Objectives

- Company Overview
- Operational Areas
- Projects, Programs, and Initiatives
- Electronic Resources
  - Overview of ProviderConnect℠
- Communicating with Beacon
- Contact Us
- Fraud, Waste, and Abuse
- Questions and Answers
Company Overview
Who We Are

- A health improvement company that specializes in mental and emotional wellbeing and recovery
- A mission-driven company singularly focused on behavioral health
- Largest privately-held behavioral health company in the nation
Our Mission

We help people live their lives to the fullest potential.

This shared mission guides our purpose.

Everything we do matters and how we do it helps us improve the lives of those we serve.
Our Values

**Integrity**
We earn trust.

**Dignity**
We respect others.

**Community**
We thrive together.

**Resiliency**
We overcome adversity.

**Ingenuity**
We prove ourselves.

**Advocacy**
We lead with purpose.
About Beacon Health Options

- Headquartered in Boston; more than 70 US locations and a London office
- 5,000 employees nationally and in the UK serving 50 million people
- 200+ employer clients, including 41 Fortune 500 companies
- Partnerships with 100 health plans
- Programs serving Medicaid recipients in 26 states and the District of Columbia
- Serving 8.5 million military personnel, federal civilians and their families
- Accreditation by both URAC and NCQA
5,000 employees nationally and in the U.K., serving 50 million people

LEADER IN QUALITY
NCQA- and URAC- Accredited Companies

KEY OPERATIONAL AREAS
- UM/CM
- QM
- IT
- Customer Service
- Data Analytics
- Reporting
- Processing
- Sales Support

LINES OF BUSINESS
- Commercial
- Federal
- EAP
- Medicaid
- Exchange
- Medicare

MEMBERSHIP
- Over 2.5 Million
- 1,000,000 – 2,500,000
- 500,000 – 1,000,000
- Under 100,000

CENTERS
- Corporate Headquarters
- Regional Service Centers
- Corporate Operation Centers
- Engagement Centers

U.K.
Alaska
Hawaii
Four Major Market Segments

- **Commercial market** featuring 200+ local, regional and national employers (41 of America’s Fortune 500 companies) as well as labor and trust funds

- **Partnerships with 100 national and regional health plans** covering Medicaid, Medicare, dual eligible, special needs and commercial populations

- **State and local governments** managing Medicaid populations and other publicly funded programs in 27 markets

- **The Federal government**, on behalf of the U.S. military, veterans, employees and their families
We implemented new Medi-Cal autism benefits on behalf of 8 Medicaid plan partners. Beacon has managed the country’s first statewide Medicaid carve-out since 1996 serving 450K children and adults. We partner with 18 health plans; 10 of them operate as a Medicaid Mainstream MCO and specialty SMI program (HARP). 500K Medicaid enrollees in 75% of Colorado counties and an ACO program.
Largest MBHO Serving Government Programs

Scaled Medicaid Coverage
- 14M Medicaid Members
- Programs serving Medicaid and other publicly funded programs in 27 markets
- 60 Medicaid Health Plan clients
- TANF, ABD, Expansion, SMI, Foster Care

Exchange Population
- Exchange Members since 2006
- 13 Clients, 8 States

Expansive Medicare Footprint
- 1.5 Million Medicare Lives
- 30+ Health Plan partners in 10 states

Beacon Government Business is approaching 17M covered lives

- Exchange – 1.1M
- Medicare – 1.5M
- Medicaid – 14M
Commercial Clients Increasingly Value Beacon’s Capabilities

**National Commercial Footprint**
- 50 State network
- 200+ employer clients
- 41 Fortune 500 clients
- Employer direct & private exchange
- Large and small groups
- EAP and MHSA

**Health Plan Partners**
- 8 million lives through 35 health plans
- Risk and ASO models
- Co-location or remote staff
- EAP and MHSA reseller agreements

**Unmatched EAP Qualifications**
- 14.6 million EAP lives
- Military OneSource
- Fortune 100 employers
- Mid-Market EAP reseller
- Innovation and product development
Unwavering Support for 8.5M Service Members and Their Families

- Beacon is honored and proud to provide behavioral health, EAP and Work/Life services to our military service members, their families, veterans and federal employees
  
  - Managed mental health and substance use disorder services for TRICARE
  
  - EAP for military programs including Military OneSource, the Coast Guard, and VA medical centers

- We have more than 25 years of experience serving this population, with a unique focus on the distinct needs and culture of the military and federal civilian workforce
Beacon Provides a Full Complement of Behavioral Health Management Programs

**Clinical Management**
- Utilization Management
- Intensive Case Management
- Aftercare

**Quality Management**
- NCQA and URAC
- HEDIS Reporting

**Specialized Clinical Programs**
- Autism
- Psychotropic Prescribing Support
- Depression

**Analytics and Reporting**
- Predictive Modeling
- Management Report Suite

**Administrative Services**
- Claims
- Customer Service

**Network Management**
- Credentialing
- Contracting
- Provider Profiling & Technical Assistance
Beacon’s Employee Assistance Program

Our award-winning EAP helps employees and their dependents achieve physical, emotional and financial well-being

- Assessments and referrals to our broad EAP provider network
- Telephonic, video, or face-to-face counseling
- The Achieve Solutions® online employee assistance library, with online requests
- Work/Life services
- Legal, financial, and identity theft services
- Health and wellness support
- Autism Family Support
- Mindfulness and Resiliency Support
- Global EAP
Our National Provider Network

• NCQA Credentials Verification Organization full three-year certification

• 88.5% overall provider satisfaction ratings

• Quarterly engagement with network regarding demographic data and appointment availability

• Save providers time and increase credentialing efficiency with CAQH
Operational Areas
Operational Areas: National Network Services

- Provider Relations
  - Ensures members’ behavioral health care needs are met through a geographically and clinically robust network of providers
  - Ensures maintenance of network composition by engaging in assertive retention strategies
  - Engages in timely and appropriate recruitment
  - Engages in professional, consistent, and educative communications with provider community and staff

- Contracting and Managers of Provider Partnerships (MPPs)
  - Regionally-based Contracting Directors and MPPs support facility and large group providers based on contract and location assignment
Operational Areas:
National Network Services

- Practitioner Credentialing and Recredentialing
  - Completion of Credentialing Application required for network consideration
    - Beacon’s online application is available for the initial provider credentialing process
    - Eligible providers are also encouraged to participate with CAQH® (Council for Affordable Quality Healthcare)
    - Once credentialed, review CAQH information regularly
  - For more information about CAQH:
    - Visit Beacon’s Credentialing Spotlight page
    - Visit the CAQH website at [http://www.caqh.org](http://www.caqh.org)
Operational Areas: National Network Services (cont’d.)

- Practitioner Recredentialing
  - Verify credentialing information every three years
  - Provide required supporting documentation such as current license, certification, and malpractice information
    - NOTE: Disclosure of Ownership Form must be received and complete for credentialing to be compliant
  - Beacon will send reminders at minimum:
    - Three months prior to due date (telephonic), one week later (email/fax), and 15 and 30 days prior to due date
    - Failure to provide required information within the recredentialing timeframe will result in disenrollment from the network
Operational Areas: Quality Management

- Medical Director oversees Quality Management Program
- Key Quality Indicators include but are not limited to:
  - Quality improvement activities/projects addressing HEDIS performance improvement
  - Quality analytics and reporting
  - Member satisfaction survey measures
  - Access/availability of services – geographic access, appointment availability, etc.
  - Complaints/Grievances – tracking, trending and reporting
  - Patient safety – adverse incidents and quality of care
  - Coordination of care/care integration
  - Accreditation (at select locations) by URAC & NCQA
Operational Areas: Quality Management

- Ongoing Quality Improvement Activities (QIAs)
  - Clinical QIAs
    - Improving Ambulatory Follow-Up following inpatient admission for mental health treatment
    - Improving initiation, engagement, and treatment for alcohol and substance use
    - Assuring accurate risk tracking – referral for urgent and emergent treatment
  - Service QIAs
    - Member satisfaction by improving customer service response
    - Provider satisfaction with utilization management
## Operational Areas: Customer Service

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<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Responds to routine claims, benefits, and eligibility questions via telephone, correspondence, and web inquiries</td>
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<tr>
<td>2</td>
<td>Responds to authorization and referral requests</td>
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<td>3</td>
<td>Facilitates the resolution of complex claims issues</td>
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<td>4</td>
<td>Provides dedicated liaisons to investigate and resolve complex client and provider issues</td>
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<tr>
<td>5</td>
<td>Responds to all administrative complaints and appeals via dedicated appeal and complaint departments</td>
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<tr>
<td>6</td>
<td>Provides education and assistance with processes and available resources</td>
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Operational Areas: Customer Service (cont’d)

- Committed to providing members and providers with the most accurate and informed benefit, eligibility, claims, and certification information in the most effective, efficient, and compassionate manner

- Puts member and provider needs and concerns first and is committed to resolving inquiries promptly without the need to make a re-contact

- Member and provider satisfaction is the heart of our Customer Service philosophy; we value questions and concerns raised by both members and providers
Operational Areas: Care Management

Key Components of the Care Management Paradigm
- Authorization and care management recommendations are individualized for diagnosis and level of care requests
- Collaborative approach with treating providers
- Symptom complex based review processes with focus on diagnosis and risk
- Utilization of treatment guidelines, level of care criteria and treatment algorithms
- Intensive care management programs for high risk, high cost members
- Intensive care management activities to impact
  - Acute inpatient
  - Residential
  - Partial hospitalization
  - Special protocols based on client nuances

Members who seek care via the clinical referral line
Members identified as high risk thru multiple other channels
Members identified by health plan disease management screening
Members identified thru pharmacy analysis
Members referred from the employer EAP provider
Members referred by the health plan care manager
Members referred by the behavioral provider
Members entering the behavioral health system in crisis
Members identified thru predictive modeling – high risk physical potential, co-morbid behavior
Operational Areas:
Care Management and Referral Assistance

- Licensed care management staff is available 24/7 for referral and utilization management
  
  - Member referral process:
    
    - Emergencies are followed until disposition
    
    - Urgent referrals are offered appointments within 48 hours and are called to ensure appointment is kept
    
    - Providers should contact Beacon for referral assistance if needed
    
    - Providers should contact Beacon anytime (24/7) if members require higher level of care or increased visit frequency
    
    - Care management staff will assist with referral to inpatient or specialty programs
    
    - Self-referral: members can submit a request for care management
Operational Areas: Utilization Management

- Inpatient
  - Complete requests through our ProviderConnect or telephonically by calling the number on the member’s identification card.
  - Some clients still require pre-authorization for HLOC – notification requirements may also vary.
  - Beacon staff are available 24/7.

- Outpatient
  - Since pass-through or registration no longer applies to outpatient services impacted by federal parity, authorization cannot be required.
  - NOTE: Not all clients are subject to federal parity.
Operational Areas: Utilization Management (cont’d)

- Outpatient care management will be conducted primarily through front-end claims or claims extracts, and will emphasize three areas:
  - Complex diagnosis
  - Intensive Care Management
  - Predictive Modeling

- Always verify benefits and authorization requirements for each member through ProviderConnect or by calling the number on the member’s identification card
Clinical Resources for Providers

- Clinical information on beaconhealthoptions.com
  - Beacon’s Expertise page
  - Medical Necessity Criteria
  - Clinical Practice Guidelines
  - PCP Toolkit & Consult line: 877-241-5575 from 9 a.m.–5 p.m. ET
  - On Track Outcomes
  - Stamp Out Stigma
  - Achieve Solutions®
  - Medication-Assisted Treatment (MAT) options
  - Project ECHO
Additional Clinical Resources for Providers

- Intensive Case Management Services
- Health Alert
  - Available through ProviderConnect
- Pharmacy program analyzes pharmacy data and uses automated rules engine to screen for:
  - Sub-optimal therapy
  - Under-use
  - Early discontinuation
  - Automatic notification to providers
Projects, Programs, and Initiatives
Demographics and Appointment Availability

- In order to be compliant with CMS, state, and client requirements, we must ensure that all provider information is accurate for our network.

- Various outreach methods include:
  
  - Webinars
  - Video tutorials
    
    - For ProviderConnect assistance, view our [Updating Demographic Information on ProviderConnect](#) tutorial
  
  - Appointment availability surveys
  
  - Monthly provider newsletter articles
  
  - Quarterly demographic information review reminders
Claims Process Improvement (CPI) Project

- **Mailroom Project**: Transition to a centralized shared-service process to improve paper claims intake
  - Mailing addresses changed in 2017
  - Incomplete or incorrect claims will be rejected

- **EDI/Data Exchange**: Implement a single gateway for front-end claims intake for all Beacon submitters to improve intake and processing of electronically submitted batch claims
  - New companion guides will be released for 837 and 277CA files

- **Payment Integrity and Claims Analysis**: Analyze claims to identify payment errors
  - Documentation requests to verify submissions and payment accuracy
  - Claim adjustments will occur if overpayment is identified
CPI Tips for Success

- When submitting any claim, be sure to complete all required fields
  - Providers: Tips for completing the CMS-1500 or UB04 located under Administrative Forms
  - Members: Tips and sample claim forms located MemberConnect Forms
  - Direct claim submission: Required fields designated with an asterisk (*)
  - Batch claim submission: Follow the Implementation and Companion Guides
Relias

- **Relias Learning**
  - Web-based training and development program available to identified providers at no cost
  - Offers a wide variety of online CEU courses
  - Self-paced courses completion
  - Instructions and user information will be shared with identified providers

- **Relias Academy**
  - Offers all the benefits of Relias Learning at a reduced rate to any participating Beacon provider
On Track Outcomes

- On Track Outcomes
  - A client-centered, feedback-informed treatment program
  - Designed to improve outcomes, especially for at-risk cases
  - Utilizes well-validated, patient-completed questionnaires
  - Allows providers to benchmark results against the largest database on mental health outcomes in the country

- The next introductory webinar is scheduled on:
  - Wednesday, June 14, 2017 from 1-2 p.m. ET

Disclaimer: Beacon’s On Track Outcomes program does not make recommendations or decisions about appropriate clinical care or service. Any questionnaires, reports, guidelines and other material related to this program are intended as an informational aid to network clinicians. They do not substitute for or limit in any way the use of other resources and the clinician's own professional judgment in the delivery of counseling services.
Beacon Thought Leadership Activities

- Beacon Lens
- Beacon Expertise (website)
- White Papers
- Clinical Topics
- Beacon Expert Panels
- Academic Affiliations
Stamp Out Stigma (S.O.S.)

- S.O.S. encourages individuals to talk to friends and loved ones about mental illness to show commitment to stamping out stigma of mental illness.

- The campaign was introduced to further support our valued providers when communicating with patients about mental illness.

- A provider toolkit is available online for our providers to access S.O.S. materials.

- Visit our [Stamp Out Stigma page](#) to access the toolkit and learn more about S.O.S.
E-Commerce Initiative

- Providers in the Beacon network are strongly encouraged to electronically conduct all available routine transactions, including:
  - Submission of claims
  - Submission of authorization requests
  - Verification of eligibility inquiries
  - Submission of recredentialing applications
  - Updating of provider information
  - Electronic funds transfer
Electronic Resources
Electronic Resources: Former ValueOptions Providers
Beacon Health Strategies Providers:
Click the first dropdown to access provider resources, including eServices

Then select your State and Health Plan information
Electronic Resources: Beacon’s Connect System

**NETWORKCONNECT℠**
Robust network management and provider relations

**PROVIDERCONNECT℠**
Secure, online administrative self-service for providers

**CARECONNECT℠**
Superior clinical case management and data collection

**TELECONNECT℠**
Easy-to-access telephonic self-service for providers and members

**SERVICECONNECT℠**
Industry-best customer service and issue resolution

**MEMBERCONNECT℠**
Online self-service and award-winning content for members
Overview of ProviderConnect
## Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Additional Information</th>
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<tbody>
<tr>
<td>Verify member benefits and eligibility</td>
<td>View and print forms</td>
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<tr>
<td>Request and view authorizations</td>
<td>Download and print authorization letters</td>
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<tr>
<td>Submit claims and view status</td>
<td>Access Provider Summary Vouchers</td>
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<tr>
<td>Request payment for EAP services</td>
<td>Submit EAP case activity forms (CAF)</td>
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<tr>
<td>Update demographic information</td>
<td>Submit credentialing applications</td>
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<td>Submit customer service inquiries</td>
<td>ProviderConnect message center</td>
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<tr>
<td>Practices can appoint an administrator, or Super User, to maintain and manage larger ProviderConnect accounts</td>
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</table>

Disclaimer: Please note that ProviderConnect may look different and have different functionalities based on individual contract needs, therefore some functions may not be available or may look different for your specific contract.
ProviderConnect: Claim Submission

- Accepts claims files from any Practice Management System outputting HIPAA formatted 837p or 837i batch files, and from EDI claims submission vendors

- Offers Direct Claims Submission on website for providers who do not have own software or who wish to submit certain claims outside their batch files
  - These claims are processed immediately and you are provided the claim number
  - You may submit batch claims files or Direct Claims interchangeably

- No charge for electronic claims submission

- Access to support:
  [https://www.beaconhealthoptions.com/providers/beacon/providerconnect](https://www.beaconhealthoptions.com/providers/beacon/providerconnect)
  EDI Helpdesk: 888-247-9311 between 8 a.m.-6 p.m. ET
How to Access ProviderConnect

- Go to www.BeaconHealthOptions.com, choose “Providers” and “Beacon Health Options (formerly ValueOptions) Providers”

- Click on “ProviderConnect” on the right side of the screen and choose the appropriate portal
Did you know the following could be updated through ProviderConnect?

- Phone number
- Fax number
- Mailing address
- Email address
- Website address
- Office hours

Also, service and billing addresses can be added or removed.

Note: Demographic updates can only be completed online.
Two registration options:

- Click the PaySpan link in ProviderConnect
- Visit PaySpanHealth.com or call 877-331-7154

Have registration code and PIN from the payment stub of a paper check handy

- Note: EFT is location specific, so if you update or add an address, you will have to contact PaySpan to add it to your file

Until successful registration with PaySpan is complete, physical checks will continue be generated
ProviderConnect Resources

- ProviderConnect Helpful Resources and Demo
- How-to video tutorials

**Training**
- Webinars scheduled monthly or training as needed
  - Topics include: Authorizations, Claim Submission, Tips and Tricks
- Next ProviderConnect webinar:
  - Authorizations in ProviderConnect
    - Wednesday, 6/7/2017 from 2-3 p.m. ET
  - Registration available through links in the Provider Newsletter or online
- Additional webinars may also be offered for particular contracts, so visit your appropriate Network Specific pages
Communicating with Beacon Health Options
Communication Channels

- Email Alerts
- Webinars
- Video Tutorials
- Monthly Valued Provider eNewsletter
- Provider Pulse℠ Messages
- Fax Communications
- Provider Mailings
Monthly Newsletter

- Relevant industry topics
  - **CMS Compliance Training Requirement for Medicare Providers**
- Reminders and relevant tools
  - **CAQH** and **ProviderConnect** as resources to review demographic data so our provider directories are current and accurate

Past editions available in the **Archive**
## Contact Us

<table>
<thead>
<tr>
<th>Beacon Health Strategies</th>
<th>Beacon Health Options (formerly ValueOptions)</th>
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<tr>
<td><strong>Website and EDI</strong></td>
<td><strong>EDI Helpdesk</strong></td>
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<td>eServices</td>
<td>8 a.m.-6 p.m. ET</td>
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<tr>
<td>Phone: 866-206-6120</td>
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<td><a href="mailto:eServices@beaconhealthoptions.com">eServices@beaconhealthoptions.com</a></td>
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<td><strong>PaySpan</strong></td>
<td><strong>Unable to locate your registration code?</strong></td>
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<tr>
<td>PaySpan Registration Provider Support</td>
<td>Email: <a href="mailto:corporatefinance@beaconhealthoptions.com">corporatefinance@beaconhealthoptions.com</a></td>
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<td></td>
<td>Phone: 877-331-7154</td>
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<td><a href="mailto:providersupport@payspanhealth.com">providersupport@payspanhealth.com</a></td>
<td>Reply will be received within three business days</td>
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<tr>
<td><strong>Provider Relations</strong></td>
<td><strong>National Provider Services Line</strong></td>
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<td>Phone: 781-994-7556</td>
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<td><a href="mailto:Provider.Relations@beaconhealthoptions.com">Provider.Relations@beaconhealthoptions.com</a></td>
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<td></td>
<td>Phone: 800-397-1630</td>
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<td>Regional Provider Relations Team</td>
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Program Integrity
Topics for Today’s Presentation

- Development of Program Integrity, Laws, and Requirements
- Current Audit Activities
- Preparing for an Audit
- Basic Documentation Requirements
Medicare Annual Fraud, Waste, and Abuse Training

- The Centers of Medicare and Medicaid Services (CMS) requires Medicare providers to complete Fraud, Waste, and Abuse and General Compliance Annual Training.

- NOTE: As this presentation is beneficial to help understand fraud, waste, & abuse, it does NOT meet the requirements for the Fraud, Waste, and Abuse & General Compliance Annual Training for Medicare providers.

- For more information, please see:
Key Terms

- Fraud – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit.

  - Many payment errors are billing mistakes and are not the result of someone such as a physician, provider, or pharmacy trying to take advantage of the Medicaid or Medicare program

  - Fraud occurs when someone intentionally falsifies information or deceives the Medicaid or Medicare program
Key Terms (cont’d.)

- **Waste** – Thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems, or controls.

- **Abuse** – Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards.
Key Terms (cont’d.)

- Compliance Program – Systematic procedures instituted to ensure contractual and regulatory requirements are being met.

- Compliance Risk Assessment – Process of assessing a company’s risk related to its compliance with contractual and regulatory requirements.

- Compliance Work Plan – Prioritization of activities and resources based on the Compliance Risk Assessment findings.

- Program Integrity – Steps and activities included in the compliance program & plan specific to fraud, waste, and abuse.
Program Integrity, Laws, & Requirements
History of Program Integrity

- Balanced Budget Act (BBA)
  - Amended Social Security Act (SSA) re: Healthcare Crimes
  - Must exclude from Medicare and state healthcare programs those convicted of health care offenses
  - Can impose civil monetary penalties for anyone who arranges or contracts with excluded parties

- Federal False Claims Act (FCA)
  - Liable for a civil penalty of not less than $5,500 & no more than $11,000, plus 3x amount of damages for those who submit, or cause another to submit, false claims

- Deficit Reduction Act (DRA)
  - Requires communication of policies and procedures to employees re: FCA, whistleblower rights, and fraud, waste, and abuse prevention, if receiving more than $5M in Medicaid
History of Program Integrity (cont’d.)

- Seven Basic Elements of a Compliance Program as Adopted by OIG & CMS (based on Federal Sentencing Guidelines)
  - Compliance Officer and Compliance Committee
  - Effective lines of communication between the Compliance Officer, Board, Executive Management, & staff (incl. an anonymous reporting function)
  - Written policies and procedures
  - Effective training
  - Internal monitoring and auditing
  - Mechanisms for responding to detected problems
  - Disciplinary enforcement
Laws and regulations are now formalizing and emphasizing the effectiveness in prevention, detection, and resolution of fraud, waste, and abuse as well as the recovery of overpayments.

- Fraud Enforcement and Recovery Act of 2009 (FERA)
- Patient Protection and Affordable Care Act (PPACA – Healthcare Reform Act)

Per Federal regulations, providers excluded from one line of business with Beacon, will not be able to participate in any Beacon network or lines of business.

Beacon is required to check Federal exclusion lists regularly to make sure no excluded providers are in network.
New 8th Element of a Compliance Program

- Compliance Programs Must be Effective
  - Must show that compliance plans are more than a piece of paper
  - Must be able to show an effective program that signifies a proactive approach to the identification of fraud, waste, and abuse
  - How much fraud, waste, and abuse have you identified?
  - How much fraud, waste, and abuse have you prevented?
Current Audits and Enforcement Entities
Types of Audits

- Compliance Audit
  - Evaluates strength and thoroughness of compliance preparations

- Program Integrity Audit
  - Evaluates strength and thoroughness of efforts to prevent, detect, and correct Fraud and Abuse
Federal Level Activities – CMS

- Medicaid Integrity Program (MIP)
- Medicaid Integrity Group (MIG)
- Medicaid Integrity Contractors (MIC)
- Medicare Zone Integrity Contractors (ZPIC)
- Medicare Recovery Audit Contractors (RAC)

Payment Suspension:

- Switch from “pay and chase” to fraud prevention.
- Requires provider payment suspension based on a credible allegation of fraud
- Good cause exception must be met if payments aren’t suspended

CMS Required Medicare Advantage and Part D Training

- CMS issued a new regulation called “Reducing the Burden of the Compliance Program Training Requirements”
- The purpose was to reduce the burden on first tier, down stream, and related entities (FDRs) by requiring CMS Compliance and Fraud, Waste, and Abuse training
- Regulation went into effect on 1/1/16
- If you are a provider receiving funding under Medicare Advantage (Part C) or Pharmacy (Part D) you will need to review this information
- For more information, please see:
  
MIC Jurisdictions/Regional Offices

- New York: Regions 1, 2
- Atlanta: Regions 3, 4
- Dallas: Regions 6, 8
- Chicago: Regions 5, 7
- San Francisco: Regions 9, 10
- Also: CNMI, Guam, American Samoa

- New York: Regions 1, 2
- Atlanta: Regions 3, 4
- Dallas: Regions 6, 8
- Chicago: Regions 5, 7
- San Francisco: Regions 9, 10
- Also: CNMI, Guam, American Samoa
Other Enforcement Entities

- U.S. Department of Health & Human Services, Office of Inspector General (OIG)
- U.S. Department of Justice (DOJ)
- Office of the State Attorney General (AG) – Medicaid Fraud Control Unit (MFCU)
- Federal Bureau of Investigation (FBI)
- Department of Insurance (DOI)
Prepare, You Will be Audited
How Do We Do This?

- Use the eight elements of an effective compliance program as a guide

- Delegate a knowledgeable point person

- Know your contractual and regulatory requirements re: fraud, waste, and abuse
  
  - Educate staff on how daily activities prevent, detect, and address fraud, waste, and abuse

Establish an Environment of Awareness

- Provide clinically necessary care through services within the scope of the practitioners’ licensure
- Routinely monitor treatment records for required standardized documentation elements
- Monitor and adhere to claims submission standards
- Correct identified errors
- Hold staff accountable for errors
- Cooperate with all audits, surveys, inspections, etc.
- Cooperate with efforts to recover overpayments
Establish an Environment of Awareness (cont’d.)

- Maintain documentation of all P&Ps, activities, audits, investigations, etc.
- Verify member eligibility
- Ensure staff know how to report fraud, waste, and abuse
- Communicate internally and externally
- Set-up a suggestion box for anonymous concerns and suggestions for improvement
- Post fraud, waste, and abuse tips
- Send out weekly tips on how to prevent fraud
Conduct Self-Assessments

- Detail all program integrity requirements and contract requirements

- Assess and prioritize gaps in compliance and develop action plans to remedy = document all efforts
Conduct Self-Assessments (cont’d.)

- Ask Yourselves Assessment Questions regarding:
  - Identification of employees who lost credentials
  - Meeting standards to ensure treatment record documentation
  - Accurate billing and documenting for services rendered
  - Routine checking of member eligibility
  - Training of staff
  - Ability to anonymously report internal fraud, waste, and/or abuse concerns
  - Effectiveness of current processes
Common Fraud Schemes:
- Billing for “Phantom Patients”
- Billing for Services Not Provided
- Billing for More Hours than In a Day
- Using False Credentials
- Double-Billing
- Misrepresenting diagnosis, type/place of service, or who rendered service
- Billing for non-covered services
Train Staff to Recognize Fraud, Waste, and Abuse

- Common Member Fraud Schemes:
  - Forgery
  - Impersonation
  - Co-Payment Evasion
  - Providing False Information
  - Sharing or theft of Medicaid benefits
Basic Documentation Requirements
“If It’s Not Documented – It Didn’t Happen”
Purposes for Documentation

- Provides evidence services were provided
- Required to record pertinent facts, findings, and observations about an individual’s medical history, treatment, and outcomes
- Facilitates communication and continuity of care among counselors and other health care professionals involved in the member’s care
- Facilitates accurate and timely claims review and payment
- Supports utilization review and quality of care evaluations
- Enables collection of data useful for research and education
Beacon's Approach to Program Integrity: Prevention

- Beacon attempts to prevent paying for billing errors through the following ways:
  - Being an Industry Partner
  - Training and Education
  - Provider Support
  - Contractual Provisions
  - Provider Profiling and Credentialing
  - Ethics Hotline
  - Claims Edits
  - Prior Authorizations
  - Member Handbook
Beacon's Provider Handbook and Contract

- The provider handbook is an extension of the provider contract and includes guidelines on doing business with Beacon, including policies and procedures for individual providers, affiliates, group practices, programs, and facilities.

- Together, the provider agreement, addenda, and handbook outline the requirements and procedures applicable to participating providers in the Beacon network(s).

- Except to the extent a given section or provision in the handbook is included to address a regulatory, accreditation or government program requirement or specific benefit plan requirement, in the event of a conflict between a member’s benefit plan, the provider agreement and the handbook, such conflict will be resolved by giving precedence in the following order: (1) the member’s benefit plan, (2) the provider contract, and (3) the handbook.
Additional Documentation Standards

- State regulations and/or disciplinary standards may also have an impact on documentation standards

- Be sure to check your state regulations and licensing standards for any additional requirements
Code of Conduct

- The Beacon Code of Conduct was created pursuant to State and Federal requirements

- Providers should read the code of conduct and comply with the parts that are applicable to their line of business
Beacon's Approach to Program Integrity: Detection

- Audit and Detection
  - Internal/External Referral Process
  - Audits
  - Post-Processing Review of Claims
  - Data Mining and Trend Analysis
  - Special Reviews

- Investigation and Resolution
  - Investigation and Disciplinary Processes
  - Reporting Requirements
Basic Documentation Needs

- All billable activities must have a start and stop time
  - Service codes used in claims for payment must match codes used in charts
- Detailed progress notes for members
- Number of units billed must match number of units in documentation
- Full signatures with credentials and dates on all documentation
- Covered vs. non-covered services
  - Services provided/documented meet service definition for code billed
  - Progress notes are legible and amendments clearly marked
Documentation – Additional Tips

- Treatment plans should be reviewed and signed by clinician and patient and should be updated when necessary.
- Activity and encounter logs should not be pre-signed.
- Progress notes must be written after the group/individual session.
- All entries should be in blue or black ink for handwritten notes, not pencil; no white-out.
- Keep records secure and collected in one location for each member.
Beacon's Provider Audits

- Referral received

- Referral reviewed and charts may be ordered

- Providers required to supply copies of the charts requested within specified timeframes

- Charts will be reviewed by Beacon's staff

- After completion of the review, results letter will be sent to the provider
Common Patient Record Errors from Beacon Audit

- Patient record not submitted for audit
- Evaluation does not meet the documentation requirements
- Assessment does not meet the documentation requirement
- No consent to treatment form
- No release of information
- Corrections to documentation were not completed appropriately
- Patient name or identifier is not on all pages of patient record
- No documentation on the weekends for residential services
Common Treatment Plan Errors from Beacon Audit

- Treatment plan is not submitted for the audit
- Treatment plan is invalid for date of service
- Treatment plan is not signed and dated by the patient, guardian, or agent
- Treatment plan is not signed and dated by the clinician
- Treatment plan does not have the required clinical elements
- Treatment plan review was not completed
- Treatment plan is illegible
Common Progress Note Errors from Beacon Audit

- Progress note is not submitted for the audit or is for the wrong date of service
- Progress note is illegible
- Progress note is duplicative or similar to another progress note
- Progress note references that no services were rendered
- Progress note does not have a narrative to describe services
- Progress note does not have the required clinical requirements
- Progress note does meet the service code billed on claim
- Progress note does not include the start and stop times
- Progress note is overlapping another service or patient
Beacon's Contact and Reporting Info

- Beacon's Safe to Say Compliance & Ethics Hotline
  888-293-3027

- Chief Compliance Officer: Rebecca White
  • 757-459-5167

- Report concerns to your organization’s compliance office, Beacon directly, or via Beacon’s Ethics Hotline
  • Remember: you may report anonymously and retaliation is prohibited when you report a concern in good faith
  • Reporting all instances of suspected fraud, waste, and/or abuse is an expectation and responsibility for everyone

- If available, report to your state’s Medicaid Fraud and Abuse Control Unit (MFCU)
Laws Regulating Fraud, Waste, and Abuse

- False Claims Act (FCA), 31 U.S.C. §§ 3729-3733
- Stark Law, Social Security Act, § 1877
- Anti-Kickback Statute, 41 U.S.C.
- HIPAA, 45 CFR, Title II, § 201-250
- Deficit Reduction Act (DRA), Public Law No. 109-171, § 6032
- Care Programs, 42 U.S.C. § 1128B, 1320a-7b
- False Claims Whistleblower Employee Protection Act, 31 U.S.C. § 3730(h)
- Administrative Remedies for False Claims and Statements, 31 U.S.C. Chapter 8, § 3801
Program Integrity Links

- Code of Federal Regulation:
  - TITLE 42-Public Health, Chapter IV-CMS, DHHS, SUBCHAPTER C-Medical Assistance Programs, Part 455-Program Integrity: Medicaid.
    - www.gpoaccess.gov/cfr/index.html

- Office of Inspector General (OIG):
  - www.oig.hhs.gov/fraud.asp

- *Center for Medicare and Medicaid Services (CMS):
  - www.cms.gov/MedicaidIntegrityProgram/

- National Association of Medicaid Fraud Control Units (NAMFCU):
  - www.namfcu.net/
Questions
Thank you