BHBS *Behavioral Health Billing Solutions, LLC.*

Thank you for allowing me to provide testimony today. As a business owner of a Behavioral Health Billing Consulting and EHR Implementation agency, I'm in a unique position because I am well versed in the redesign changes, have strong experience in behavioral health billing and am currently working with agencies across Ohio that use a variety of different vendors. I am also testing for two agencies on two different software vendors that between them, represent about 90 BH agencies in Ohio.

I have **direct, first-hand knowledge** that these vendors, and others, may not be ready in time to meet the scheduled deadline.

The issue is related, in part, to recent policy changes that were announced April 12th. As an example, one impactful policy change is the one that relates to how the supervising NPI is used. The policy change removed it in most situations. **Every** vendor that provides behavioral health software in Ohio, has spent 12 months building this functionality in their systems. While I agree with the changes in policy, for software vendors, they had to go back to the drawing table.

I've been testing the past two weeks, thoroughly documenting the challenges with each system as I go through this process. I will try to explain in layman's terms just a small example of what I am seeing.

The first vendor, NextGen, is currently working with me proactively to develop functionality to accommodate the redesign coding and modifier changes. However, their development is not complete and at this point, they cannot guarantee the utility they are building will be available as of July 1st. However, I must state due to the size of NextGen and the skill set of the development team I've been working with, if anyone can do it, it will be NextGen. But they are also undergoing development of their next software release that expands their functionality in many areas including substance abuse residential functionality that is needed to expand their ability to adequately offer inpatient modules and their team essentially is working around the clock to make both pieces move forward as needed.

Due to this ongoing development, I have been working with some extremely knowledgeable peers, one from the Stark County Board system, Partner Solutions, and another from OSIS, Ohio Shared Information Services, to get assistance in creating a trigger to provide similar functionality until NextGen can provide a permanent solution. However, after sending test files to Medicaid, we discovered there were additional modifiers needed in particular situations that we were unaware of and the trigger needed further development.

The other vendor I'm testing for is only currently testing the new EDI file structure at this point. Their functionality changes to accommodate the changes will not roll out into their client test systems until June 14th, which means their agencies will not be able to send test files based on the actual functionality changes until June 14th at the earliest. And I also found out that their planned update to their client's production systems is planned for June 28th. The amount of customization an agency must do at that point to modify the system, based on the lines of service they provide and their provider structure, makes this timeline unattainable. In addition, I know from speaking to them directly that their functionality delay, is due for the most part, to the change in functionality for the Supervising NPI previously mentioned. I honestly believe many vendors, including this one, may still be working under an incomplete or possibly incorrect understanding of how this policy change should work in relation to the functionality of their system due to all of the recent policy changes.

At the May 24th EDI workgroup meeting, we were seeking information about the changes and demonstrating variances between the new behavioral health manual, the posted coding workbook and a coding modifier workbook that was provided to us. In other words, we found inconsistencies between the information available to us and the information we are being told is needed for claims to be paid. The final redesign meeting held last week reinforced the fact that incorrect information is still posted on the Medicaid redesign website and the guidance we received was to revert to the information in the manual rather than the official coding workbook provided by the state.

Also at this meeting, we asked for information on testing to include how many Trading Partners have tested, how many Medicaid providers they tested for, a pass/fail percentage as well as a reimbursement percentage of billed verses paid claims. We were only able to obtain that 6,000 test claims have been processed. We feel getting this information is critical to determine whether or not ALL agencies and vendors are ready. Redesign is 31 days away.

Recently, I spoke to an agency who plans on being prepared financially to not be able to bill for the next 6 months because they do not believe their vendor will be ready. **Think about this**…. How many agencies can sustain not being able to bill for one month, let alone 6? That is simply not an option for this agency or any other that I'm aware of. The vendor this agency uses is not a vendor I am currently testing for but I have worked with them in the past. I do not know their plans for the redesign and neither do their clients. Their standard answer is "We will be ready" however they do not state how or provide training to the agencies they serve on how to adapt to the changes.

In addition, I reviewed another software's official redesign documentation they are providing to their client base. In a quick, 5-minute review, I found no less than 8 incorrect or inconsistent statements within their redesign plans that do not correctly correlate to the required changes for the redesign. Between these 4 software vendors, they provide software to almost 150 agencies across Ohio.

According to an editorial in the Akron Beacon Journal, the Summit County Alcohol, Drug Addiction and Mental Health Services Board states they are ready and have resources in place to meet the current deadline. I think it's important to ask a few questions about that statement. What software do they utilize, how many agencies do they serve or what is the size of the organization they represent and are they willing to share their plans for the functionality or the results of their testing to date so we can have an idea of the complexity of the type of billing they do and gauge the success of their solution?

Yes, I have been able to successfully bill test files for any agency I am testing for, however, my completed testing **CANNOT** be counted as successful for the redesign. The certificate I received for "Successful Testing" is essentially incorrect. The functionality needed to meet the changes simply does not exist in either system and it is only because of my knowledge of the redesign changes, my experience in behavioral health billing and the tools I utilize from EMS Healthcare Informatics to work around system deficiencies that these files are passing. In addition, the reimbursement percentage for my test files range from 25%-70% not the 96%-98% the agencies I work with usually receive.

Also, there are 146 Behavioral Health Agencies with no affiliated providers. This is a **REQUIRED** first step in the process to initiate the Redesign coding changes. An agency without affiliated providers will not only be unable to bill as of July 1st, we found out last week that they will be unable to request a prior authorization, which is required for a number of services.

What does this mean to Ohio behavioral health agencies and the communities they serve?

It means that as of July 1st, a small percentage of agencies will be able to bill. The fact is, most agencies don't have the level of experience to navigate the technical knowledge that is necessary to make this work if their software is not ready. So by August 31st, smaller behavioral health agencies in Ohio and perhaps larger ones, will be in financial trouble. When, not if, they dissolve, the impact to their communities will mean less access to service, longer wait times for treatment, and the public will not receive the treatment they need. This decreased access to service will inevitably lead to increases in crime, increased overdoses, and potentially an increase in alcohol and drug and mental health related deaths because people suffering with these diseases can't get access to care. Not one of the systems I am testing from or have working knowledge of, have current functionality in place to meet the redesign needs today.

Let me close with the fact that I agree the proposed changes to behavioral health are needed for us to be compliant with national coding standards. And I must say the state departments involved have faced huge challenges in developing these changes and done an excellent job at listening to stakeholders and ensuring the changes do not negatively impact agencies. I've been very impressed with the entire team at the state level that I have worked with over the last year and a half as they build, develop, and provide training on these changes.

The fact is that once the Ohio rules that drive these changes are finalized, vendors and agencies should have 6 months to develop software, train billing staff and implement the necessary clinical changes at the agency level. That's why I respectfully request that you, as representatives for our state and the communities we all serve, please give serious consideration to HB 49 and the requested delay of the BH Redesign and the move to Managed Care to January 1st, 2018 and July 1st, 2018 respectively.

Sincerely,
Teresa Heim
Behavioral Health Billing Solutions, LLC