.

4.6.5. All costs assigned to each cost pool must be allowable and comply with cost pool and allowability descriptions in the CAP and Manual.

4.7. Calculating Allowable Medicaid Administrative Time

The Contractor must:

4.7.1. Use only the RMTS or the Direct Charge method to calculate the percent of reimbursable time.

4.7.2. Use the RMTS for all eligible staff who are not certified as a Single Cost Objective.

4.7.3. Use the RMTS results produced by the System.

4.7.4. Will not alter the RMTS results and will certify the accuracy of the data by signing the A19 by an authorized Contractor representative.

4.7.5. Use only the Direct Charge method for staff who are certified as a Single Cost Objective.

4.7.5.1. These staff are required to document their daily work activities in fifteen (15) minute increments.

4.7.5.1.1. Daily logs must be maintained according to the SOS record's retention schedule.

4.7.5.1.2. All daily logs must have a quarterly summary rolling up all time over the quarter.

4.7.5.2. These staff must complete a single cost objective certification quarterly using an HCA approved form.

4.7.5.3. Each single cost objective staff must be reported individually on the invoice.

4.7.5.4. The invoice must report the name, the actual amount of time spent performing allowable MAC activities, and total dollar amount claimed for reimbursement for each staff.

4.8. Direct Charge for Interpretation Service Contracts

The Contractor may only direct charge for a portion of the Interpretation Service contracts and only for allowable interpretation activities as described in this Agreement.

4.8.1. Services direct charged must be for interpretation activities identified as allowable activities within the Manual, the CAP, and this Agreement. The Contractor is prohibited from including any other portion of an Interpretation Services Contract in the calculation for FFP reimbursement.

4.8.2. Each interpretation activity must be documented to HCA's satisfaction, in fifteen (15) minute increments, using a patient encounter form that includes, at minimum, the following data elements:

4.8.2.1. Appointment time/duration;

4.8.2.2. Client Name/ID/transaction information;

4.8.2.3. Interpreter Agency;

4.8.2.4. Interpreter Name or Employee ID;

4.8.2.5. Language/communication type;

4.8.2.6. Requestor or nurse name; and

4.8.2.7. The forms must be maintained according to SOS Record's retention schedule.

4.8.3. The above data from all patient encounter forms, except Client Name/ID Information, must be transferred onto a single spreadsheet that is searchable and sortable must be available upon request. When requested, the data will be provided in a readable, usable, mutually agreed upon format.

4.8.4. The invoice must report a summary for each Interpretation Service contract including the names of the interpreting staff, the total amount of time spent performing allowable MAC activities, and total dollar amount claimed for reimbursement.

4.8.5. The Contractor is prohibited from altering the information on the patient encounter forms and certifies the accuracy of the data entered into the spreadsheet and the System by signing the A19 by an Authorized Representative.

4.9. Calculation and Application of the Pertinent MER

4.9.1. All MERs must be calculated quarterly and match the methodology outlined in the contractor's annual MER proposal.

4.9.2. All MERs must be based on the quarter claimed.

4.9.3. All MAC activities that benefit the Contractors Clients directly and are performed within a program that identifies Clients may use a Client-based MER as described in the CAP and Manual.

4.9.4. All MAC activities that benefit the Contractor's Clients directly and are performed within a program that operates a primary care or specialty clinic may use a clinic-based MER as described in the CAP and Manual.

4.9.5. All MAC activities that benefit a larger population in the geographical region served by the Contractor, or in programs that do not identify Clients or collect demographic data may use the modified county-wide MER.

4.9.6. The Contractor is required to collect and maintain demographic data used to determine Medicaid enrollment for all Clients served within budget units whose costs are included in the FFP reimbursement. The Contractor is prohibited from including clients from any budget unit that is not allowable within the MAC program.

4.10. Demographic Data Requirements for the Client MER:

4.10.1. All data related to Medicaid enrollment and the MER must be maintained according to the SOS records retention schedule.

4.10.2. The information collected must be sufficiently detailed to determine Medicaid enrollment through HCA's ProviderOne System.

4.10.3. The information must be entered in the Contractor's Client information System or database.

4.10.4. The Contractor must produce a single electronic list of all unduplicated Clients served over the quarter within thirty (30) business days of the end of the quarter.

4.10.5. The Contractor is prohibited from including the same Client more than once (duplicating) on the quarterly list.

4.10.6. The Contractor must submit the quarterly list to either their third party System operator or other System operator which calculates the Client-based and clinic-based MER.

4.11. Calculation and Application of the Indirect Cost Rate

All indirect cost rates must be developed in accordance with all applicable regulations and guidelines including the 2 CFR Chapter I, Chapter II, part 200, et al (OMNI Circular).

The Contractor will ensure the following:

4.11.1. Have an indirect cost rate proposal approved by their Cognizant Agency;

4.11.2. Certify the accuracy of the indirect cost rate annually using HCA form 02-568 Certificate of Indirect Costs;

4.11.3. Verify all costs submitted to HCA for reimbursement are not duplicated through the indirect rate or any other mechanism; and

4.11.4. The Contractor is prohibited from requesting duplicate FFP for any cost.

4.12. Application of the Appropriate FFP Rate

The Contractor is:

4.12.1. Permitted to claim seventy five percent (75%) enhanced FFP only for specific allowable MAC activities accurately reported to SPMP or Interpretation Activity Codes as described in the CAP and Manual;

4.12.2. Required to verify the accuracy of activities reported to Activity Codes 12b, 12c, 7c and 7d;

4.12.3. Prohibited from claiming seventy five percent (75%) FFP for any other activities.

4.12.4. Permitted to claim fifty percent (50%) for all other accurately reported MAC Activity Codes; and

4.12.5. Required to certify the accuracy of the FFP claimed for reimbursement by signing the A19.

4.13. Certified Public Expenditures

The MAC invoice must document that there are adequate non-federal, local matching funds to support the costs of allowable MAC activities and be used as CPE.

The Contractor is:

4.13.1. Prohibited from using any source of funds as CPE that do not comply with federal, state, HCA and CMS Regulations, the CAP, Manual, and this Agreement;

4.13.2. Required to certify all sources of funds used as for CPE are accurate, allowable, and in compliance with all federal, state, HCA and CMS Regulations, the CAP, Manual, and this Agreement quarterly by completing a Certified Public Expenditure Local Match Certification quarterly and by signing the A19;

4.13.3. Required to use the Budgeting, Accounting and Reporting System (BARS manual) prescribed accounting and reporting for local governments to identify and document the revenue account codes for all local matching funds reported as CPE;

4.13.4. Required to ensure the source of all CPE funds are not federal tax money and are not used as a match for federal money (by the Contractor or any other agency);

4.13.5. Only permitted to use these funds to supplement, not supplant the amount of federal, state and local funds otherwise expended or services provided under this Agreement;

4.13.6. Required to have funds available for MAC activities and the funds must be within the Contractor's control and budget;

4.13.7. Prohibited from using provider-related donations or impermissible heath care related tax source for CPE;

4.13.8. Prohibited from using any private donations or non-public funds as a source for CPE without authorization from CMS' Center for Medicaid and State Operations' National Institutional Reimbursement Team (NIRT);

4.13.9. Prohibited from requiring or allowing private non-profits to participate in the financing of the non-federal share of expenditures;

4.13.10. Prohibited from allowing non-governmental units to voluntarily provide, or be contractually required to provide, any portion of the non-federal share of the Medicaid expenditures;

4.13.11. Prohibited from using funds payable under this Agreement for lobbying activities of any nature. The Contractor certifies that no state or federal funds payable under this Agreement shall be paid to any person or organization to influence, or attempt to influence, either directly or indirectly, an officer or employee of a state or federal agency, or an officer or member of any state or federal legislative body or committee regarding the award, amendment, modification, extension, or renewal of a state or federal contract grant;

4.13.12. Required to expend the total computable cost to Subcontractors for performance of allowable MAC activities;

4.13.13. Prohibited from submitting a request for FFP reimbursement to HCA until they have actually incurred the total computable cost; and

4.13.14. Prohibited from requiring the Subcontractor to provide the non-federal share of the payment, or return any portion of the total computable cost to the Contractor.

4.14. Revenue Offset

Federal or other unallowable funds that paid for MAC activities must be offset in the MAC invoice.

The Contractor is:

4.14.1. Prohibited from submitting a request for FFP reimbursement to HCA unless all funds are appropriately offset according to all federal, state, HCA and CMS Regulations, the CAP, Manual and this Agreement;

4.14.2. Required to certify the accuracy of the funds that are offset and the accuracy of the requested FFP reimbursement by signing the A19;

4.14.3. Required to ensure there is no duplication in FFP reimbursement between programs or cost objectives;

4.14.4. Financially responsible for repayment of any duplicated funds;

4.14.5. Required to provide documentation that Coordinators have been trained and fully understands the scope of work and terms of each funding source; and

4.14.6. Required to perform an assessment to determine whether each cost objective contained within the MAC budget unit(s) has potential to overlap with MAC;

4.14.7. The Contractor is prohibited from using any source of funds contained within the MAC budget unit until they have been assessed and determined appropriate;

4.14.8. The Contractor must complete the assessment as frequently as necessary to ensure proper allocation of cost, but at least annually and must be available upon request.

4.14.9. If the assessment determines any portion of the scope of work overlaps with MAC activities, the entire cost objective is deemed to overlap and is prohibited from being used as CPE; and

4.14.10. Required to identify costs that must be offset, and verify the remaining net costs are allowable for inclusion in the MAC program and eligible for FFP reimbursement.

5. Skilled Professional Medical Personnel (SPMP) Requirements

Contractor staff who have completed a two-or-more-year program leading to an academic degree or certificate in a medically related profession, demonstrated by possession of a medical license, certificate or other document issued by a recognized National or State medical licensure or certifying organization, or a degree in a medical field issued by a college or university certified by a professional medical organization are eligible for a seventy five percent (75%) enhanced reimbursement for specific MAC activities. Years of experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care. The Contractor is permitted to perform SPMP activities as directed by HCA's Chief Medical Officer (CMO) to assist in achieving HCA's goals and administering the Medicaid State Plan.

The Contractor must:

5.1. Monitor and ensure that FFP reimbursement for SPMP activities are in compliance with all federal, state, HCA and CMS Regulations, the CAP, Manual and this Agreement. Federal requirements include 42 CFR § 432.2, 432.45, 432.50, and 433.15.

5.2. Have all forms and documents supporting the designation of an SPMP entered into the System and retained according to the SOS record's retention schedule.

5.3. Not, and is prohibited from, requesting seventy five percent (75%) enhanced reimbursement for:

5.3.1. Any staff who are not certified as an SPMP, as stated above;

5.3.2. Any staff whose position descriptions do not require certified SPMP duties or responsibilities;

5.3.3. Any staff who are not directly employed by the Contractor;

5.3.4. Medical assistance expenditures;

5.3.5. Any SPMP activities that are not directed by HCA's CMO and explicitly described in this Agreement (All other allowable MAC activities performed by an SPMP are eligible for 50% FFP); and

5.3.6. Any activities that are not directly related to the administration of the State Medicaid plan.

5.4. Contribute to a quarterly SPMP report as needed by HCA and/or WSALPHO. Provide details and additional information needed for the report as requested by HCA and/or WSALPHO, within a mutually agreed upon time frame.

5.5. Participate in program planning and policy development meetings as requested by HCA.

5.5.1. The meetings will include discussions related to, but not limited to, reviewing the SPMP reports and related topics or the effectiveness of the activities performed in support of HCA's goals and the Medicaid State Plan.

5.6. Comply with any changes to the allowable SPMP activities as directed by the CMO.

5.6.1. Failure to comply with CMO directives may result in termination of SPMP participation in the MAC program.

5.7. Monitor and ensure that all activities reimbursed at the seventy five percent (75%) enhanced FFP are in support of the Medicaid State Plan and fall within the categories below. All other allowable MAC activities performed by an SPMP are eligible for fifty percent (50%) FFP.

5.8. Comply with any changes to allowable SPMP activities as directed by the CMO that may include, but is not limited to the following:

5.8.1. Clinical consultation with medical providers regarding best practices and adequacy of medical care covered by Medicaid. Includes, but is not limited to the following areas:

5.8.1.1. Pediatric immunization issues;

5.8.1.2. Access to Baby and Child Dentistry (ABCD) Emerging treatment/therapies for high risk populations;

5.8.1.3. Coordination of Medicaid-covered medical services for medically at-risk populations;

5.8.1.4. Medically fragile children;

5.8.1.5. High risk pregnant women;

5.8.1.6. Homeless individuals; and

5.8.1.7. Individuals with multiple medical conditions.

5.8.2. Case staffing on the medical aspects of cases requiring Medicaid-covered services including:

5.8.2.1. Medically involved children in foster care;

5.8.2.2. High risk pregnant women; and

5.8.2.3. Individual with communicable diseases requiring extraordinary/non-standard medical care.

5.8.3. Planning and coordination with local medical providers to facilitate earlier referrals and treatment for high-risk populations including but not limited to the following:

5.8.3.1. Children in foster care;

5.8.3.2. Homeless individuals; and

5.8.3.3. Children with developmental delays or behavioral challenges.

5.8.4. Providing medical consultation to the state regarding the Medicaid state plan including the following:

5.8.4.1. Consultation with medical providers to improve birth outcomes for Medicaid children; and

5.8.4.2. Consultation with school personnel to improve health outcomes for children exhibiting developmental delays or behavioral challenges due to medical condition, family stress, or other factors.

5.8.5. Pediatric immunizations including but not limited to:

5.8.5.1. Clinical consultation with providers concerning strategies to improve rates for pediatric immunizations.

5.9. Corrective Action Plan

5.10. HCA has the authority to require the Contractor to devise a Corrective Action Plan whenever HCA concludes that the Contractor is out of compliance with any MAC program requirements described in the CAP, Manual, or in the terms and conditions of this Agreement. HCA will require a Corrective Action Plan if the Contractor fails to address or correct any problems sufficiently and in a timely manner, as determined by HCA.

5.10.1. In the event HCA determines that the Contractor has failed to comply with the terms and conditions of this Contract, HCA will notify the Contractor in writing of the need to take corrective action.

5.10.2. The Contractor must develop and submit a Corrective Action Plan to HCA for approval within thirty (30) calendar days of HCA's notification.

5.10.2.1. If corrective action is not taken within the time period agreed to by both parties in writing, the Contract may be terminated per Section 29, *Termination for Cause*.

5.10.3. If the Contractor fails to meet the requirements outlined in the Corrective Action Plan, HCA may impose remedial actions including, but not limited to:

5.10.3.1. Conducting more frequent reviews;

5.10.3.2. Delaying or denying payment of MAC claims;

5.10.3.3. Recouping of funds; or

5.10.3.4. Terminating the Contract.

5.10.4. Contractor actions that may result in HCA remedial actions include, but are not limited to:

5.10.4.1. Repeated and/or uncorrected errors in financial reporting and MAC invoicing;

5.10.4.2. Failure to maintain or provide adequate documentation;

5.10.4.3. Failure to certify quarterly invoices within 120 days after the end of a quarter;

5.10.4.4. Failure to cooperate with state or federal staff;

5.10.4.5. Failure to provide accurate and timely information to state or federal staff as required;

5.10.4.6. Failure to meet time study minimum RMTS response rates;

5.10.4.7. Failure to meet RMTS statistical validity requirements; and

5.10.4.8. Failure to comply with the terms and conditions of this Agreement.

6. Administrative Fee

HCA charges MAC contractors an Administrative Fee to offset HCA's costs for the administration of the MAC program. The rate is based on the costs associated with the staff effort spent on MAC related work for an entire State Fiscal Year (SFY) and is billed as a line item on the quarterly claim form A-19-1A submitted by the MAC contractor. This cost is divided by the dollar amount of administrative claims submitted by the participating contractors in the MAC program for the same SFY. The calculated rate is used on the claims for the subsequent SFY. At the end of the period, the rate used will be validated using the actual claimed expenditures for that period and any variances will be settled with the contractor during the second quarter of the new SFY.

7. HCA Responsibilities

Health Care Authority is responsible for performing oversight of the Contractor's MAC program to ensure the effective administration of the MAC program and complying with all roles, responsibilities, limitations, restrictions, and documentation requirements described in the CAP, Manual, and this Agreement.

Including but not limited to the following:

7.1. Maintain oversight of the Contractor's MAC program and monitoring activities including review of all components of the time study, claiming, training, or anything MAC related.

7.2. Direct the MAC activities reimbursable at the enhanced seventy five percent (75%) rate for all Skilled Professional Medical Personnel (SPMP) participating in the Contractor's MAC program.

7.3. Review the Contractor's monitoring activities to ensure monitoring is occurring and any identified issues are addressed as deemed appropriate by HCA.

This will include but is not limited to the following:

7.3.1. Review of time study responses;

7.3.2. Accuracy of coding;

7.3.3. Appropriateness of code changes; Sufficiency of backup documentation; and

7.3.4. Non-response rates.

7.4. Verify the Contractor has entered all necessary data into the System and verify all data entered was certified by the Contractor as accurate.

7.5. Review all claimed costs prior to issuing reimbursement to ensure they are allowable, reasonable, and are supported by documentation that is sufficiently detailed to permit HCA, CMS, or others to determine whether the costs are

necessary for the proper and efficient administration of the state plan. This includes but is not limited to; source documentation of staff costs, operating expenses, and subcontracted vendor costs.

7.6. Review the RMTS Consortia organization and membership, including the Lead Agency identified, annually and issuing an official notice of approval or denial.

7.7. Review all MAC related training materials prior to their use in the MAC program and issuing an official notice of approval or denial. This includes multimedia video, audio, digital, or other electronic sources, and paper based training materials.

7.8. Evaluate RMTS and claiming data prior to issuing quarterly reimbursements to ensure the RMTS results and claimed costs are appropriate according to all applicable laws, Regulations and guidelines specific to the MAC program. This evaluation will also be used to identify trends, best practices for the MAC program, quality assurance, training needs, areas in need of improvement, or other concerns related to the MAC program and HCA's oversight responsibilities.

7.9. Issue corrective action plans as necessary and determined by HCA's oversight capacity that includes but is not limited to, quarterly reviews of RMTS and claiming data, the Contractor's failure to be in compliance with all applicable laws, Regulations and guidelines specific to the MAC program and this Agreement, or other quality assurance needs.

7.10. Produce and update the CAP, Manual, Contracts, training materials, or other MAC related documentation as needed and make it available to the Contractor.