BHBS *Behavioral Health Billing Solutions, LLC.*

I'd like to thank you for your time and attention today. My name is Teresa Heim and I am the CEO of a Behavioral Health Billing Consultation and EHR Implementation agency, Behavioral Health Billing Solutions. I have provided testimony to the Senate Finance Committee in the past, regarding the Redesign. My intention at the time was to help provide a different perspective of the challenges created by the coding changes.

Today, I am here for a different reason. My company works with a number of clients on a variety of software packages, and we are currently working with each to test their software to ensure readiness. This includes clinical training, software set up, scenario testing, and extensive EDI file review. Not all of their software packages are ready so we are working with them to get them up and functional.

Testing opened with Medicaid on October 25th and as of November 6th, 65 out of 650 agencies have sent test files. 243 Beta Testers signed up and I have been told that at least one agency was denied the ability to beta test because their software wasn't ready. If this is true, technically no agency should be prevented from beta testing regardless of software readiness.

In May, I asked specifically for several items related to testing:

- **How many files passed or failed?**
- **What is the reimbursement percentage on the passed files?**
- **And how many Medicaid providers have tested?**

Today, I still have many of the same questions. I know how many have tested, but I also know how many agencies are in Ohio, and in my opinion, an assumption cannot be made that the 585 agencies that have not tested are or will be ready by January 1st. Just because agencies are not testing, does not mean they are ready.

I have reviewed the common error list provided by Medicaid. It includes billing the current code set, billing decimal units instead of whole units, billing for clients who are ineligible, and much more. These three concern me, because they represent a lack of knowledge of the changes, as well as inconsistent skill sets within the agency billing departments.

At the EDI meeting on November 8th, several changes were made to coding and provider submission. These changes obviously impact vendor readiness. The most challenging revision involves dual providers. Fortunately, several of the software providers we work with have a viable solution for allowing dual providers to perform MH and SUD services. The vendors I am referring to are:

- **Accumedic** – Offers Behavioral Health, an OTP module, offers Developmental disability billing, full residential templates and billing of per diems, integrated with primary care and some of the best reporting I've seen in a software. Appr. 5 agencies
- **Streamline** –Specializes in Behavioral Health, I believe they offer development disability and have plans to add primary care. Best redesign functionality I've seen. Offers a date variable upload of the redesign changes upon request. Appr. 5 agencies.
- **NextGen**- Full spectrum software with a Behavioral Health module. Fully functional for Redesign, dependent upon the stage of your implementation and the assistance you are receiving. Appr. 30 agencies
- **Carelogic/Qualifacts** - although this software requires an additional license purchase and the provider to log out of one session and into another to provide the other type of service, they can provide dual provider functionality. This I can tell you from experience is a challenging venture, however they are redesign ready. Appr. 90 agencies.

Combined 130 agencies out of 650

I want to stress that I know there are other vendors who are ready, however I can only speak to the ones I work with or know of and have seen their plans for the Redesign. One of our client's is using one of these vendors and we have been aggressively addressing the Redesign changes for the last two years. We have weekly meetings, work closely with their development team, and continue providing clinical training. They will be able to bill, however as a larger SUD agency it is a huge undertaking. We are on our third round of clinical testing due to errors discovered during the first two runs.

Other available software packages I am aware of are:

- Xact Claim and Echo – Appr. 20 agencies
- ProComp – Appr. 40 agencies

I have been told by various colleagues that two of these software providers have plainly stated that they are not currently ready. The other I am currently working with a client on beta testing and they have invested a tremendous amount of time and effort on development and training, to be Redesign ready. However, they are not prepared to address the dual provider issue. And we have found that if the agency is on an older version of this software, the Redesign development changes are causing glitches, which have to date prevented us from testing. From a clinical standpoint, we have yet to address the newest revisions to clinical data entry. However, I am confident that we will get it working, but it is unlikely that we will be clinically testing before the testing period ends on November 30th.

We need the coding change. All of us agree we need to be Nationally Compliant, and most of us are excited about some of the new service offerings. But we need to ensure that all agencies are successful, and I have a few suggestions to consider:

1. **Remove the education level requirements. Pick one and have agencies use that modifier. This requirement adds a level of complexity that is unnecessary. The financial impact is inconsequential to Medicaid.**

2. **Provide a mechanism to accurately track all incoming test files and report on Pass vs. Fail and actual reimbursement percentage. We have a way to do this and do it with every client. Medicaid should have an independent contractor tracking and reporting testing results.**

3. **Keep testing open through go-live and until JMOC approves that the beta testing cycle is successful. Testing has always been available up to go live date and this time, it's more critical than ever.**

4. **Adjust the go-live date to whenever JMOC approves the beta testing process and deems it successful. All agencies are at different stages in this process dependent on the software they use. The additional requirement of registering all providers is a significant burden, in addition to contracting with MCO's. However, realistically, the functionality requirements are easier for the July 1st go live. More software can manage billing with an NPI then implementing the use of various licensure modifiers.**

5. **Make the authorization process an online portal, not a form as it currently is with Managed Care. Realistically, we could use the MITS portal we were trained on and have transmissions from the Medicaid portal to the Managed Care agencies.**

6. **Stop making policy decisions that result in functionality changes.**

If we don't seriously consider making some immediate changes to the timeline and process, BH Redesign will fail, including the MyCare plans. I receive regular requests from MyCare agencies asking me to send test files. They are struggling because agencies are not testing with them.

I estimate that over half of the agencies in Ohio will not be able to maintain the current billing and reimbursements and we will see an almost immediate impact with access to services. We are number 1 in the nation for the opioid epidemic**. We cannot afford to decrease access to care**.

We have options to consider. I understand how much time, effort, sweat and tears, the State of Ohio has put into these changes. My goal is to make this a successful change, not hinder or even delay it. I'm willing to do whatever I can to provide assistance to agencies or at the state level, in order to make this work.

Sincerely, Teresa Heim, Behavioral Health Billing Solutions, LLC