**CHAPTER 6**

**Interlocal Agreements and Contracting for Client Services**

**Purpose of Chapter**

The purpose of this chapter is to outline contracting and monitoring requirements for programs and services that are in addition to, or an interpretation of, state and federal contracting and monitoring regulations listed in the next section. AAA’s may develop alternative procedures than those outlined in this chapter to more efficiently and effectively meet these requirements, provided they give advance notice in writing that includes a clear rationale to DSHS/Aging and Long Term Support Administration (ALTSA). ALTSA reserves the right to deny the change if it concludes the effect of the alternative would be a violation of legal requirements, Medicaid or other funding requirements, risk to client health or safety, or place additional liability on DSHS.

This chapter contains the following sections:

1. **Governing Regulations and Guidelines**
2. **ALTSA/AAA Agreements**
3. **Overarching Provider Selection Principles for AAAs**
4. **Specific Medicaid Provider Selection Principles for AAAs**
5. **Overarching Contracting Procedures for AAAs**
6. **Specific Medicaid Provider Contracting Procedures for AAAs**
7. **Contract Monitoring Principles for AAAs**
8. **Tools and Templates**

**I. Governing Regulations and Guidelines**

The major federal and state regulations and policies pertaining to the information in this chapter can be found in the documents, acts, and laws listed below. AAA‘s are responsible for identifying and understanding the full range of requirements that apply to their agency.

[Statutory mission of AAA 45 CFR Sec. 1321.53](http://www.ecfr.gov/cgi-bin/text-idx?SID=690740e9fe569db457c96f374577feba&mc=true&node=se45.4.1321_153&rgn=div8)

[Procurement Standards 45 CFR 75.326 through 75.335](http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5#sg45.1.75_1324_675_1325.sg2)

[Grants and Agreements 2 CFR 200.317 through 200.326](http://www.ecfr.gov/cgi-bin/text-idx?SID=611b449164acc3b09c86995b664b88d1&mc=true&node=sg2.1.200_1316.sg3&rgn=div7)

[Interlocal Cooperation Act Chapter 39.34 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=39.34)

[Public Assistance Chapter 74.34 through 74.41 RCW](http://app.leg.wa.gov/RCW/default.aspx?cite=74)

[Social Security Act Sec. 1902. 42 U.S.C. 1396a(a)(23)](http://www.ssa.gov/OP_Home/ssact/title19/1902.htm)

[Public Health 42 CFR 434 Medicaid Contracts](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr434_main_02.tpl)

Medicaid State Plan

Medicaid Waiver Requirements

[DSHS Management Bulletins](https://dshs.wa.gov/altsa/home-and-community-services/hcs-management-bulletins)

**II. ALTSA/AAA Agreements**

1. Interlocal Agreement Authority - As the State Unit on Aging (SUA) for the state, DSHS executes interlocal agreements governed by the Interlocal Cooperation Act, RCW Chapter 39.34 with all AAAs. Those agreements outline the cooperative arrangement with the AAAs for administering funds, programs and contracts for services for older people and people with disabilities.
2. Interlocal Agreement Execution - Interlocal agreements between AAAs and DSHS shall be executed prior to performing services. ALTSA will notify the AAA of the due dates, fund allotments, and necessary administrative steps to execute each of these agreements. Whenever possible, AAAs will be given an opportunity of 30 days to review and comment on interlocal agreements prior to finalizing or modifying them.

AAAs must provide services per the requirements of their interlocal agreement.

AAAs must provide ALTSA with written verification of persons having signature authority and must notify ALTSA of any changes. Whenever possible, AAAs will have up to 60 days to review, sign and return an interlocal agreement.

1. Amendments – Requirements for amendment are specified in each agreement.
2. Duty to monitor – ALTSA will monitor performance of the Area Agency on Aging. AAAs are responsible for monitoring AAA contracts and subcontracts.
3. ALTSA monitoring of interlocal agreements – ALTSA will use desk monitoring and/or on-site monitoring approaches. Procedures will include:
	1. Sharing the monitoring findings with the AAA prior to any action being taken.
	2. In the event of performance problems:
		1. The development of a plan for correcting the non-compliance with specific compliance dates.
		2. Progressive steps up to and including withholding payment when an established compliance date has not been met under the affected interlocal agreement.
		3. Determination of any compliance deadlines.
		4. Possible termination as outlined in the applicable interlocal agreement.
	3. Documentation of whether:
		1. Contract deliverables are on time
		2. Standards of operation are met.
	4. ALTSA will share a draft monitoring report with the AAA that includes:
		1. All findings of noncompliance
		2. Date when corrective action plan is due to ALTSA
		3. Dates of when findings of noncompliance need to be completed
4. Corrective action plans - for each finding of noncompliance, corrective action plans must include the following:
	1. Action to be taken to resolve the finding of noncompliance
	2. Date each action will be completed
	3. Person responsible for implementation of each step

**III. Overarching Provider Selection Principles for AAAs**

1. AAA Contracting - AAAs may subcontract for services to be provided under the AAA’s interlocal agreements consistent with the approved AAA Area Plan. (note: under certain conditions the AAA may also provide some services directly as long as DSHS is informed and the AAA complies with any related requirements) .

1. Responsible Providers - AAAs must award contracts only to responsible providers possessing the ability to perform successfully under the terms and conditions of the contract.
2. Conflicts of interest - AAAs must maintain written standard of conduct covering conflicts of interest that complies with applicable federal regulations and state ethics laws. Written standards must include conflict of interest for AAA advisory council members.
3. Objective provider selection - AAAs must ensure that procurement transactions are conducted in a manner that provides full and open competition, ensures objective bid review. AAA’s must avoid placing qualification requirements that are not typical for the type of service and requiring irrelevant experience or excessive bonding
4. Imposing additional requirements - AAAs may impose additional, reasonable requirements on subcontractors, provided they are in conformance with the applicable rules and regulations. Special contract conditions may be imposed as part of corrective action, including situations where the provider is:
	1. Financially unstable
	2. Has a history of poor performance
	3. Has a management system which does not meet federal and state standards of administration
5. Specifying service delivery area - In order to ensure an adequate service delivery network, AAAs may specify service delivery areas that may include requiring a provider to serve all counties or cities in their area or allowing providers to serve only specific niche areas based on provider expertise.
6. Written standards - AAAs must adhere to written standard contracting procedures that follow appropriate rules and regulations and contain the following:
	1. The strategy for methods used to obtain qualified providers.
	2. Standardized forms and contracts.
	3. Criteria and timelines for review, selection and approval of bids, proposals, and applications.
	4. A methodology for objective review of bids, proposals, and applications.
	5. A process to determine reasonable rates of payment. Medicaid rates must fall within the ranges published by DSHS.
7. Purchases through state contracts –A AAA may utilize state contracts with the Washington State Department of Enterprise Services if the AAA signs a Master Usage Agreement with DES and follows State Master Contracts purchasing guidelines.
8. Contracting with small and minority businesses and women’s business enterprises – The AAA must take all necessary affirmative steps to assure that small, minority businesses and women’s business enterprises (SMBWBE) are used when possible. Affirmative steps must include:
	1. Placing qualified SMBWBE on a solicitation list
	2. Assuring that SMBWBE are solicited whenever they are potential sources
	3. Dividing total requirements, when economically feasible as determined by the AAA, into smaller tasks or quantities to permit maximum participation by SMBWBE
	4. Establishing delivery schedules, where the requirement permits, which encourage participation by SMBWBE
	5. Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and Minority Business Development Agency of the Department of Commerce.
	6. Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in 1 through 5 of this section.
9. Contracting Processes –Contracting for Medicaid services should follow the Medicaid provider application process as described in Section IV. Specific Medicaid Provider Selection Principles for AAAs.

AAAs may choose to use the Medicaid provider selection process to award a non-Medicaid contract, as long the amount of the contract does not exceed $150,000 in federal and/or state funds over its course and in the judgment of the AAA all the necessary rules and regulations have been met.

For contracts that exceed $150,000 in federal and/or state funds over the course of the contract performance period, see Section III. Overarching Provider Selection Principles, Policy P. Competitive procurement.

1. Non-Medicaid service procurement - Except as noted above, non-Medicaid service procurement must use one of the following methods:
	1. Micro-purchase through purchase orders or vendor agreements
	2. Small purchase procedures that result in a contract
	3. Competitive procurement that results in a contract through:
		1. Sealed Bids
		2. Competitive Proposals
	4. Noncompetitive proposals that result in a contract
2. Micro-purchase – Procurements with a value below $3,500 in federal and/or state funds do not require competitive procurement. The AAA must have written methods to determine reasonable prices for micro-purchases.
3. Small purchase procedures – If the total contract, including amendments, is below $150,000 in federal and/or state funds, the AAA must obtain a price or rate quotation from an adequate number of qualified providers prior to contracting. This may include documented phone quotes, response to advertisement, catalog pricing, and internet pricing.
4. Competitive procurement – The AAA must use competitive procurement if the amount awarded to any provider will exceed $150,000 in federal funds over the contract performance period.
	1. Competitive procurement through sealed bids – Bids are publicly solicited and a firm fixed price contract (lump sum or unit rate). The following requirements apply:
		1. Bids must be solicited from an adequate number of known suppliers, providing them sufficient response time prior to the date set for opening the bids,
		2. The invitation for bids must be publicly advertised;
		3. The invitation for bids must define the items or services;
		4. All bids will be opened at the time and place prescribed in the invitation for bids and must be open publicly
		5. A firm fixed price contract award will be made in writing to the lowest responsive and responsible bidder.
		6. Any or all bids may be rejected at the discretion of the AAA if there is a sound documented reason.
	2. Competitive proposals - When the AAA chooses to use competitive proposals, standard processes must include:
		1. Publicized requests for proposals that identify all evaluation factors and their relative importance
		2. Methods to ensure an adequate number of qualified sources are notified of the request
		3. A written review process for review and scoring of proposals.
5. Noncompetitive proposals – The AAA may solicit a proposal from only one source when one or more of the following circumstances apply:
	1. The item is available only from a single source based on the uniqueness, location, or the required timeframe in which the services are to be provided.
	2. A public exigency or emergency exists.
	3. After solicitation competition is deemed inadequate
	4. ALTSA expressly authorizes noncompetitive proposals in response to a written request from the AAA.

The rationale for non-competitive proposals must be documented.

1. Procurement and provider application records - Copies of the approved proposals or applications, criteria used to approve the proposals or applications, contracts and amendments, must be retained in accordance with the ALTSA/AAA Interlocal Agreement and AAA’s record retention policies (whichever is greater).
2. Procurement and provider application disclosure - AAAs must disclose or protect bid information as required by law.
3. Provider selection grievances and appeals – AAA’s must have standardized, written appeal procedures which include informing ALTSA of any appeals.

**IV. Specific Medicaid Provider Selection Principles for AAAs**

1. Provider recruitment - AAA’s must recruit adequate service providers for Medicaid State Plan (Community First Choice, Medicaid Personal Care, etc.), Medicaid Waiver, and Roads to Community Living services in their area sufficient to allow access to all clients for needed services and where possible to provide clients with choice of provider.
2. Provider qualifications - Medicaid Long Term Services and Supports (LTSS) provider qualifications and scope of work are established by ALTSA and maintained on this website along with application materials: <https://www.dshs.wa.gov/altsa/home-and-community-services/information-potential-medicaid-contractors>. Providers awarded a contract prior to posting qualifications on the website may remain providers without going through any additional processes.
3. Contracting with qualified providers – The AAA must contract with all willing and qualified providers. If the AAA determines it is necessary to contract with a provider that does not meet the qualifications, the AAA must receive prior written approval from ALTSA. The AAA cannot waive professional licensing or certification qualifications.
4. Provider application processes –AAAs are encouraged to move applications through the qualification and review process as quickly as possible. AAAs must review the completed application and notify the applicant of the final status within 90 days of receipt of all required documentation specified on the Provider Qualifications website.

It is the responsibility of applicants to provide the required documentation within a reasonable timeframe. With notification of the remaining missing items to the applicant, the AAA may close the application process and notify the applicant that they may not reapply for six months following the date the file was closed.

1. Review of application materials - When reviewing applications for Medicaid services, AAAs must evaluate provider applications only against the qualifications published by ALTSA and state and federal guidelines. The review must be accomplished in a consistent, objective manner.
2. Providers deemed not qualified - If a provider is determined not qualified, the AAAs must document the basis for its decision, including consultation with other AAAs that may have reached a different decision regarding that applicant. The AAA must notify ALTSA if a provider deemed not qualified is contracted with another AAA to provide the same service.

The AAA must notify the provider of its decision and the appeal process.

1. Provider application tracking – The AAA must maintain record of all provider applications, significant dates, and communication with the applicant, including:
	1. When the provider applied
	2. When the provider was notified of approval or denial by the AAA (by day 90 after all required application materials were received)
	3. If the provider is not qualified, the basis for the decision

**V. Overarching Contracting Procedures for AAAs**

1. Pricing Models - The AAA may use five types of pricing methodologies for purchasing services. AAAs must follow written policies to determine reasonable rates regardless of the methodology chosen or funding source. Performance based contracting is the preferred method of contracting where practicable. Models are listed below in order of risk from lowest to highest.
	1. Performance Based: The provider is paid based on the completion of deliverables, performance measures, or outcomes.
	2. Set Rate/Fixed Price/Lump Sum: The provider is paid a set fixed amount or lump sum based on the terms established in the contract. Typically payment is tied to completion, review and acceptance of agreed upon tasks.
	3. Fee for Service: The provider is paid a set fee for the delivery of a defined unit of service, for example, hourly rates or a per-session fee.
	4. Cost Reimbursement: The provider is reimbursed for all costs incurred performing the work set forth in the contract.
	5. Time and Materials: The provider is paid a fixed hourly rate and for the costs of certain specified materials.
2. Contract format and terms – AAAs shall use a standard contract format for all contracts that includes all of the requirements from the relevant interlocal agreement, data share agreement, and whatever other requirements the AAA determines are legally prudent.
3. Contract duration, amendments and renewals - AAAs may award a multiple-year contract for a period not to exceed four years. AAAs may choose to renew contracts after the multiple-year period in accordance with relevant procurement laws and policies. See Section VI. Specific Medicaid Provider Contracting Procedures for renewal procedures of contracts that contain Medicaid funding.
4. Subcontracts by providers – Subcontracting by providers should be limited but is allowed at the discretion of the AAA. Direct services provider subcontractors are subject to the same background check requirements as the provider and qualifications appropriate for the task/service provided. The provider must have prior written approval by the AAA to subcontract. See Section VI. Specific Medicaid Provider Contracting Procedures for more information on providers subcontracting for Medicaid services.
5. Background checks - AAAs must assure that background checks are conducted on providers, employees and volunteers who will have unsupervised contact with vulnerable clients as required by law. Background checks must be repeated every two years. Background checks must be conducted through Washington State Patrol’s Washington Access to Criminal History (WATCH) system or a [National Association of Background Screeners accredited company](https://portal.napbs.com/i4a/member_directory/feResultsListing.cfm?directory_id=12). See Section VI. Specific Medicaid Provider Contracting Procedures for specific information on Medicaid contractor background checks.
6. Insurance requirements – AAAs must ensure providers meet insurance requirements specified in the relevant interlocal agreement, plus whatever additional coverage the AAA determines is prudent. AAAs may waive an insurance requirement for providers who report a hardship, provided the decision is adequately documented. ALTSA must be notified of any such waiver. Section VI. Specific Medicaid Provider Contracting Procedures for more information on DSHS contracts, which may have additional requirements.
7. Contract termination – AAAs shall terminate contracts with service providers according to the termination clauses of the contract. See Section VI. Specific Medicaid Provider Contracting Procedures, Policy K and L. Medicaid Contract Termination for more information on terminating Medicaid contracts.
8. Contract termination notifications – Prior to terminating a contract, the AAA will notify affected parties, including affected clients.
9. Contract termination grievance – Every effort shall be made to resolve all complaints, disputes, or grievances informally and at the lowest level. AAAs must have written standard grievance procedures which include informing ALTSA of any formal contract termination grievances.

**VI. Specific Medicaid Provider Contracting Procedures for AAAs**

1. Contracting Authority - The Centers for Medicare and Medicaid Services and Health Care Authority (HCA) as the state Medicaid agency are the primary sources for Medicaid policy. The HCA has delegated operations of Medicaid long-term services and supports (LTSS) for home and community-based services to DSHS. Via interlocal agreement, DSHS has delegated contracting authority to AAAs for a number of home and community-based services known as Core Services. AAAs are responsible to execute, manage, and monitor contracts with qualified service providers to ensure a quality service delivery network.

Providers for these LTSS services are paid primarily through the Health Care Authority's Maintenance Management Information System (MMIS), ProviderOne.

1. Medicaid contracts and the DSHS Agency Contracts Database (ACD)– All DSHS Medicaid contracts with the exception of home care agency services are set up to be executed directly in the ACD. All outside contracts must be entered into the ACD appropriately and in signed status before providers can be paid through ProviderOne. Please see the [ACD Manual](http://one.dshs.wa.lcl/FS/OSS/CCS/ACD/Pages/default.aspx) for detailed instructions.

AAAs may execute Medicaid contracts outside of the ACD only under the following circumstances.

* 1. The contract is for home care agency services.
	2. The AAA has an existing contract for an identical service funded from non-Medicaid sources
	3. All definitions, qualifications, statement of work and other clauses specific to the DSHS Medicaid contract in the Agency Contract Database are incorporated and only reasonable additional requirements are incorporated, per policies listed in Section III. Overarching Provider Selection Principles, Policies F., G., and H.
	4. The AAA incorporates the appropriate terms and conditions as required in Section V. Overarching Contracting Procedures, Policy B. Contract format and terms.
1. Medicaid provider subcontracts: Homecare agencies may not subcontract for direct client services. Other Medicaid providers that have been approved by the AAA to subcontract must include all DSHS contract language in the subcontract with the exception of the following, which may be excluded at the discretion of the AAA:
	1. Tasks within the statement of work or special terms and conditions that are clearly not relevant to the work performed by the subcontractor
	2. The following clauses in the DSHS General Terms and Conditions:
		1. Section 1. Definitions
			1. Central Contracts Services
			2. Contracts Administrator or CCLS Chief
			3. Program Agreement
		2. Section 4. Billing Limitations
		3. Section 9. Independent Contractor
		4. Section 12. Order of Precedence
		5. Section 15. Contract Renegotiation, Suspension, or Termination Due to Changes in Funding
		6. Section 16. Waiver
		7. Section 17. Advance Payment
		8. Section 18. Construction
		9. Section 21. Indemnification and Hold Harmless
		10. Section 23. Notice of Overpayment
		11. Section 25. Subrecipients
		12. Section 26. Termination for Convenience
	3. Additional clauses the AAA has received approval from DSHS to waive.

1. Insurance for Medicaid providers – Specific insurance requirements are specified in the DSHS ACD contract for each provider type. Insurance certificates must remain up to date in the provider file. AAAs must follow the ACD contract language which will specify whether DSHS and the AAA must be listed as an additional insured. Under limited circumstances, AAAs may decide to accept an insurance waiver request from providers who report a hardship to the mandatory insurance requirements. DSHS must provide prior approval of any such waiver.
2. Required DSHS forms, screenings, and background checks – All Medicaid providers must complete a DSHS Contractor Intake form, Medicaid Provider Disclosure Statement, and DSHS Background Check Authorization form prior to signing a contract. Documents must be maintained in the provider contract file. Providers must pass all screenings and background checks prior to signing a contract.
3. DSHS Background Check Review – The agency owner/contract signatory must pass a DSHS criminal history background check run through the DSHS Background Check Central Unit (BCCU). This individual must not have a disqualifying crime per the BCCU results letter. If the contractor will have unsupervised access to vulnerable adults, the AAA must consider any non-disqualifying results such as convictions, pending charges, or negative actions and may use the following factors:
	1. Whether you have a reasonable, good faith belief that he or she would be unable to meet the care needs of clients (e.g., if he or she would be responsible for driving the client, and has multiple DUIs)
	2. Vulnerability of the clients and the service that will be provided
	3. Behaviors since the conviction(s), negative action(s) or other adverse behavior(s)
	4. Pattern of offenses or other behaviors that may put clients at risk (e.g., if he or she would be working for a client with dementia, and has recent theft convictions)
	5. Number of years since the conviction(s), negative action(s), or other issue(s)
	6. Whether he or she self-disclosed the conviction(s), pending charge(s) and/or negative action(s)
	7. Other health and safety concerns
4. Updating required DSHS required forms, screenings and background checks – The documents below are required to maintain or renew a contract that contains Medicaid funds. Contract renewal is based on the contract end date documented in the ACD. AAAs may seek and rely upon information from other AAAs that have a current Medicaid contract with the provider to renew a contract, however, files must remain complete and current at each AAA that holds a contract.
	1. Information contained in the Contractor Intake Form including attached supporting documentation such as the W-9, business license, and insurance certificate. AAAs may require providers to complete a new Contractor Intake form or use the Contractor Information Update for existing DSHS contractors. Information in the ACD must be updated to reflect any new information. All information must be updated upon expiration or when changes with the provider occur.
	2. Medicaid Provider Disclosure Statement (MPDS) – This form is current for two years as long as provider ownership has not changed. Contracts that span four years must have a biennial MPDS update. AAAs may rely on ACD to verify whether the provider has an “Intake/Disclosure Form” check in the ACD within the last two years.
	3. DSHS Background Check Authorization – Background checks must be completed every two years on the agency owner/signatory authority (a.k.a. contractor). If a contractor changes, a background check must be run on the new contractor prior to executing a new contract. Contracts that span four years must have a biennial background check run on the contractor. Background checks must be reviewed per Section VI. Specific Medicaid Provider Contracting Procedures, Policy E. Required DSHS forms, screenings, and background checks and Policy F. DSHS Background Check Review.
5. Contracted home care agency acquisitions – Any entity acquiring a Washington State contracted home care service provider must meet the provider qualifications for a home care agency listed on the Medicaid LTSS provider qualification website with the following exception:
	1. If the entity does not have at least three years’ experience in Washington State as a licensed in-home service provider in the home care agency category, the entity must have at least three consecutive years of experience as a licensed in-home service provider to medically frail and/or functionally disabled persons in at least one state.
6. Medical providers – All medical providers must have a Core Provider Agreement (CPA) with the Health Care Authority to be paid in ProviderOne. Each contractor must have the same taxonomy in the DSHS ACD contract and ProviderOne system. The EIN/SSN must be the same in ProviderOne and the ACD to get the correct taxonomy assigned. If a provider needs a Core Provider Agreement, it will be indicated as a qualification in the Medicaid Provider Application.
7. Maintaining and managing access to a list of Medicaid contracted agencies – AAAs must maintain a list of Medicaid contracted agencies that can be easily accessed by case management staff at AAA, HCS, and DDA, ALTSA AAA Specialists and Resource Developers and is updated each quarter. Populations served must be identified on the list.
8. Medicaid contract termination - AAAs that decide a contract must be terminated for convenience or default should follow the procedures below so the contract can be terminated in the ACD system:
9. Termination for convenience –send a termination for convenience request to the ALTSA HCS or DDA contracts manager with a copy of the contracts cover page and the reason for termination. The ALTSA HCS or DDA contracts manager will terminate the contract, enter the termination date into the ACD, and send a copy of the termination letter to the AAA.
10. Termination for default – The AAA will send a termination for default request to the ALTSA and DDA Contracts Specialist with a copy of the contracts cover page, the reason for termination, and relevant justification documentation. In certain circumstances DSHS Central Contract and Legal Services department may need to be consulted before a termination for default may occur. DSHS will inform the AAA of any concerns and the parties will collaborate in reaching a solution.
11. Medicaid notifications for contract termination – The following entities must be notified of contract termination prior to the effective date of termination:
	1. Regional Home and Community Services offices via the Regional Service Administrator
	2. Developmental Disabilities Administration as applicable
12. Home care agency contacts – Upon execution of a home care agency contract, the AAA shall send contact information for the owner or head of the home care agency to the State Unit on Aging Home Care Agency Program Manager, who maintains a list of active contracted home care agency contacts for DSHS.

**VII. Contract Monitoring Principles for AAAs**

1. Written policies - AAAs must have written policies and procedures that address monitoring of service providers based on applicable law, regulation and program standards. See AAA Policy and Procedures Manual Chapter 9: Fiscal Operations for information on fiscal monitoring policies.

1. Contract monitoring responsibility - AAAs are responsible for monitoring the administrative, service delivery and fiscal procedures of all service providers with whom they have executed contracts. The monitoring tests whether providers are complying with applicable laws, regulations, and contract provisions. It also tests whether performance goals are being achieved and clients are receiving quality services.
2. Vendor monitoring responsibility - AAAs are responsible to test whether the vendor agreements and purchase orders are fulfilled according to the terms of the agreement. Documentation must be included in the vendor file.
3. Monitoring of provider qualifications - The AAA shall test whether the provider has maintained any required license, certification, or other qualification on a current basis.
4. Investigating complaints – The AAA must develop a standard process whereby complaints about service providers can be uniformly collected, investigated, documented. Trends should be addressed in provider monitoring. The AAA is responsible for addressing significant client health and safety issues with the provider at the time they occur.
5. Evaluation of provider risk – AAAs shall conduct an annual program risk assessment on each contracted service provider. The results of this risk assessment will determine the type and frequency of monitoring that must be conducted by the AAA and provide input into the AAAs annual monitoring schedule. A risk assessment is required for fiscal monitoring per AAA P&P Chapter 9 and AAAs are encouraged to conduct a joint program/fiscal risk assessment whenever possible. The AAA is not required to evaluate the following providers using the risk assessment and monitoring is not required when:
	1. Goods or services are contracted on behalf of DSHS using the Community Transition and Training Specialist Contract (CTTS) with the Community Transition Services/Residential Care Discharge Allowance (CTS/RCDA) subcode in the Agency Contractor Database (ACD); or
	2. No service authorizations have been made in the past year
	3. Vendors are providing goods or services for the general operation of the AAA (e.g. janitorial services, staff trainers, supplies)
6. Provider risk assessment elements –The AAA shall develop a risk assessment method that at a minimum includes the first five elements below:
	1. Client health and safety: Provider has unsupervised contact with clients or access to their belongings or finances; the nature of the service or vulnerability of the clients subjects the clients to health and safety risks
	2. Contractor expertise: Experience and competency of the provider in providing services for which the contract is written
	3. Key staff turnover: Recent turnover of key staff, new personnel or abnormal frequency of personnel turnover
	4. Performance history: Compliance issues which include known audit findings, litigation, or corrective actions
	5. Policy changes: Major policy changes regarding program or service

Additional risk assessment elements may include:

* 1. Budget: A large percentage of a provider’s funding comes through contracts with the AAA
	2. Reporting, billing, responsiveness: Frequency of reports, response times and accuracy of submitted budgets, reports, billings, and other contract deliverables
	3. Time since last monitoring: No on-site monitoring in the last two years
	4. Length of time providing services under the current contract: Contracted for less than one year
	5. Clinical and/or administrative expertise: Level of clinical and/or administrative expertise required to provide service
	6. Service level fluctuations: Significant expansion or decline in services
	7. Media: High profile entity or negative press in the past two years
	8. Data sharing: Electronic sharing of confidential or protected health information
	9. Subcontracting of services: Key activities are subcontracted and monitored by the provider
1. Types of provider monitoring – Based on the risk assessment, all contracted providers must receive at least one type of monitoring during the year, as follows:

* 1. On-site comprehensive review – Typically used when the risk is high, a comprehensive on-site review examines financial and programmatic records and allows direct observation of operations.
	2. Focused review – Typically used when the risk level is moderate or the breadth of risk is narrow, regular focused contact and appropriate inquiries and follow up concerning program activities is sufficient.
	3. Desk review – typically used when risk is low, a review of financial records and performance reports is sufficient.

1. Comprehensive review - An onsite review occurs at the provider’s office (when feasible) where documentation is held or services are delivered. The fiscal component of an onsite/comprehensive review is required per AAA P&P Chapter 9, however, this onsite review may occur separate from the programmatic onsite review. Program and fiscal are encouraged to conduct onsite reviews together whenever possible. The following elements are reviewed and documented:
	1. Items where compliance was not met during the previous monitoring to evaluate the agency’s effectiveness in implementing corrective actions and resolving findings
	2. Any problems, complaints, and follow-up related to quality of service, client safety, or financial activities
	3. Compliance with the contract terms, including a sample of priority requirements specified in the general and special terms and conditions and the statement of work
	4. Adherence to priority internal and external policies and procedures that govern service delivery
	5. A review of the delivery of program services including direct observation as appropriate
	6. Mechanisms for determining quality of services including processes for collecting and addressing client satisfaction, complaints, and grievances
	7. Results and resolution of client satisfaction surveys, complaints, and grievances
	8. Reliability of program and financial reports which may include requesting a sample month and replicating or monitoring the process to ensure information was reported accurately
	9. An adequate sample of employee files (and supervisor files as applicable) to determine compliance with qualifications required in contract including background checks, training, and licensure or certification. Sample size is at the discretion of the AAA depending on assessment of risk and size of the relevant universe of records. For Medicaid contracted homecare agencies, the minimum sample size is 10 files.
	10. An adequate sample of client records to determine the following:
		* 1. Clients were eligible for services
			2. Services were provided according to program standards
			3. Submitted reports were accurate
			4. Services billed were provided
			5. Unauthorized services were not billed and
			6. Appropriate documentation is provided (ex. authorization and billings have supporting documentation)

Sample size is at the discretion of the AAA depending on assessment of risk, but generally should be at least 5% of the relevant universe of records.

1. Focused review – This type of review does not require an on-site visit at the discretion of the AAA. A focused review is intended to detect and address issues that can be resolved with technical assistance and may require formal corrective action. Sample review of files (5 & 6 below) only needs to be completed at minimum biennially (or annually for homecare agencies); regardless of how often 1-4 are needed. The following elements are included:
	1. Items where compliance was not met during the previous monitoring to evaluate the agency’s effectiveness in implementing corrective actions and resolving findings
	2. Any problems, complaints, and follow-up related to quality of service, client safety, or financial activities
	3. Discussion of risk assessment elements
	4. Technical assistance provided to the contractor by the AAA
	5. A sample of direct service worker files, at least biennially, to determine compliance with qualifications required in contract including background checks, training, and licensure or certification. For Medicaid contracted homecare agencies, the minimum sample size is 10 files annually.
	6. A sample of client records, at least biennially, to determine that:
		* 1. Clients were eligible for services
			2. Services were provided according to program standards
			3. Submitted reports were accurate
			4. Services billed were provided
			5. Appropriate documentation is provided (ex. authorization and billings have supporting documentation)
2. Desk review – This type of review is to determine whether providers are fulfilling service-level contract obligations and to detect any issues that may result in unspent funds, underserved clients, or unnecessarily costly services/units throughout the course of the contract. The following elements are included in a desk review:
	1. Projected budget and service levels (e.g. enrolled clients, units of service) in comparison to actual expenditures and service levels.
	2. Review of program and/or financial reports
	3. Contact with the provider to address any concerns, discrepancies, or previously required corrective actions.
3. Monitoring tools – AAAs must establish monitoring tools (when one is not prescribed by DSHS) prior to conducting the monitoring. Monitoring tools must be used for all monitoring to ensure priority issues are documented and addressed.
4. Monitoring schedule - AAAs must establish and maintain an annual schedule of formal monitoring visits for all programs.
5. Notification to providers – Notification of monitoring must be sent to the provider at least 30 days in advance of any formal monitoring unless there is a reason to conduct an unannounced visit. Notification must include a list of the items to be covered so the provider can provide any documentation.
6. Exit interviews - An exit interview with the provider may be provided at the AAA’s discretion or as requested by the provider.
7. Draft written report - The AAA must give the provider an opportunity to review a draft written report of monitoring findings and provide the AAA with feedback that may impact the final report.
8. Final written report - The AAA must give the provider the final written results of the monitoring visit within 90 calendar days of the last date of the on-site visit. If the monitoring is not on-site, a final written report must be provided 90 days from the monitoring start date. Results may include:
	1. Positive feedback of sound or improved practices.
	2. Recommendations of alternative methods to improve practices.
	3. Deficiencies of regulation or contract that require corrective action.
	4. Date when corrective action plan is to be submitted to the AAA.
9. Progressive corrective actions – The AAA may choose the degree of corrective action that is most appropriate to resolve the area of concern. Corrective actions that impact client safety must be prioritized and addressed. For suspected fraud, the AAA must follow Chapter 1 of the AAA P&P Manual and in Medicaid services, the AAA must also follow the Long Term Care Chapter 28 – Medicaid Fraud.
10. Corrective action compliance - The AAA must review the subcontractor’s progress toward corrective actions. In the event the subcontractor does not demonstrate adequate progress, the AAA will determine next steps based on assessment of risk.
11. Sanctions - Sanctions may be imposed for non-compliance at the discretion of the AAA including one or more of the following actions:
	1. Limiting referrals of new clients
	2. Suspending all referrals of new clients
	3. Terminating the subcontractor’s authorizations to provide services to existing clients
	4. Withholding payment to subcontractor
	5. Terminating the contract. See Sections VI. Overarching Contracting Procedures for AAAs and VII. Specific Medicaid Contracting Procedures for AAAs
12. Communication regarding sanctions - ALTSA shall be notified of any sanctions at the time they are imposed or prior when possible. The AAA must notify the appropriate authorizing and referral entities of the sanction and when sanctions are imposed and are lifted.
13. Sharing monitoring outcomes - AAAs will share outcomes of monitoring with other AAAs contracting with that subcontractor when findings result in health and safety concerns for clients or significant concerns regarding a subcontractor’s ability to appropriately deliver and/or bill for services. For Medicaid providers, these results will be shared with the Regional Home and Community Services office and the Developmental Disabilities Administration office as applicable. AAAs will share final monitoring reports of Medicaid providers with the ALTSA AAA Specialist at the time the report is submitted to the provider.
14. Joint monitoring - The AAAs are encouraged to share monitoring responsibility for a service provider that has clients in more than one AAA. The AAAs sharing a monitoring shall reach agreement on which AAA will be the lead, the areas to be monitored by each AAA and areas to be monitored jointly by AAAs.

The following elements must be reviewed uniquely for each region, but may be combined in the final monitoring report:

* 1. Client records
	2. Payment for provided services
	3. Referrals and complaints

AAAs participating in a joint monitoring should coordinate the site visits. Timelines for assembling the coordinated report should be coordinated between the cooperating AAA’s.

1. Homecare Agency Monitoring – All homecare agency monitoring reports shall be sent to the ALTSA homecare agency program manager. A statement of work and monitoring tool are released by ALTSA annually via management bulletin. AAAs are required to follow instructions in this management bulletin.
2. Medicaid provider monitoring reports – All Medicaid provider final monitoring reports will be available for ALTSA on-site monitoring of AAA contract management or sent to ALTSA if requested. Homecare Agency and Adult Day services reports must be sent to ALTSA upon completion of the final report due to the high-risk nature of services provided and agreements with the Department of Health.

**VIII. Tools and Templates**

1. Tools and Templates: IV. Specific Medicaid Provider Selection Principles
	1. Policy G. Provider application tracking: Sample Tracking Sheet



1. Tools and Templates: VI. Specific Medicaid Provider Contracting Procedures
	1. Policies D. & F. Required DSHS forms, screenings, and background checks: Forms and instructions: Updated versions may be found here: <http://forms.dshs.wa.lcl/>



 

* 1. Policy C. Insurance for Medicaid Providers: Insurance requirements exception to policy form



1. Tools and Templates: VII. Contract Monitoring Principles for AAAs
	1. Policy F. Evaluation of Provider Risk: Sample Risk Assessment Worksheet

