Bureau for Medical Services

Managed Care Organization (MCO) / Foster Care Frequently Asked Questions

Question	Response
MCOs are assuming financial risk and will be negotiating rates with providers	This is true; however, all child residential rates will be mandated in the contract to be at least 100% of the current rate
MCOs want to package medical, behavioral and social services. All these needs will be assessed by MCOs	Medical, behavioral and social services will not be packaged/bundled together. The MDT will determine the treatment needs of the child. The MCO will pay for individual services provided.
MCOs will be responsible for bringing all information to the MDT that will require legislation. Must look at unintended consequence for all of this	MCO care coordinators will be a support for the MDT and will attend at the state's request.
BMS will pay MCOs then when they deny services the state will have to pay out of another pot of money this will lead to MCOs to deny.	MCOs will have braided funding for Medicaid services (CMS)and Socially Necessary Services (ACF). MCOs will be required to pay all court ordered services. BMS may override any decision made by the MCO and require payment
Services gaps like transportation and mentoring will not be addressed by the MCOs	MCOs do not currently cover NEMT services. LogistiCare is the NEMT provider. MCOs will help with services like the coordination of transportation through the Socially Necessary Service bundle
BCF does not know what BHHF and BMS are doing.	BCF, BHHF and BMS are now meeting multiple times a week to coordinate Child Welfare reform.
What percentage of the MCO contract will go for profit to the MCO company? If not determined, give the potential range.	Under the current MCO contract the MCO is required to maintain a Medicaid Medical Loss Ratio of 85% for the entire Medicaid population. MCOs are required to rebate to the Department 100% of the difference between the total amount of capitation revenue received by the MCO less any adjustments. In addition, WV requires a 50% reimbursement to the state for any capitation not used on medical costs between 85-88% MLR.

What percentage will go for administration? If not determined, give the potential range.	Under the current MCO contract, 7-9% of capitation is for administration. This may be altered under this procurement given the high complexity of needs of these children and the level of coordination that will be required. Same
What relationship will the care managers have to members, e.g. will they visit their homes, meet them and their families and foster families, meet their case workers, etc.?	MCO care coordinators will provide these activities at the state's request.
What restrictions will be placed on the member in terms of who they can go to for services, including health, behavioral health, and socially necessary services? How does this compare with the restrictions they have now? Will this change under Family First and, if so, how?	The MCO will be required to contract with any current providers enrolled with the State, so as not to disrupt the current care being provided to our youth. This differs from the current MCO contract in that a defined network may be established by each MCO, so long as it meets the state's network adequacy standard guidelines. Family First Prevention Services Act will have no impact on the above requirements.
If the MCO denies services ordered by the court, how will those services be paid for?	The MCO cannot deny court ordered services.
If the MCO gets more money for each additional child or youth in	Over 80% of Medicaid enrollees are currently in managed care. If the child is not a part of the child welfare system, they would already be enrolled with an MCO, so there is no incentive to try increase

foster care, what is the incentive to reduce the number of kids in foster care?	foster care enrollment. The MCO will serve as a partner to DHHR and its community partners in trying to help keep children in their homes, assuming it is a safe environment.
What is the decision-making time frame for the MCO contract following the public forums? For the Family First plan and implementation?	The timeframe for issuing the procurement for care management services is between January and March 2019, pending state review processes. Family First Prevention Services Act implementation is outside the scope of the procurement however the federal date for FF is October 1, 2019.
What role will DHHR have in the Family First planning if it goes ahead with this MCO contract?	DHHR will have full authority in implementing the Family First Prevention Services Act, with the MCO serving in a collaborating partner capacity.
Will all willing providers be allowed into the network?	Yes, per the RFP, DHHR will require the MCO to offer a contract to any currently enrolled provider.
What restrictions will be placed on the member in terms of who they can go to for services, including health, behavioral health, and socially necessary services? How does this compare with the restrictions they have now? Will this change under Family First and, if so, how?	The MCO will be required to contract with any current provider enrolled with the State, so as not to disrupt the current care being provided to our youth. This differs from the current MCO contract in that a defined network may be established by each MCO, so long as it meets the state's network adequacy standard guidelines. Family First Prevention Services Act will have no impact on the above requirements.
How will provider rates be determined?	The Bureau for Medical Services defines rates for each Medicaid-covered service that the MCO may adopt and build into their contract with providers. If this is not done, the provider and MCO may negotiate the rate to be reimbursed for the services rendered. In some cases, under the current MCO

	contract, (behavioral health and DME), MCOs are required to reimburse at least 100% of the Medicaid fee schedule. Child residential rate will be reimbursed at least 100% or the rate.
What is best practice nationally in allowing authorized casework staff to have access to the records of a child or youth in custody if they move among placements?	DHHR believes the caseworker will have access to all documents related to the child as they move amongst placements to help with the coordination of their care and so there is consistency in assisting the child in whatever means necessary.
Will the existing referral process for socially necessary services remain in place under this model?	Yes, the MCO will coordinate with the caseworker, who retains the responsibility of requesting the services to be provided for authorization. The MCO will be required to follow the current 24-hour authorization requirement, but will relieve the caseworker of having to identify a provider for those services and will assume that responsibility. The caseworker will continue to develop the service plan for the child, with the MCO providing clinical knowledge to review the plan to determine the success of its implementation and to make recommendations to the worker to then take back to the Multi-disciplinary Team (MDT).
Will BCF provider agreements remain in place with Residential and Emergency Shelter providers?	Yes, the BCF agreement will remain in place. The caseworker will continue to work on referrals and placements, with the MCO assisting the worker in finding placement and capacity where there is not a bed available. The MCO will be responsible for assisting and handling clinical supports, monitoring placements, etc. The MCO will be responsible for engaging providers to determine if setting is most appropriate for child and is to be seen as a support to the caseworker.
Will MCOs participate in MDTs?	The MCO will participate in any MDT in which the caseworker, MDT, or judge has made such a request, but not in all MDTs.