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To: Credible Documentation
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Behavioral Health Software



Industry News

DEAR CREDIBLE,

Based on Partner surveys and user group feedback, Credible is now providing monthly updates on billing and payer, clinical, and industry news to help keep our Partner community up-to-date. Below please find our monthly updates focused on industry oriented news. You can find all previous updates for billing and payer, clinical, and industry news in Credible Help under General Information > Release Notes and Communications.

Legislative and Regulatory News

Senate ObamaCare repeal bill falls in shocking vote

Source: thehill.com

In a shocking vote, the Senate rejected a scaled-back ObamaCare repeal bill. This is a major defeat for GOP leaders and their seven-year effort to repeal the health law. The Senate voted 49-51 against the "skinny" bill, which would have repealed ObamaCare's individual and employer mandates and defunded Planned Parenthood. Sen. John McCain (R-Ariz.) provided the crucial vote against the bill, alongside GOP Sens. Susan Collins (Maine) and Lisa Murkowski (Alaska).

Senate ACA replacement bill dies after more senators withdraw support

Source: modernhealthcare.com

Following the announcement by two Senate Republicans, Utah's Mike Lee and Kansas' Jerry Moran, that they won't vote to advance the revised GOP bill to repeal and replace the Affordable Care Act, Majority Leader Mitch McConnell may have to follow through on his warning to Senate Republicans that the next step on healthcare is negotiating fixes to ObamaCare with Democratic Minority Leader Charles Schumer. McConnell previously said that if the repeal effort fails, Republicans will have to work with Democrats to craft fixes in the ACA-regulated individual insurance markets.

The GOP healthcare plan just got more brutal poll results

Source: businessinsider.com

The Republican healthcare plan proposed by the House and Senate is not getting much support from the American public. A new poll from Morning Consult and Politico found that many Americans don't think the GOP healthcare push will result in better outcomes for the healthcare system or for themselves. The Polls show the House bill to be among the [most unpopular of any major piece of legislation in the last two decades](#). Overall, 44% said that the US healthcare system would be worse off under the GOP legislation, while 28% said it would improve. 45% of the American people believed the Republican healthcare plan would increase their personal costs, while only 21% thought it would decrease costs. The Congressional Budget Office said in its analysis of both the House and Senate bills that premiums for people in the individual insurance market [would be lower than the current baseline](#) by 2020, but out-of-pocket costs would increase.

Bipartisan bill aims to ease meaningful use requirements

Source: connectedcarewatch.com

Supporters of a bill submitted to the U.S. House last Friday say the legislation will ease the burden put on healthcare providers by the meaningful use electronic health records (EHR) incentive program requirements detailed in the HITECH Act.

[H.R 3120](#), introduced by Texas Republican Rep. Michael Burgess, MD, eliminates language from the HITECH Act mandating progressively stringent meaningful use measures. Burgess said in a statement, "Electronic health records have failed to live up to their promise to improve healthcare delivery for patients." "Unfortunately, current law places an arbitrary requirement on the Secretary of Health and Human Services to impose an increasingly stringent burden on physicians' use of these records systems." Burgess, chairman of the House Committee on Energy and Commerce's health subcommittee, added, "This bipartisan legislation provides a common-sense solution for a burden that negatively impacts both patients and providers, resulting in better care." Politico [reports](#) that the "simple one-paragraph bill eliminates part of a sentence in the 2009 HITECH Act that requires the HHS secretary to create 'more stringent measures of meaningful use' over time."

Mental healthcare in the crosshairs of Senate health reform bill

Source: modernhealthcare.com

Experts say that the Senate GOP bill to repeal and replace the ACA could reverse progress in expanding access to behavioral health and substance abuse treatment. An analysis conducted by the Congressional Budget Office (CBO) found that under the Better Care Reconciliation Act, 22 million Americans would lose coverage, and federal Medicaid spending would be cut by an

estimated \$772 billion, or 26% by 2026. Additionally, 15 million fewer people would be on Medicaid by 2026. Advocates for mental health fear large cuts to Medicaid because it is the single largest payer for mental health services, and it would allow states to waive the ACA's requirement that commercial insurers and Medicaid plans cover benefits such as mental health and substance abuse treatment. Medicaid covers more than a quarter of all spending for mental health and substance abuse services. The Senate bill allows states to seek waivers that would grant health insurers the option not to cover benefits such as mental health and substance abuse treatment. Those changes could remove the ACA's limits on patient out-of-pocket costs.

SC hospital to pay \$1.3 million for not properly treating emergency psych patients

Source: modernhealthcare.com

AnMed Health, a not-for-profit three-system hospital based in Anderson, South Carolina, has agreed to pay \$1.3 million to settle federal allegations that in 2012 and 2013 it held patients with unstable psychiatric conditions in its emergency department without providing appropriate psychiatric treatment in 36 incidents. This is largest-ever settlement in a case brought under the federal law requiring hospitals to stabilize and treat patients in emergency situations.

Market Intelligence

Whistleblowers: United Healthcare Hid Complaints About Medicare Advantage

Source: khn.org

United Healthcare sales agents in Wisconsin filed a lawsuit against United Healthcare Services Inc., the nation's largest private Medicare Advantage insurance plan, alleging the insurer concealed hundreds of complaints of enrollment fraud and other misconduct from federal officials as part of a scheme to collect bonus payments it didn't deserve. A federal judge unsealed the lawsuit, first filed in October 2016, which accuses the giant insurer of keeping a "dual set of books" to hide serious complaints about its services and of being "intentionally ineffective" at investigating misconduct by its sales staff.

CMS proposes chopping \$1B from home health reimbursement over two years

Source: modernhealthcare.com

The CMS is proposing to drop reimbursement for home healthcare agencies in the Medicare program, including a \$950 million cut for 2019 for the fourth straight year. The CMS [proposed a 0.4% decrease, or \\$80 million](#) cut for the providers in 2018, less than \$130 million that was cut in 2017. The CMS is also proposing a major change in how it pays for home health services. Medicare now pays for up to 60 days of home health services if a physician certifies the patient need and submits a plan of care. Most of the cuts were [called for in the ACA](#), which mandated the reduction to address Medicare overpayments for home health services dating back to 2000. The CMS cut payments by \$260 million for 2016, \$60 million for 2015 and \$200 million for 2014. Starting Jan. 1, 2019, the CMS is proposing to reimburse for home healthcare in 30-day episodes as there is evidence more home healthcare is received in the first month of authorization. Overall, the CMS found that the average length of home healthcare was 47 days, but roughly a quarter of all 60-day episodes of care lasted 30 days or less.

Molina to lay off 10% of its workforce

Source: modernhealthcare.com

Medicaid health plan Molina Healthcare sent an internal memo to their employees early this week stating that they plan to lay off 1,400 employees, or 10% of its workforce, over the coming

months to try to offset losses from its ObamaCare exchange business. Interim CEO and Chief Financial Officer Joe White said in the memo, "The cuts will be across-the-board, including senior leadership," and "As part of our drive for operational efficiencies, we are simplifying our organizational structure and reducing the size of our workforce. This was a very difficult decision, and one that I do not take lightly."

Four health systems on the brink of dropping payers

Source: beckershospitalreview.com

Listed are four health systems on the verge of ending in-network agreements with payers.

- Annapolis, Md.-based **Anne Arundel Medical Center** and Baltimore-based CareFirst BlueCross BlueShield may [end](#) their in-network agreement due to reimbursement di AAMC said it will terminate its contract if the two sides fail to reach a resolution by Sept. 30.
- Oklahoma City-based **Integrus Health** and Tulsa-based Blue Cross Blue Shield of Oklahoma [reached](#) a stalemate in contract negotiation An in-network agreement between the payer and provider concludes Aug. 31. The parties are in a 60-day contract extension period, but all Integrus hospitals and ancillary facilities will be out-of-network with BCBSOK by Sept. 1 if a resolution is not inked.
- Asheville, C.-based **Mission Health System** [plans](#) to leave Durham-based Blue Cross and Blue Shield of North Carolina's network by Oct. 5. Some Mission Health physicians would remain in-network with the payer until March 2, 2018, if a resolution is not reached.
- **Cleveland Clinic** said CareSource, a Dayton, Ohio-based Medicaid managed care plan, may [end](#) its in-network relationship with the clinic. If a resolution is not inked, affected policyholders would lose in-network access to Cleveland Clinic Sept. 1.

UnitedHealth 2Q profit surges as ACA participation shrinks

Source: miamiherald.com

Second-quarter earnings for UnitedHealth Group skyrocketed as the nation's largest insurer dove deeper into government-funded health coverage like Medicare and Medicaid and continued to distance itself from the ACA insurance exchanges. CEO Stephen Hemsley promised analysts that his company would have no meaningful exposure to the exchanges this year. Other big insurers like Humana, Aetna and the Blue Cross- Blue Shield carrier Anthem have since left the exchanges entirely or scaled back their presence in that market, which allows people to buy individual insurance with help from an income-based tax credit. Partially due to the dwindling competition, the exchanges are expected to give consumers fewer choices and higher prices in many parts of the country when 2018 enrollment starts this fall.

Senate Requests Return of \$729.4M in Overpaid EHR Incentives

Source: ehrintelligence.com

Members of the Senate recently issued a letter to CMS Administrator Seema Verma requesting that the federal agency recover approximately \$729.4 million in overpaid EHR incentive payments. Senator Orrin Hatch (R-UT) and Senator Charles Grassley (R-IA) co-authored the letter as Chairman of the Committee on Finance and Chairman of the Committee on the Judiciary. The Office of Inspector General (OIG) reported a large sum of inappropriate payments and was investigating whether CMS was sufficiently overseeing the Medicare EHR Incentive Program and making EHR incentive payments according to federal requirements. As a result of

its investigation, OIG provided CMS with [six recommendations](#) to resolve the listed issues. CMS concurred with four of these recommendations but only partially concurred with two of them.

Fraud and Billing Mistakes Cost Medicare and Taxpayers Tens of Billions Last Year

Source: khn.org

James Cosgrove, a top congressional auditor who directs health care reviews for the Government Accountability Office, testified for the House Ways and Means oversight subcommittee that Federal health officials made more than \$16 billion in improper payments to private Medicare Advantage health plans last year and need to crack down on billing errors by the insurers. Cosgrove testified that the Medicare Advantage improper payment rate was 10 percent in 2016, which comes to \$16.2 billion adding in the overpayments for standard Medicare programs. The tally for last year approached \$60 billion, almost twice as much as NIH spends on medical [research](#) each year. Cosgrove stated that “Fundamental changes are necessary” to improve how the federal Centers for Medicare and Medicaid Services ferrets out billing mistakes and recoups overpayments from health insurers.

CMS looks to launch behavioral health pay model

Source: modernhealthcare.com

CMS announced that its Innovation Center would like to design a payment or service delivery model to improve healthcare quality and access for Medicare, Medicaid or Children's Health Insurance Program beneficiaries with behavioral health conditions. The model may address the needs of beneficiaries battling substance use or mental disorders. It could also target Alzheimer's disease and related dementias. The Innovation Center will be [soliciting ideas at a public meeting](#) on Sept. 8 at CMS headquarters in Baltimore.

Kaiser Permanente Health Plan Falls Short on Behavioral Health

Source: healthpayerintelligence.com

A survey released by the California Department of Managed Health Care found that Kaiser Permanente's health plan does not adequately ensure that patients can access behavioral health services in a timely and effective manner. [The report](#) identified six major deficiencies in the plan's behavioral healthcare services division, adding to shortcomings that led to a \$4 million fine in 2013. Kaiser is bound by California's [timely access laws](#), which state a patient must receive care within 48 hours for an urgent problem, or wait no more than 10 days for an appointment with a mental health provider.

Aetna threatens to exit Illinois Medicaid over budget crisis

Source: modernhealthcare.com

Aetna Better Health, subsidiary of Aetna, which the state of Illinois owes at least \$698 million, has given the state notice that it plans to terminate its Medicaid contracts. Aetna spokesman T.J. Crawford wrote in an email today, "We have filed notices of intent to terminate our contracts but hope those terminations will ultimately be unnecessary upon resolution of the current Medicaid funding crisis."

Aetna's exit would be the latest casualty of a chaotic state budget standoff that has left \$14.7 billion in overdue bills. For Illinois Medicaid, the loss of a big insurer would mean a major shift. The roughly 235,000 low- income and disabled recipients Aetna covers would have to be moved to another health plan that might not have the same network of doctors and hospitals. Aetna estimates that Illinois will owe the insurer more than \$1 billion by the end of October, and nearly \$1.3 billion by the end of 2017, which includes interest for late payments.

As Seniors Get Sicker, They're More Likely to Drop Medicare Advantage Plans

Source: khn.org

A recent report by the Government Accountability Office adds to recent criticisms that some health plans may leave sicker patients worse off. The GAO report reviewed 126 Medicare Advantage plans and found that 35 of them had disproportionately high numbers of sicker people dropping out. Patients cited difficulty with access to “preferred doctors and hospitals” or other medical care as the leading reasons for leaving. James Cosgrove, director of the GAO’s health care analysis, said “People who are sicker are much more likely to leave than people who are healthier.” The GAO urged federal health officials to consider a large exodus from a plan as a possible sign of substandard care. Most of the 35 health plans were relatively small, with 15,000 members or fewer, and had received poor scores on other government quality measures. Medicare Advantage plans now treat more than 19 million patients, and are expected to grow as record numbers of baby boomers reach retirement age.

Thank you for your continued Partnership,

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Mission: Improve the quality of care and lives in Behavioral Health
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