The Second-Quarter Divide: MA Operations Fared Well, While Medicaid Plans Stumbled

It has been a tale of two markets, with divergent trends in the initial batch of second-quarter earnings results reported by government-program health insurers. The carriers reporting so far generally have posted strong Medicare Advantage and Part D results, but ailing managed Medicaid bottom lines as new markets there have come with very high cost ratios. The exception on the MA side was Humana Inc., which accelerated its reporting date to disclose MA earnings problems (see story, p. 7), prompting securities analyst Carl McDonald of Citigroup Global Markets to say “this is the first time we’ve seen anyone stumble on Medicare Advantage this year.”

The reporting insurers all voiced optimism about future results in both the Medicare and Medicaid markets, with the common caveat that utilization, particularly at the outpatient-services level, has resumed going up. Optimism notwithstanding, stock prices of several of the reporting insurers got hit as the details, particularly on the Medicaid side, left some investors concerned.

Perhaps one example of all the trends was WellPoint, Inc., which on July 25 lowered its full-year 2012 earnings guidance even while reporting a slight increase in per-share net income, to $2.04 a share in the second period of 2012 from $1.83 a share in the year-ago period, excluding extraordinary items in both periods.

On the plus side of WellPoint’s results, the company posted gains in its Senior unit’s operating results, including 19,000 members added in the second quarter. Chair and CEO continued on p. 5

Aetna Gets Pact to Move 226,000-Member Teacher Retirement Plan From ASO to MA

In what could be one of the largest shifts of an employer’s retiree medical plan to Medicare Advantage, Aetna Inc. said July 17 it obtained a contract to convert its current administrative-services-only (ASO) plan for the Teacher Retirement System of Texas (TRS) to MA effective Jan. 1, 2013. The change for the 75-year-old retirement system, an Aetna client for more than 25 years, affects more than 226,000 retired public school employees and dependents who may move to an MA PPO with an extended service area (ESA).

While TRS is not the first large state teacher retirement plan to move to MA, notes consultant Jean LeMasurier, senior vice president, public policy at Gorman Health Group, LLC, it may be another indicator that employers finally are beginning to step up the pace in long-awaited moves of retirees to both MA and stand-alone Medicare Prescription Drug Plans (MAN 5/24/12, p. 1). Changing to an MA PPO rather than an HMO, LeMasurier says, is an “easier shift” for a retiree plan such as TRS that is accustomed to provider choice.

The TRS MA plan, according to materials distributed to plan members and obtained by MAN, provides for automatic enrollment of current beneficiaries in the ASO plan but allows those beneficiaries to opt out. However, those who do opt out will have a plan year ending next Aug. 31, meaning they will have a shorter period to meet deductible and
coinsurance requirements before incurring new annual deductible and coinsurance obligations.

The materials describing the changes, including an article in the TRS member newsletter, tout “richer benefits, including lower deductibles, and lower premiums.” They explain that TRS members in an MA plan can opt for providers in or out of the plan’s large network without incurring larger cost sharing as long as the providers are willing and eligible to accept the plan. “Historically, more than 90% of retiree medical services provided to TRS-Care participants were from providers who have accepted Aetna’s Medicare Advantage plans,” the brochure for TRS members adds.

The conversion of current eligible TRS commercial ASO beneficiaries to the new MA product “could yield over $800 million of additional Medicare premiums in 2013, subject to the number of members that convert,” Rick Frommeyer, head of group Medicare at Aetna, tells MAN. That figure, Chairman and CEO Mark Bertolini said in Aetna’s July 31 second-quarter earnings call with investors, is based on converting 60,000 to 70,000 of the beneficiaries to MA, but the insurer would not forecast how many beneficiaries actually will convert.

The move of employer retirees into MA plans, says Frommeyer, “is a trend we have seen already in recent years in the commercial Medicare space. In addition, there’s a growing opportunity in state and municipal governments to address their unfunded retiree health obligations, which are estimated to be $600 billion and severely stressing state budgets.”

Asked about the oft-mentioned hesitance of employers to pull the trigger and make the long-contemplated moves to MA, Frommeyer replies, “We did see a fair amount of inertia among large employers this year, as many wanted to learn more about the Supreme Court decision on health care reform before making significant benefit changes. For large employers, the ruling came too late in the year to influence their 2013 benefits, so many chose to defer any strategic benefit changes for another year.”

Despite this, he continues, “in the public sector, states, counties, cities and other municipalities are taking a fresh look at their retiree obligations in light of significant budget shortfalls. Taft-Hartley plans and labor unions face similar challenges. They have multi-year, collectively bargained agreements in place that preclude rapid changes…...We are actively involved now with a number of states as well as smaller municipalities and labor organizations that are trying to develop better solutions for their retirees. Medicare Advantage is proving to be a valuable solution for these employers.”

### Accounting Guidelines Also Spur Moves to MA

There are other factors at work too, suggests LeMasurier, who heads the employer practice at Gorman. She tells MAN that many public retiree systems can no longer afford their promised medical benefits and that Government Accounting Standards Board accounting guidelines furnish incentives for them to shift risk. Among state teacher retirement systems, she says, Michigan, Pennsylvania and West Virginia made earlier moves to MA, although Michigan switched back from its MA private-fee-for-service plan after the 2008 Medicare law resulted in the exit of many PFFS plans.

There are additional incentives for these public retirement plans to shift now, LeMasurier contends, since Medicare Part D coverage has improved through the partial filling in of the “doughnut hole” gap as a result of the 2010 health reform law. While the end of the tax deductibility of the Medicare Retiree Drug Subsidy for employers in 2013 is another reason some retiree plans may shift to MA, it is less of a factor for the teacher retiree plans since they generally are not-for-profit entities, she adds.

Speaking of the overall trend of employer moves to MA, she says, “It’s been a very slow shift over the years.”

Humana Inc. benefited in 2010 from a move of several state retiree populations into managed care, recalls securities analyst Carl McDonald of Citigroup Global Markets in a July 20 research note. In 2011, however, he added, “many employers were preoccupied with figuring out the impact
health reform legislation would have on their active populations, and weren’t really focused on making significant changes to the retiree benefit structure. Humana noted earlier in the year [i.e., 2012] that group retiree interest has picked up quite a bit, while UnitedHealth Group’s is projecting an uptick in enrollment growth due to the group retiree segment.”

Contact Frommeyer via spokesperson Christine Erb at erbc@aetna.com, LeMasurier at (202) 204-6180 and McDonald at carl.mcdonald@citi.com.

**Tufts Touts Benefits of Linking Initiatives in Star-Ratings Efforts**

A strategy of linking risk adjustment, care management, network management and improvements in CMS star ratings makes sense for Tufts Health Plan’s Medicare Advantage operations and could be useful for other MA sponsors as well, the plan’s medical director for senior products told a conference session July 25.

One reason for the linkage, Jonathan Harding, M.D., said at the World Congress Leadership Summit on Medicare in Arlington, Va., is that “programs deferred due to low ROIs [i.e., returns on investment] for one department may become financially viable when combined ROIs are considered.”

Harding noted that Tufts Medical Preferred (TMP) has 92,000 Medicare Advantage HMO members and more than 100,000 total Medicare members when small Medicare products also are figured in. Most of the medical groups in its network, he said, share both upside and downside risk with the insurer. It has major MA operations in regions where the payment rates Tufts receives are in the process of going from $112 per member per month to $95 PMPM within five years, he added.

With that kind of a financial picture, there is a need to “get more out of the programs we’re already doing,” according to Harding. But there are barriers to doing that in such forms as “limited receptive bandwidth among providers and members” to constant efforts by the Tufts MA plan to contact them, he asserted, so there is a need to use those channels more wisely.

With this in mind, he explained, there are incentives to combine TMP’s risk adjustment operations (RAO), for example, with such other functions as case management, quality improvement and skilled nursing facility (SNF) management efforts. Starting with the disclaimer that the examples he was about to give come from several

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organizations and not just Tufts, Harding said there are various ways in which this can work.

In one situation he cited, RAO sends lists of Hierarchical Condition Categories (HCCs) codes used to determine the diagnoses for which the MA plan is paid and risk adjustment factors (RAFs) for the members to the case management department. Case management then checks high-risk member lists for those with high RAfs but no other high-risk case management triggers and reviews the HCCs identified. The case managers use the information to assess risks and prevent first hospital admissions, and the HCCs can suggest which program is most appropriate for the member, Harding said. On the flip side, he added, case management can identify members it is caring for with a “high burden of illness” but low RAfs, and RAO can take that into account in risk-adjustment determinations.

He illustrated the RAO-quality management teamwork with an episode surrounding chronic kidney disease (CKD). TMP data that Harding recalled seeing indicated the MA plan had CKD prevalence about one-quarter of the nationwide rate. Even in the plan’s home state of Massachusetts, which ranks very high in most MA quality rankings, this seemed far too low, he said, so he wondered if it is not being diagnosed frequently enough. Tufts now uses prevalence data to identify service areas where CKD may be underdiagnosed, and the results can both improve quality of care by avoiding complications and also boost risk scores and therefore revenues, he explained.

Similarly, according to Harding, using nurse practitioners to make visits to SNF patients raised quality of care, but the ROI on the extra resources was only “marginal” based on that alone. However, adding coding and HCC training for the persons making those visits, he said,

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**Opportunities Vary Greatly by State for CMS Duals Initiatives**

The “addressable” market for managed care organizations in caring for Medicare-Medicaid dual eligibles is between $86 million and $183 million over the next five years, but the potential for MCOs in the CMS duals initiatives (MAN 6/7/12, p. 1) varies considerably by state, according to Sundar Subramanian, a principal in consulting firm Booz & Company. Speaking at a session of the World Congress Leadership Summit on Medicare in Arlington, Va., July 26, Subramanian presented a map that classified states by their number of duals and the models of integrated care they were pursuing. California, Tennessee and Texas comprised the states with the highest number of duals available for an MCO approach. Contact Subramanian at (718) 419-3082.

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**Opportunities for Managed Care Organizations Through CMS Duals Programs**

(States coded by approach category and market sizing)

![Map of opportunities for managed care organizations through CMS Duals Programs](image)


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boosted the ROI by finding legitimate additional codes to enhance revenues.

Another example he cited involved a member survey TMP conducted with the aid of a vendor to furnish provider-level data useful in efforts to improve star ratings. The survey replies included approximately 4,000 members (out of 40,000 responding) who in completing the survey authorized the plan to contact them regarding medical conditions. Those contacts turned up medical issues such as untreated incontinence, unevaluated falls, and low self-reported health status that are leading to case-management contacts and mailings with targeted health information, Harding reported. The impact of this on star ratings is not known yet, he acknowledged.

With all these kinds of initiatives, he said, TMP will be looking for correlations based on two years of data on such aspects as primary care physician access measures and both emergency room visits and hospital visits. The results of such analysis, which has not yet been done, can help identify medical groups that Tufts needs to focus on, including in coding, he added.

Contact Harding at jonathan.harding@tufts-health.com.

MA Plans Accelerate Enrollment Gains in July, CMS Data Show

Medicare Advantage plans, which already showed strong growth during the first six months of 2012, accelerated that growth rate in July, adding 69,716 lives, according to new CMS data. That brings the total gain so far in 2012 to approximately 965,000 lives, or 7.6%, according to data released by CMS covering enrollments received through June 8.

Nationwide, CMS’s data for the July 1 payment date show 13,587,616 total MA enrollees, up from 13,517,894 as of the June 1 payment, reflecting enrollments accepted through May 11 (MAN 7/5/12, p. 6).

MA Special Needs Plan enrollment increased by 18,683 lives, or 1.3%, to 1,492,657, and Medicare-Medicaid dual-eligible SNP enrollment rose by 13,896, or 1.1%, to 1,230,236, according to securities analyst Michael Wiederhorn of Oppenheimer & Co.

Meanwhile, MA private-fee-for-service (PFFS) plan enrollment fell by 127 lives in July for a year-to-date loss of 65,505, or 11.3%, and now totals 514,598. Stand-alone Prescription Drug Plan (PDP) enrollment totaled 19,839,418 with growth of only 594, down from the 29,069 lives added in June. PDPs have grown by 959,007 members, or 5.1%, since December, the data show.

MA growth continues stronger in 2012 than it was in 2011, when the industry added an average of 53,000 lives per month, analyst Carl McDonald of Citigroup Global Markets said in a July 20 research note.

“Since March,” McDonald added, the industry is growing monthly enrollment at about 54,000 lives on average, which is way up from the 38,000 lives added during the same period last year.” He noted that 3.3 million Americans are turning age 65 and thus Medicare eligible in 2012, up from 2.8 million in 2011.

UnitedHealth Group, which now holds 20% of the MA market, gained the most members in July. Acquisitions of Preferred Care Partners and Medica Healthcare Plans (MAN 3/15/12, p. 1) led to total gains for United of more than 99,000 lives, said McDonald. Excluding the lives from those acquisitions, United has added a total of about 177,000 Medicare lives in 2012 for a 7.6% growth rate, he said.

WellCare Health Plans Inc., which added 2,800 members for the July report, tallied a growth rate of 19%, the fastest in the industry, according to McDonald. WellCare has grown by 25,300 lives this year, aided by its MA Special Needs Plans, which can enroll year-round. Meanwhile, Universal American Corp. lost 400 lives in July and has lost 22,000 lives, or 14%, since the beginning of 2012. These losses primarily are driven by PFFS market exits, said McDonald.

The MA plan growth pace is likely to continue throughout 2012 and into 2013 as increasing numbers of baby boomers become eligible for Medicare and choose MA plans, Jean LeMasurier, senior vice president for public policy at Gorman Health Group, LLC, tells MAN.

“They grew up in PPOs, and most of the [MA] growth is in PPOs,” LeMasurier says. “It’s a more familiar product for baby boomers. Also, premiums for MA plans have been very steady or on the decline, and they can still get a zero-premium plan.”

Contact LeMasurier at (202) 364-8283, McDonald at (617) 247-6312 and Wiederhorn at (954) 356-8312. View the CMS data at www.cms.gov/Plan-Payment/PPData/list.asp.

Quarter Was Mostly Strong for MA

Angela Braly also said in the conference call with investors that “we expect to expand our Medicare Advantage service territory again next year.” The company, Braly added, now has 30 CareMore MA care centers operating, in the wake of the acquisition of CareMore Health Group it unveiled last year (MAN 6/16/11, p. 3). She also reported plans to open another — in Arizona — by year’s end and 12 more in January 2013 — in California, New York and Virginia.

WellPoint had severe earnings problems in MA last year, largely as a result of adverse selection of members of...
its regional PPO in California (MAN 7/28/11, p. 8) that since has been discontinued. “Our senior business is clearly moving in the right direction and will be a continued tailwind for, we believe, multiple years,” said Chief Financial Officer (CFO) Wayne DeVeydt in the earnings call.

“Medicare Advantage results were much improved year over year,” McDonald wrote in a July 25 research note. He estimated the company’s Medicare medical loss ratio (MLR) at 95% in the second quarter, compared with above 100% in California last year.

But the Medicaid operations were another story. “Our state-sponsored operating gain declined from the prior-year quarter as we anticipated it would due to higher medical costs and the impact of state budgetary pressures, particularly in California,” Braly reported. DeVeydt noted that “during the second quarter we saw an uptick in [cost] trend, most notably in outpatient services and physician visits.”

The company’s stock fell more than 12% on July 25, primarily because of WellPoint’s commercial-market woes, and other managed care stocks also slumped that day.

**United Fares Better, but Not Great**

*UnitedHealth Group* seemed to be an exception to the Medicaid problems, perhaps largely a reflection of the states where it operates. President and CEO Stephen Hemsley, in the July 19 earnings call, said the insurer gained 210,000 Medicaid members in the second quarter to finish the period at 3.8 million, pacing a 14% jump in its United Healthcare Community & State unit revenues to $3.8 billion. But even for United, McDonald wrote in a July 20 research note, “margins in the Medicaid segment were below year-ago results.” The company itself noted that payment “rates in some Medicaid venues are even slightly negative” and, unlike in prior years, are not being offset by corresponding reductions in benefits or provider fee schedules.

On the Medicare side where, as on Medicaid, the company does not break out earnings, performance versus the company’s expectations was a little better, executives said in the earnings call. United said its Medicare and Retirement unit, which include MA, stand-alone Prescription Drug Plans and Medicare supplement products, had revenues of $10.1 billion in the 2012 second period, up from $9 billion in the year-ago period.

But there was mixed news for that unit too, since the membership United acquired by purchasing Preferred Care Partners and Medica Healthcare Plans in Florida (MAN 3/15/12, p. 1) was only 65,000 and not 85,000 as anticipated, McDonald said, because United elected to exit certain products and areas.

There was no enrollment gain at all in MA for *Universal American Corp.*, which on July 26 posted membership at the end of the second quarter of 137,900, down from 139,000 on March 31, but some of the firm’s other MA results showed improvement, pointed out analyst Thomas Carroll of Stifel Nicolaus in a July 26 research note. The firm’s MA selling, general and administrative expense ratio, for instance, beat Stifel’s estimate, falling to 13.3% from 14.6% in 2011’s second quarter, he wrote.

The company reported MA operating income for the second quarter of $10.7 million, down from $20.3 million in the 2011 period, reflecting the continued exits from many MA private-fee-for-service markets. Revenue dropped to $397.3 million from $503.0 million. The MA MLR in the second period, according to Universal American’s Medicare Advantage, was 83.9%, up from 82.8% in the year-ago period before adjustments.

In the company’s just-beginning Medicaid-related operations, results of the newly acquired APS Healthcare, Inc. were “weaker than expected” in the second quarter, and they also will be for the full year, Chairman and CEO Richard Barasch said in the earnings call July 26.

**Coventry’s Solid Results Are Hurt by Ky.**

*Coventry Health Care, Inc.* was another insurer posting stronger Medicare than Medicaid results, although it recorded strong growth in both markets. One difference, company data released July 27 showed, was that the MA MLR rose only to 84.1% in the second quarter from 82.9% in 2011’s second period, while the Medicaid MLR soared to 93.3% from 86.9%, largely reflecting problems with new business in Kentucky (MAN 3/1/12, p. 6). Without Kentucky, said Chairman and CEO Allen Wise in the earnings call, the Medicaid MLR would have been 83.5%. MA revenue per member per month, Coventry said, dipped to $902.61 from $909.10 in the year-ago period, while Medicaid revenue PMPM jumped to $248.48 from $218.28.

MA enrollment totaled 253,000 as of the end of June, the company said, up from 219,000 one year earlier, while Medicaid risk enrollment soared to 697,679 from 305,788.

Although Kentucky Medicaid still is a big problem for Coventry and the other insurers in this market, there were signs of improvement at least in Coventry’s case. The MLR there, Carroll noted, dropped from 120.7% in the first quarter to a still-hefty 110.8% in the second period as the company received a partial risk-adjustment payment and a retroactive payment for hospital pass-through costs. And it stands to get a 5.3% rate hike in October.

Wise in the earnings call characterized the showing in Kentucky as “very significant progress.” The company still feels it is owed additional retrospective revenue and will litigate if it doesn’t get that, he asserted. Predicting that the firm will be at least breaking even and likely making a “reasonable profit” in Kentucky in 2013, Wise said Coventry is weeding out various forms of provider and

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Web addresses cited in this issue are live links in the PDF version, which is accessible at MAN’s subscriber-only page at http://aishealth.com/newsletters/medicareadvantagenews.
prescription drug abuse in the state, adding that “it can’t get any worse” there.

It still seems to be getting worse in Kentucky, though, for Centene Corp., which on July 24 reported a worse-than-expected 16 cents per share operating loss (68 cents net loss after an impairment charge) for the second period, largely because of problems with Medicaid operations in that state and the Hidalgo expansion area in Texas. In the second period of 2011, the company posted net earnings of 54 cents a share.

Chairman and CEO Michael Neidorff said in the earnings call that while Kentucky will change effective

**Humana Slashes Guidance in Light of High Cost for New MA Members**

While most of the initial insurers reporting second-quarter results lauded the performance of their Medicare Advantage operations, one big exception emerged late July 30. Humana Inc. moved up its scheduled second-quarter financial results release by one week to disclose that it is cutting earnings guidance for full-year 2012, largely because the costs of its new MA members were much higher than anticipated.

In lowering its earnings-per-share target range for this year to $6.90 to $7.10 from the previous $7.38 to $7.58, the company said the reduction “primarily reflects higher-than-expected individual Medicare Advantage benefit ratios associated with new members and increased utilization for both new and existing members.” In its retail segment, which includes MA, Humana reported a medical loss ratio (MLR) for the second quarter of 84.1% versus 81.4% in the year-ago period.

“One potential cause we are in the process of analyzing suggests that the 2012 [MA] age-in members may not have had access to prior coverage due to the difficult economy, and as a result have some level of pent-up demand which should ease over time,” said Chief Operating Officer Jim Murray in the earnings call with investors. New members, he said, usually cost more at the outset than do existing members since it takes time to assess their risk profile and get their risk scores adjusted. But this situation went beyond that, with new members having an MLR five to seven percentage points above that for existing members.

Wall Street didn’t take well to the disclosures, even though the second-quarter earnings Humana reported — $2.16 a share, down from $2.71 in the second period of 2011 — actually were better than securities analysts had expected. “It was increasingly clear that Humana management had been aggressive and mispriced their retail Medicare book of business for 2012,” said, for instance, Sanford C. Bernstein & Co. analyst Ana Gupte in a July 31 research note. Humana’s stock price by midday July 31 had fallen nearly 15%.

“The crux of the issue for Humana’s stock is the timing of when the company realized its problems,” wrote analyst Carl McDonald of Citigroup Global Markets in a July 31 research note. By that, McDonald was referring to the June 4 date by which MA plans had to submit their bids for 2013. They therefore are still at risk during the full following calendar year for any late-discovered problems.

Analyst Christine Arnold of Cowen & Co. echoed this concern in her July 31 research note. “The magnitude and timing of the Medicare Advantage medical trend issues that surfaced in 2Q12 leave us concerned that 2013 bids likely did not fully capture run-rate 2012 medical costs,” she wrote.

On that count, Humana executives tried to reassure the financial community — partially. “As we began our 2013 bid work in approximately February of 2012,” said Murray in the earnings call, “we had already determined that we needed to make adjustments to address a series of factors before any issues related to 2012 came to light.”

But he also said that “the extent of the trend issues for the 2012 new members was not totally included in our 2013 bids.” It was not till early July that Humana spotted “some additional issues and some trends” while reviewing its June incurred claims, he acknowledged.

The problems did not extend to Humana’s group MA business, Murray stressed. And President Bruce Broussard said that even in the individual MA business, Humana adjusted the benefit package in its bids for 2013 in a way that, while keeping “premium increases to a minimum,” is likely to result in slower member growth next year than in 2012.

Among specific measures, Humana said individual MA enrollment on June 30 was 1,895,800, up from 1,602,500 one year earlier and from 1,640,000 at the end of last year, although 62,600 of the 2012 member gain stems from an acquisition. Group MA membership totaled 388,400 at the end of last quarter, up from 309,700.

Contact McDonald at (617) 247-6312 and Arnold at (646) 562-1322.
Molina Healthcare, Inc. also is in the Hidalgo area and, largely as a result, posted on July 26 second-quarter results that CEO J. Mario Molina, M.D., called “a disappointment.” The company reported a net loss of $37.3 million or 80 cents a share, compared with net income of $17.4 million or 38 cents a share in the year-ago period.

The firm’s MLR in Texas, said CFO John Molina, climbed to 92.3% in the second quarter from 84.1% in the 2011 period, and it was 139% and 146% in the Hidalgo and El Paso expansion areas, respectively. But a new rate hike in Texas “will bring us halfway to breakeven,” and the company expects to get the rest of the way by year’s end, he added.

Contact McDonald at carl.mcdonald@cit.com and Carroll at tacarroll@stifel.com.

NEWS BRIEFS

◆ Republicans at a July 25 House Committee on Oversight and Government Reform hearing questioned HHS’s legal authority to create the $8.3 billion Medicare Advantage star quality bonus demonstration program. The Republicans alleged that the three-year demonstration program spent more money than is authorized by Congress for experimental initiatives. Jonathan Blum, director of the CMS Center for Medicare, responded that he disagrees with the Government Accountability Office’s (GAO) recent letter “suggesting that there are questions regarding our legal authority for implementing the demonstration” (MAN 7/19/12, p. 8). In the July 11 letter, GAO said that demonstrations under which the payment changes are initiated must meet the criteria set forth in the statute, which include “enabling the agency to determine whether these changes in payment methods increase the efficiency and economy of Medicare services.” Edda Emmanuelli-Perez, GAO’s managing associate general counsel, at the hearing again expressed doubts as to whether HHS had the legal authority to launch the program, adding that it was hard to know because the case law and legislative history are “virtually nonexistent,” according to the National Journal. Queried by MAN about the contentions in the hearing, CMS spokesperson Brian Cook said, “There is longstanding precedent for this type of demonstration, with Republican and Democratic administrations using this authority in this way.” To view the hearing, visit http://tinyurl.com/OversightHearing.

◆ The Florida Pharmacy Association filed a lawsuit July 26 in Leon County Circuit Court against Florida’s Agency for Health Care Administration (AHCA) for allegedly preventing pharmacists from participating in the state’s Medicaid managed care program. The suit by the association, a group of Medicaid patients, independent pharmacies and pharmacists, seeks to stop AHCA from continuing to enter contracts with for-profit managed care organizations that it contends “force Medicaid patients to use only out-of-state pharmacy conglomerates and their affiliated mandatory mail order pharmacies,” thereby leaving local pharmacies out of the equation. The association also asserts that AHCA has violated its own Florida Medicaid State Plan “by denying Medicaid patients the pharmacy access and freedom of provider choice that is rightfully theirs.” An AHCA spokesperson said the agency has not yet received a copy of the complaint, and therefore will not comment on it. Visit www.pharmview.com.

◆ UCare, a Minnesota-based Medicare and Medicaid plan operator, and WellShare International launched a voluntary pilot program called Your Health to help Somali and East African immigrants learn about the western health care system. Your Health is offered at no cost to eligible UCare members of Minnesota’s Hennepin and Ramsey counties, according to the insurer. UCare members who join Your Health receive a one-to-one visit at a location of their choosing, during which a WellShare community health worker offers “culturally competent” communication about the program. During the visit, UCare said, the health worker informs the member about levels of care offered from metro-area providers. The UCare member learns the “how and when” of accessing the types of care available at various sites of care, the insurer added. According to UCare, out of the 12,372 Somali members in these two counties, 6,601 are UCare members. Visit www.ucare.org.
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