Agenda

1. Introduction to Beacon and CHIPA
2. Review of the new Medi-Cal managed care mental health benefits
3. Beacon and CHIPA’s role in managing the new benefit
4. How beneficiaries will access the benefits
5. eServices – Beacon’s web-based portal
6. Claims information
7. Contact information
History and Overview

**Beacon Health Strategies**

- Since 1996 Beacon Health Strategies has been a leader in the managed behavioral care industry, with business in sixteen states.
- Beacon is accredited with both NCQA and URAQ.
- Beacon currently serves over 9 million covered lives in 16 states, including 3.1 million Medicaid members in 13 programs.
- Beacon’s Integrated Partner Model features Beacon staff co-located with Health Plan staff to ensure improved coordination of care and the integration of both behavioral and medical treatment services.

**College Health IPA**

- CHIPA is a physician owned provider organization.
- Since 1991, CHIPA has been providing managed behavioral health services to California residents, making it one of the state’s largest regional behavioral health delivery systems.
- Today, CHIPA currently serves over 1.4 million members in California through its contracted network of over 3,000 professional providers.
Beacon-CHIPA Relationship

- **Beacon** and **College Health IPA (CHIPA)** work collaboratively to perform all behavioral health plan management functions on behalf of our California health plans.

- The relationship and operations are seamless to members and providers.

- CHIPA and Beacon have developed effective programs built upon seamless integration with our clients' medical and disease-management programs to improve patient outcomes and lower the total cost of care.

**BEACON - CHIPA DIVISION OF RESPONSIBILITY**

<table>
<thead>
<tr>
<th>Function</th>
<th>Beacon</th>
<th>CHIPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracting for Outpatient Professional services</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Credentialing</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Member Services</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Utilization Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Adjudication/Payment</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Beacon Provider Network Team - Cypress, CA
Provider Network Operations Organization Chart

Alice Kuchinskas
Vice President of Operations

Maureen Tarpinian
Director of Operations

Bonita Meredith
Senior Network Operations Manager

Kelly Coleman
Manager of Provider Relations

Catrina Rodriguez
Manager of Provider Operations

Provider Relations Team
Contracting Team
Credentialing and Data Team
Network Operations - Key Functions

- Network Development and Contracting
- Credentialing and Re-Credentialing
- Site Visits
- Provider Training
- Provider Data Entry and Maintenance
- Provider Relations - assisting providers with any issues or questions in a timely manner.
  - Provider Relations can be reached at **800-779-3825 option 6, then 3**, or **ProviderInqury@beaconhs.com**.
New Medi-Cal Managed Care Mental Health Benefits

**Target population:** Medi-Cal beneficiaries with a diagnosis in the DSM-IV and a “**mild to moderate**” condition

**Affects both current and future expanded Medi-Cal population**

1. **Individual and group mental health treatment (psychotherapy)**
2. **Psychological testing to evaluate a mental health condition**
3. **Outpatient services to monitor drug therapy**
4. **Psychiatric consultation**
5. Outpatient laboratory, supplies and supplements
6. Prescription drugs carved into Medi-Cal managed care

- **Atypical Psychiatric Medications**
  - Antipsychotics remain the responsibility of DHCS

- **Children**
  - Beacon is responsible for “mild to moderate” cases.

- **Family Therapy**
  - Family therapy is not covered for family relational issues
### Financial responsibility for Medi-Cal mental health services

This chart shows how responsibility for the mental health benefits is divided between Medi-Cal managed care plans and County MHPs.

<table>
<thead>
<tr>
<th>Medi-Cal Managed Care Plans</th>
<th>County Mental Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maternity and newborn care</td>
<td>8. Rehabilitative and habilitative services (for mental health services)</td>
</tr>
<tr>
<td>2. Pediatric services, including oral and vision care</td>
<td>9. Emergency mental health services</td>
</tr>
<tr>
<td>3. Ambulatory patient services</td>
<td>10. Inpatient mental health hospitalization</td>
</tr>
<tr>
<td>4. Prescription drugs (carved in)</td>
<td></td>
</tr>
<tr>
<td>5. Laboratory services</td>
<td></td>
</tr>
<tr>
<td>6. Preventive and wellness services and chronic disease management</td>
<td></td>
</tr>
<tr>
<td>7. Mental health disorder services</td>
<td></td>
</tr>
<tr>
<td><strong>Mild to Moderate acuity</strong></td>
<td></td>
</tr>
<tr>
<td>• Medication management</td>
<td>• Targeted case management</td>
</tr>
<tr>
<td>• Individual and group therapy</td>
<td>• Day treatment intensive programs</td>
</tr>
<tr>
<td>• Psychological testing</td>
<td>• Day rehabilitation</td>
</tr>
<tr>
<td><strong>Moderate to severe acuity</strong></td>
<td>• Adult residential treatment services</td>
</tr>
<tr>
<td>• Medication management</td>
<td>• Full service partnerships</td>
</tr>
<tr>
<td>• Individual and group therapy</td>
<td></td>
</tr>
<tr>
<td>• Psychological testing</td>
<td></td>
</tr>
<tr>
<td>• Substance use</td>
<td></td>
</tr>
</tbody>
</table>

To receive services through a county MHP, a Medi-Cal beneficiary must be determined by the county to meet the following medical necessity criteria set in state regulation:

1. **Diagnosis:** Must fall within one or more of the 18 specified diagnostic ranges
2. **Impairment:** The mental disorder must result in one of the following:
   a) Significant impairment or probability of significant deterioration in an important area of life functioning
   b) For those under 21, a probability that the patient will not progress developmentally as appropriate, or when specialty mental health services are necessary to ameliorate the patient’s mental illness or condition
3. **Intervention:** Services must address the impairment, be expected to significantly improve the condition, and the condition would not be responsive to physical healthcare-based treatment.

Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210
<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>• Contracting and Credentialing</td>
</tr>
<tr>
<td></td>
<td>• Individual outpatient providers</td>
</tr>
<tr>
<td></td>
<td>• FQHCs; community clinics</td>
</tr>
<tr>
<td></td>
<td>• Organizational/agencies</td>
</tr>
<tr>
<td></td>
<td>• County MHP/ contractors</td>
</tr>
<tr>
<td>Claims</td>
<td>• Payment: EFT and Paper</td>
</tr>
<tr>
<td>Screening &amp; Referral</td>
<td>• Telephonic intake, screening and referral process—either to county for assessment for Specialty Mental Health Services (SMHS) or to a Beacon provider</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>• Clinical review of outpatient claims and peer-to-peer outreach</td>
</tr>
<tr>
<td>Quality Management &amp; Improvement</td>
<td>• Quality oversight and reporting on outcomes</td>
</tr>
<tr>
<td></td>
<td>• HEDIS and as required by DHCS</td>
</tr>
<tr>
<td>County Integration</td>
<td>• Support development of MOUs</td>
</tr>
<tr>
<td></td>
<td>• Support data exchange and analytics</td>
</tr>
<tr>
<td></td>
<td>• Dispute resolution process</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>• For members with complex co-morbidities, ensuring coordination between physical and behavioral health care</td>
</tr>
<tr>
<td>PCP Support</td>
<td>• Physician advisors panel for consultation</td>
</tr>
</tbody>
</table>
Clinical Overview

Members served
- Medi-Cal beneficiaries
- DSM diagnosis
- Mild to moderate impairment related to diagnosis not able to be successfully treated in PCP setting

Registering services
- Member or provider can call Beacon to complete screening and register for services
- Clinic providers may complete the screening on site and submit information to Beacon for registration

Outpatient services
- Evaluation
- Medication management
- Psychotherapy - Individual and group
- Psychological testing to aid in the diagnosis and treatment of a mental disorder, with prior approval

Model of Care
- No prior authorization for medication management/therapy services
- Services will be subject to ongoing clinical review to ensure member meets medical necessity for Managed Care Plan benefit
- Review will also determine if member would be better served through Specialty Mental Health Services based on criteria for the County Mental Health Plan
- Clinical review will identify appropriate treatment plan, progress towards goals, and barriers related to treatment progress
Overview of Beacon’s Screening of New Medi-Cal Enrollees

Member calls to access mental health treatment

Beacon licensed clinician will conduct a screening to determine appropriate system of care for member referral

**Mild to Moderate Acuity**
Managed Care Plan

**Moderate to Severe Acuity**
County Mental Health Plan

*Note:* FQHC/RHC/IHC/PCP have the option to conduct screening internally.
Accessing Services: Beacon’s initial intake workflow

Member/Provider/Health Plan/County/PCP Call Beacon

Service Coordinator Answers all calls to verify eligibility, demographics, etc

Beacon Licensed Clinician screens Patient history, Diagnosis and SMHS/AOD Criteria

If Mbr receiving services thru county no longer meets criteria, Mbr will transition back to Beacon as appropriate

Crisis Calls Immediate transfer to clinician for triage and linkage to services as needed

FQHC/PCP/RHC

Option A: Refer member to Beacon’s Access Line to triage/screening

Option B: Conduct Screening Internally. Submit screening to Beacon via fax @ 866.422.3413

Crisis Situation Follow crisis protocol

County Services

Member is referred to County for assessment for SMHS

Health Plan Benefit

Member gets Primary Care based tx & Beacon provides psych consultation

Members with primary AOD referred to County for Substance Abuse Services. May be referred for BH services as appropriate

Health Plan Benefit

Member is given referrals to in-network providers

Does member meet criteria for Specialty Mental Health services through the County?

YES

NO
Accessing the New Benefits

- Members may continue self-referring to the county MHP or call county Access.
- Members may call the Health Plan or Beacon directly.
- Member may receive referral for mental health care from primary care; directed to a toll free Beacon # for screening and referral.

Note: SBIRT is not covered by Beacon however more information will follow from the health plans.
Authorization Process

• Beacon/CHIPA does not require prior authorization for most outpatient services.
• The exception is psychological testing, which does require online or telephonic prior authorization.
• Upon completion of screening, a six-month open registration for outpatient mental health services with no limit on # of visits is generated, subject to ongoing clinical review.
• Services can be provided by Psychiatrists, PhDs/PsyDs, LCSWs, LMFTs, and ARNPs.

Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>Patient screening through Beacon</td>
</tr>
<tr>
<td>New Patient Evaluation and Management (60 min):</td>
<td></td>
</tr>
<tr>
<td>- A Comprehensive History</td>
<td>Patient screening through Beacon</td>
</tr>
<tr>
<td>- A Comprehensive Examination</td>
<td></td>
</tr>
<tr>
<td>- Medical decision making of high complexity</td>
<td></td>
</tr>
<tr>
<td>- Develop an appropriate treatment plan</td>
<td></td>
</tr>
<tr>
<td>Psychological testing</td>
<td>Phone or online prior-authorization.</td>
</tr>
<tr>
<td>Medication management</td>
<td>Patient screening through Beacon</td>
</tr>
<tr>
<td>No limit on number of visits</td>
<td></td>
</tr>
<tr>
<td>Psychotherapy: individual and group</td>
<td>Patient screening + six-month registration</td>
</tr>
<tr>
<td>No limit on number of visits</td>
<td></td>
</tr>
</tbody>
</table>
# Beacon Phone Numbers by Medi-Cal Managed Care Plan

<table>
<thead>
<tr>
<th>Geographic Service Area</th>
<th>Health Plan</th>
<th>Beacon Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda County</td>
<td>Alameda Alliance</td>
<td>(855) 856-0577</td>
</tr>
<tr>
<td>Sonoma, Solano, Marin, Yolo, Mendocino, Napa, Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity counties</td>
<td>Partnership Health Plan</td>
<td>(855) 765-9703</td>
</tr>
<tr>
<td>Merced, Monterey and Santa Cruz counties</td>
<td>Central California Alliance</td>
<td>(855) 765-9700</td>
</tr>
<tr>
<td>Ventura County</td>
<td>Gold Coast Health Plan</td>
<td>(855) 765-9702</td>
</tr>
<tr>
<td>LA County</td>
<td>LA Care</td>
<td>(877) 344-2858</td>
</tr>
<tr>
<td>LA County</td>
<td>Care 1st</td>
<td>(855) 765-9701</td>
</tr>
<tr>
<td>Orange County</td>
<td>Cal Optima</td>
<td>(800) 723-8641</td>
</tr>
</tbody>
</table>
Continuity of Care

- Beacon/CHIPA will make every effort to ensure current Medi-Cal beneficiaries that are currently receiving services through Medi-Cal fee-for-service or other funding do not encounter any disruption in services.

- In an effort to do so, providers are invited to join the network as quickly as possible either by submitting a signed contract or letter of intent (LOI) to contract.

- For providers that do not intend to contract, Beacon will follow the state’s continuity of care requirements that allow Medi-Cal managed care plan members to continue seeing an out-of-network provider for up to 12 months based on medical necessity, at a negotiated rate so long as there are no major quality of care concerns or the member does not meet the criteria for Specialty Mental Health Services.
This is a free service that Beacon offers to all contracted and in-network providers. The goal of using eServices is to make clinical, administrative, and claims transactions easy to do. By utilizing eServices you will be able to perform the following:

- **Submit claims**
- **Verify member eligibility**
- **Check claim status**
- **View or print explanation of benefit (EOB) reports**
- **View claims performance information**
- **Access to provider manuals, forms, bulletins and mailings**
- **View or print frequently asked questions (FAQs)**
Welcome to eServices, Beacon's web tool for providers.

All eServices functions are provided free to Beacon contracted providers and are aimed at enabling easy and secure access to a host of clinical, administrative and patient information, as well as all provider business transactions with Beacon. eServices allows providers to:

- Verify member eligibility quickly and easily
- Request authorizations — eAuthorizations receive priority review!
- Confirm the status of authorizations and print all authorization details, including the number of units utilized
- Submit claims, including reconsiderations
- Check the status of claims
- View and print explanation of benefit (EOB) information
- View and print claims performance information
- View, update and print provider demographic and directory information
- View, print and download provider documentations such as manuals, forms, bulletins, mailings etc.

If you are not registered for eServices, simply click the Register link on this page to start!

**EFT (Electronic Funds Transfer) begins September 22, 2011 as a payment option for providers in CA, FL, MA, NY, RI and WI.**

- For payments AFTER 9/22/11, EOBs will still be mailed to providers who opt out of EFT, and electronic EOBs can be downloaded at www.payspanhealth.com.
- However, these EOBs will not be posted on eServices. EOBs for payments BEFORE 9/22/11 and for Touchstone claims with dates of service before 10/1/10 only, will remain available on Beacon's eServices.
- Register for EFT and to access electronic EOBs by calling the PaySpan Health Provider Hotline at 877.331.7154.
eServices is simple to log into and use. You create your own username and password.
Allows you to quickly and easily submit a claim via eServices.
Submitting a claim electronically takes less time and is more efficient than a paper claim. Once the fields are entered just hit submit!
Now that your claim has been submitted, you will receive a transaction number. You may also print the page for your records.
Claim reconsiderations may be done online, for claims that were submitted and denied and require an in depth review.
Use the free text box to enter your explanation. Always make sure to enter the original claim's RecID.

Once you have entered your claim info and explanation, you can submit.
Claims that may have denied for incorrect procedure code or diagnosis code may also be re-submitted electronically.
Once the claim has been chosen, click on the resubmit link.
After you have clicked on re-submit, the information will auto fill from the previous submission. You can then make corrections and re-submit. Re-submissions must be made within the timely filing limit.
Electronic Data Interchange (EDI)

• For larger providers, EDI is the preferred method for receiving claims. We accept the standard HIPPA 837 format and provide 835 transactions.

• Beacon also uses 270/271 transactions for eligibility purposes.

• EDI claims may also be submitted to Beacon via Office Ally. Beacon’s Office Ally payer ID is 43324.

• All EDI claims submitted via Office Ally must include the members Health Plan “Plan ID” and Beacon’s Office Ally payer ID. Using just one or the other will cause claims to reject.

• Beacon EDI registration forms are on the Beacon web site at http://www.beaconhealthstrategies.com/private/pdfs/forms/EDI_Trading_Partner_Setup.pdf

• Beacon’s EDI companion guide can be located on the Beacon web site at http://www.beaconhs.com/private/pdfs/edi/Beacon_837CompanionGuide_5010_v3%203.pdf

• After testing submissions have been completed, contact EDI Operations to request a production setup. They can be reached at 781-994-7500, or via email at edi.operations@beaconhs.com.
Important Claims Reminders

- All claims must be received by Beacon within the plan’s timely filing limit. The filing limit is **180 calendar days**.

- All clean claim submissions (meaning no missing or incorrect numbers or information) will be processed and paid by Beacon within **30 days**.

- The top denial reasons for claims submitted to Beacon, are as follows:
  - Timely filing (claim denied as it was not received within the plan’s timely filing limit)
  - Missing or incorrect NPI number (all claims must list the rendering clinicians individual NPI number, along with the site NPI number. If either of these numbers are missing or entered incorrectly, the claim will deny)
Where to Submit Claims

- In addition to Beacon/CHIPA accepting claims electronically, claims can also be submitted by mail or fax.

**Beacon accepts claims via mail or fax**

**Mailing address:**

**Beacon Health Strategies**

**Attn: Claims**

**5665 Plaza Drive**

**Suite 400**

**Cypress, CA 90630**

**Confidential claims fax number:** 877-563-3480
Claims Dispute Resolution

• Claims dispute must be submitted in writing using Claims Dispute Resolution Form Timelines
• Provider has 365 days from date of denial to submit a Claims Dispute Resolution Form
• Providers must receive notification of receipt of claims dispute by Beacon with 15 working days from date of receipt 2 days if dispute received electronically
• Beacon has 45 working days from date of receipt to issue a determination regarding dispute
• Once a determination has been made, Beacon has 5 working days to notify provider and/or issue payment of claim
# Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonita Meredith</td>
<td>Senior Manager of Network Operations</td>
<td>562.293.0660</td>
<td><a href="mailto:Bonita.Meredith@Beaconhs.com">Bonita.Meredith@Beaconhs.com</a></td>
</tr>
<tr>
<td>Kelly Coleman</td>
<td>Manager of Provider Relations</td>
<td>562.467.5531</td>
<td><a href="mailto:Kelly.Coleman@Beaconhs.com">Kelly.Coleman@Beaconhs.com</a></td>
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