



Selective Contracting
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Training Description

The Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver permits counties to selectively contract with providers of DMC services, and establishes requirements for counties to follow in selecting contractors.

This training will provide counties an understanding of the DMC-ODS requirements for selective contracting, and support counties to conduct selection processes that are in compliance with state and federal requirements, efficient and timely, and select the highest quality providers.



Learning Objectives

Learning objectives for the training are:

1. Understand Drug Medi-Cal Organized Delivery System Requirements

Participants will understand Drug Medi-Cal Organized Delivery System requirements for selective contracting as described in the Drug Medi-Cal Organized Delivery System Waiver Terms and Conditions, 42 CFR (Code of Federal Regulations) Section 438 pertaining to Managed Care Entities, and the State/County Drug Medi-Cal Organized Delivery System contract.



Learning Objectives

2. How to Conduct a Fair and Efficient Provider Selection Process.

Participants will understand options for conducting a provider selection process (e.g., sole source, letter of interest, request for qualifications, request for proposals), and will examine these options in light of the county's goals, requirements, established county contractor selection processes, and the need for efficiency. This objective also includes discussion of contractor selection criteria, review committees, managing communications, contract negotiations, and protest appeals procedures.

3. What the County's Solicitation Documents Must Include

Participants will understand state and federal requirements for elements that must be included in county solicitation documents for Drug Medi-Cal Organized Delivery System services.



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Overview

1. Introductions and background in selective contracting
2. Introduce all participants (if time)
3. Must have written policies and procedures for selection and retention of providers that are in compliance with the DMC-ODS terms and conditions and CMS (federal Center for Medicaid and Medicare Services) regulations 42 CFR Part 438
4. Selection process must be in compliance with County Policies and Procedures for contractor selection
5. How to keep it simple, in compliance, and effective?
6. Will review selection process and solicitation content



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Selection Process

Selection requirements from Medi-Cal 2020 Terms and Conditions (T&C's), and Section 438

1. Beneficiary access cannot be limited in any way when counties select providers. Standards for access include:
 - a. Timeliness
 - b. Geographic distribution of care
 - c. Threshold language and cultural competence
 - d. Physical access for disabled beneficiaries
 - e. Coordination of physical and mental health services with waiver services at the provider level
 - f. Assessment of beneficiaries' experiences



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Selection Process

- 2. Access to State Plan services must remain at the current level or expand
- 3. Must have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions and Section 438 (see Attachment 1)
- 4. Apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status
- 5. May contract with providers in another state
- 6. Counties may contract individually with licensed LPHAs (Licensed Practitioners of the Healing Arts) to provide services in the network



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Selection Process

- 7. Must not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their Department of Healthcare Services Drug Medi-Cal certification. Does not preclude county from not contracting with providers beyond the number necessary to meet the needs of its enrollees; use different reimbursement amounts for different specialties or for different practitioners in the same specialty; or establish measures to maintain quality of services and control costs



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County Requirements and Considerations

- 1. Sole source, LOI (Letter of Interest), RFQ (Request for Qualifications) or RFP (Request for Proposals): Which process to use?
- 2. What are your county requirements (e.g., county purchasing Policies and Procedures, dollar threshold for solicitation processes, sole source requirements)?
- 3. Clarify roles and relationships between County AOD (Alcohol and Other Drug) Program and County Purchasing Department in the solicitation process
- 4. Are there any conflicts between your county requirements and Department of Healthcare Services/CMS requirements (e.g., low bid)?



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County Requirements and Considerations

- 5. County goals: Amending Drug Medical Organized Delivery System services into the contracts of existing county contractors who meet Drug Medical Organized Delivery System requirements; selecting new providers; and screening out programs performing below acceptable standards.



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County Requirements and Considerations

- 6. Keeping it simple: What do you really need to know about a provider to make a good selection recommendation to your Board? Providers to attest to meeting a requirement vs. explaining how they will meet a requirement?
 - a. Assurance and a plan for meeting key elements of DMC-ODS T&C's
 - b. Documentation of fiscal stability
 - c. Line item budget to document charges and/or justify unit of services rates
- 7. Selection Criteria: How can you incorporate what county staff knows about a proposer? (prior contract performance, fiscal stability, quality of relationships with other providers and county, strong agencies who write weak proposals and weak agencies who write strong proposals); Compliance with solicitation content requirements



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County Requirements and Considerations

- 8. Contract negotiations to address circumstances where:
 - a. There are areas of weakness in an otherwise good proposal which may require specific action for remediation
 - b. There are questions about staffing patterns, staff productivity (particularly in outpatient levels of care), staff qualifications (licensed, certified, threshold language, cultural competence), etc.
- 9. Process Considerations Up the County Chain of Command: frequency and types of communications with higher ups; provide recommendations to Board prior to announcing review committee results?



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Denials

Denial Requirements from T&C and Section 438

1. Counties shall have a protest procedure for providers that are not awarded a contract (see Attachment 1)
2. County Protest: Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision
3. Counties shall serve providers that apply to be a contract provider but are not selected with a written decision including the basis for the denial
4. The protest procedure shall include requirements outlined in the State/County contract (see Attachment 1)



Denials

5. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to the Department of Health Care Services (DHCS). If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS.
6. Department of Health Care Services Appeal Process: A provider may appeal to DHCS as outlined in Attachment Y (of Medi-Cal 2020 Waiver, p. 265) DHCS appeals process should be attached to County's solicitation.



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Denials

7. Attachment Y Drug Medi-Cal Organized Delivery System (DMC-ODS) Department of Health Care Services (DHCS) Appeals Process:
 - i. Following a county's contract protest procedure, a provider may appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.
 - ii. A provider may appeal to DHCS, following an unsuccessful contract protest, if the provider meets all objective qualifications and it has reason to believe the county has an inadequate network of providers to meet beneficiary need and the provider can demonstrate it is capable of providing high quality services under current rates, and it can demonstrate arbitrary or inappropriate county fiscal limitations; or it can demonstrate that the contract was denied for reasons unrelated to the quality of the provider or network adequacy.



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Denials

- iii. DHCS does not have the authority to enforce State or Federal equal employment opportunity laws through this appeal process. If a provider believes that a county's decision not to contract violated Federal or State equal employment opportunity laws, that provider should file a complaint with the appropriate government agency.
- iv. A provider shall have 30 calendar days from the conclusion of the county protest period to submit an appeal to the DHCS. Untimely appeals will not be considered. The provider shall serve a copy of its appeal documentation on the county. The appeal documentation, together with a proof of service, may be served by certified mail, facsimile, or personal delivery.



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Denials

- v. The provider shall include the following documentation to DHCS for consideration of an appeal:
 - a) County's solicitation document
 - b) Provider's response to the county's solicitation document
 - c) County's written decision not to contract
 - d) Documentation submitted for purposes of the county protest
 - e) Decision from county protest
 - f) Evidence supporting the basis of appeal



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Denials

- vi. The county shall have 10 working days from the date set forth on the provider's proof of service to submit its written response with supporting documentation to DHCS. In its response, the County must include the following documentation:
 - a) the qualification and selection procedures set forth in its solicitation documents;
 - b) the most current data pertaining to the number of providers within the county, the capacity of those providers, and the number of beneficiaries served in the county, including any anticipated change in need and the rationale for the change; and
 - c) the basis for asserting that the appealing Provider should not have been awarded a contract based upon the County's solicitation procedures. The county shall serve a copy of its response, together with a proof of service, to the provider by certified mail, facsimile, or personal delivery.



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Denials

- vii. Within 10 calendar days of receiving the county's written response to the provider's appeal, the Department of Health Care Services will set a date for the parties to discuss the respective positions set forth in the appeal documentation. A representative from DHCS with subject matter knowledge will be present to facilitate the discussion.
- viii. Following the facilitated discussion, Department of Health Care Services will review the evidence provided and will make a determination.



Denials

- ix. Following Department of Health Care Services' determination that the county must take further action pursuant to Paragraph viii above, the county must submit a Corrective Action Plan (CAP) to Department of Health Care Services within 30 days. The CAP must detail how and when the county will follow its solicitation procedure to remedy the issues identified by DHCS. DHCS may remove the county from participating in the Waiver if the CAP is not promptly implemented. If the county is removed from participating in the Waiver, the county will revert to providing State Plan approved services.
- x. The decision issued by DHCS shall be final and not appealable.



County Considerations for Denials

1. Selection processes are most often overturned on process flaws, not content flaws
2. How to avoid common process flaws:
 - a. Equal access to communication among proposers (centralized point of county contact, bidders conference, limit informal communication, any information communicated to one proposer gets distributed to all proposers in writing)
 - b. Clear submission procedures and deadlines
 - c. Put your scoring instrument in the solicitation document
 - d. Put your selection process and appeals process in the solicitation document



County Considerations for Denials

- e. Choosing your selection committee (content areas experts, no appearance of bias or perceived conflict of interest, no communication by selection committee members with proposers, diversity on committee reflects the community)
- f. Managing the selection committee meeting (score in pencil with opportunity to change scores as a result of discussion among selection panel members, turn in scoring sheets, keep written minutes reflecting consensus, keep in mind what is discoverable in a lawsuit)



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Solicitation Content

Content Requirements from T&C and Section 438

1. Require providers to meet DHCS standards for timely access to care (from initial contact to face-to-face appointment; timeliness of access to after-hours, urgent and emergency care; must be equivalent to non-DMC services offered by the provider)
2. Must not discriminate against persons who require high-risk or specialized services (e.g., co-occurring disorders, culturally specific services)
3. Select only providers that have a license and/or certification issued by the state that is in good standing (require documentation of license/certification)



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Solicitation Content

4. Select only providers that, prior to the furnishing of services under this pilot, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450(c) as a "high" categorical risk prior to furnishing services under this pilot, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104.
5. No selection of providers who are under investigation for Medical fraud (Ask provider to attest to not being under investigation. Does DHCS notify counties when a provider is under investigation? Verify non-investigation status with DHCS prior to signing a contract with a provider?)



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Solicitation Content

- 6. As required by 42 CFR Section 438, ensure that all selected providers have a Medical Director who, prior to the delivery of services under this pilot, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under this pilot, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107 (request a copy of the Medical Director's application to DHCS).



Solicitation Content

- 7. All contracts with providers must include the following provider requirements:
 - a. Services furnished to beneficiaries by the provider under this amendment are safe, effective, patient-centered, timely, culturally competent, efficient and equitable, as defined by the Institute of Medicine
 - b. Possess the necessary license and/or certification (contractor must have a credentialing process for its staff)
 - c. Maintain a safe facility by adhering to the state licensing and certification regulations
 - d. Maintain client records in a manner that meets state and federal standards



Solicitation Content

- e. Shall meet the established ASAM (American Society of Addiction Medicine) criteria for each level of residential care they provide and receive an ASAM Designation (for residential services only) prior to providing DMC-ODS services
- f. Be trained in the ASAM Criteria prior to providing services
- g. Meet quality assurance standards and any additional standards established by the county or other evaluation process (QI (Quality Improvement), Utilization Management, EQRO (External Quality Review Organization))
- h. Provide for the appropriate supervision of staff



Solicitation Content

- 8. Provider contracts must include (see 2020 Waiver #149): Culturally competent services; MAT (provider will regularly communicate with medication assisted treatment (MAT) prescribers); implement at least two EBPs (evidence-based practices.)
- 9. Residential treatment providers shall seek county approval of residential treatment admissions
- 10. Providers must meet standards for timely access to care and services, considering the urgency of the service needed. Medical attention for emergency and crisis medical conditions must be provided immediately.



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Solicitation Content

- 11. Inform clients of grievance and complaint procedures
- 12. Comply with county requirements for annual program and financial monitoring
- 13. Data: provider must agree to meet county requirements regarding provision of data on appeals, grievances, timeliness of access to care, access to after-hours care, assessment of the beneficiaries' experiences, provision of services in the client's preferred language, and data for the UCLA (University of California, Los Angeles) evaluation on the effectiveness of services (see Medi-Cal 2020 Waiver Attachment DD)



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Programmatic Content Requirements

- 1. Have staffing necessary to conduct medical necessity determinations (LPHAs –Licensed Practitioners of the Healing Arts) and six-month redeterminations
- 2. Provide services consistent with DMC-ODS definitions of ASAM levels of service (e.g., outpatient, case management, recovery services, residential, MAT, withdrawal management, etc.) (see MediCal 2020 Waiver #129 – 140)
- 3. Case management and care coordination: may vary depending on whether case management services are county-operated, contract out, or both and may include: seamless transitions between SUD levels of care; accessing recovery supports and services after discharge from acute care; coordination of services with physical and mental health care providers; tracking of bidirectional referrals between systems of care



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